Feeding Aversion in Intellectual and Developmental Disability: Identifying and Treating the Root Cause

Jennifer S. Meyer, M.A. CCC-SLP

In 2005, the Surgeon General released a “Call to Action to Improve the Health and Wellness of Persons with Disabilities” where he stated, “Good health is necessary for persons with disabilities to secure the freedom to work, learn and engage in their families and communities.” Proper nutritional intake is a key component in accomplishing this goal. A registered dietitian nutritionist can design a healthy well-rounded menu, beautifully balancing carbohydrate, protein, fat and all necessary nutrients, including a rich variety of healthy, tasty foods; but what happens when the patient just doesn’t like to eat? Feeding aversion is not uncommon in individuals with intellectual and developmental disabilities (Zangen, Ciarla, Zangen, Di Lorenzo, Flores, Cocjin, Reddy, Rowhani, Schwankovsky, Hyman, 2003). All too often, as professionals, we assume it to be an untreatable part of the disability profile and quickly fall back to alternative routes of supplementation or foods/textures (such as puree) that are not as socially appropriate for the patient’s age. While these interventions may help to increase nutritional intake, they reduce sensory input to the mouth necessary for neurological organization across the lifespan (Ayers, 1970), and can reduce opportunities for social interaction at mealtime.

As a Speech-Language Pathologist specializing in dysphagia (difficulty swallowing) and as a Feeding Specialist, I have found that quite often, if we take the time to analyze the root cause of feeding aversion, there may well be facilitations, strategies and/or treatments that could promote improvement of oral intake and, most importantly, enjoyment in eating. (Miller, 2009)

Think of the acronym, SuRF. In order to eat and enjoy the experience, we all need Safety, Respect, and Fun. If any of these is missing, intake will decrease. Let’s start by looking at safety.

Safety
When a patient demonstrates a feeding aversion, we, as the professionals, need to look at what is actually causing the aversion. Most often, the primary cause of reduced intake is pain. Where is the pain? What is the root cause? Physical pain can be due to sensory, motor, medical, or environmental issues. Often, these factors can be reduced when appropriately addressed, thereby improving intake. To make eating more pleasurable, steps should be taken to remediate the underlying issues for future enjoyment.

Texture, Temperature and Taste
When addressing safety, start by assessing the sensory value of foods. This can be the foundation of the physical factors affecting feedings. Foods have different properties that can make them more or less alerting to an individual’s sensory system. Those properties include texture, temperature, and taste.

The least alerting texture is liquid. Unless it has a strong taste or is a temperature other than body temperature, it is difficult to even notice it in the mouth. Think of how unaware you are of your saliva. Crunchy foods can be very alerting. Snack manufacturers spend a lot of time and money getting the crunch “just right” (Drenwoski & Moskowitz, 1985). Even more alarming can be a mixed texture,
From the Chair
Sharon Lemons, MS, RDN, CSP, LD, FAND

Dear Colleagues,

Can I just say that being a leader in a dietetic practice group has been one of the most rewarding experiences of my life? I truly enjoy working with all of the fantastic people on the Executive Committee. I certainly don’t consider myself to be impressive, but I have had the honor to hang around with some really impressive people while working with this group. If you truly want your skills and knowledge to be challenged and to grow, working with the Executive Committee is the place to be. Of course, for me personally, holding the Chair position was a professional goal I set for myself ten years ago. As I finished my internship I answered that questionnaire we were all given. One of the questions was what is your career goal for 10 years from now? I answered; I want to be Chair of DDPD, which of course is now BHN. As they say, the rest is history.

Planning for the Academy’s annual Food & Nutrition Conference & Expo® (FNCE®) for the year you serve as Chair actually starts 2 years in advance. In my case, this came on the tail end of some major changes for me. I had worked in an Early Intervention program for almost 8 years when I was suddenly laid off. My job change took me to the opposite end of the life spectrum, but still working with the Intellectual and Developmental Disabilities (IDD) population. I was amazed. I felt like I was seeing the exact same kids, but in bigger, aging bodies. The phenomenon of dietary needs of the IDD population and Jennifer Meyer is the expert on eating skills and feeding/eating skills and dysphagia that also considered the needs of the individual from IDD that surprised me the most was the nutritional and eating challenges I saw in small children were still present in this older population. From this experience grew the idea for the spotlight session presented at FNCE 2014 by Joan Medlen, MEd, RD and Jennifer Meyer, MA, CCC-SLP. Joan is truly the expert on person centered care throughout the life span and Jennifer Meyer is the expert on eating skills and dysphagia in the special needs population. I knew a session that incorporated the idea for the spotlight session presented at FNCE 2014 by Joan Medlen, MEd, RD and Jennifer Meyer, MA, CCC-SLP. Joan is truly the expert on person centered care throughout the life span and Jennifer Meyer is the expert on eating skills and dysphagia in the special needs population. I knew a session that incorporated feeding/eating skills and dysphagia that also considered the needs of the individual through person centered strategies would make for a fantastic session! I was absolutely right. These ladies were dynamite together. Of course, in the process of planning the three of us have laughed and enjoyed an even deeper friendship. I hope you enjoy the CPE article in this newsletter. As you read it, keep in mind this isn’t just professional to all three of us, it’s personal. We are all Moms of children, some of which are now adults, who have faced some challenges.

While I still have a lot of work to complete before my term as Chair is complete, next year’s events have been in the planning stage for a while now. If you haven’t been involved in BHN before, I encourage you to get involved now. This next year (2015-2016) will have some really wonderful opportunities for our practice group. Adrien Paczoza, RD, LD, CEDRD, is going to rock this group as Chair! Even if you don’t have a lot of time to participate there are positions that can be done from the comfort of your home. I’d love to see someone from each of our four practice areas posting useful information on social media. We have a very active presence on Facebook and Twitter, but could use some additional help with Pinterest and Instagram. We are also going to need a lot more help developing future Fact Sheets for our website. Just imagine you enter into a house to see a kid

continued on page 3
From the Chair
(continued from page 2)

with Congenital Sucrose Isomaltase Deficiency (CSID), but you have never heard of this. Now imagine picking up your smartphone to find the information you need to help this family right at your fingertips. Our goal is to provide Fact Sheets that help you do your job just by signing in and accessing the website. Of course, we want information you can use in all four of our practice areas. Therefore, we need a very very large team to put this together. We are going to need experts on each of these subjects to write and review. We will also need members who have access to research material. (Hint: Students that includes you.)

Coming up in the next few months there will be several webinars. We have worked hard to improve our webinar planning process to bring you relevant high quality information that covers all our practice areas. In addition, we have had the opportunity to provide a few free webinars this year. Look for another free webinar coming to you from the Academy on the Nutrition Care Manual. Also, don’t forget to take advantage of your member benefits which include: Resource Professionals for each of the four practice areas, the Electronic Mailing List (EML), and this newsletter, to name a few. As always if you have ideas on how we can provide more value for your membership, we encourage you to contact one of the members of the Executive Committee with your ideas. We may just find a way for you to be part of making your idea a reality!

In Good Health!
Sharon Lemons,
MS, RDN, CSP, LD, FAND
Chair of
Behavioral Health Nutrition

Feeding Aversion in Intellectual and Developmental Disability...
(continued from page 1)

such as cereal and milk or a broth soup with vegetables. The brain is designed to pay attention to novel signals. If the signal is repeated over and over, habituation or “tuning out” occurs. However, if different types of sensory input regarding the texture are experienced throughout the “oral prep phase” (chewing), the neurological system will be much more aroused.

Warm foods tend to be comforting, while extremes in temperature are more stimulating. Alternating temperatures, as in eating a bite of something chilled, followed by a bite of something served warmed, give the strongest sensory input. Once again, the brain does not habituate to one steady sensory stimulus (in this case, temperature) but is re-alerted with each new bite.

The effects of taste are better recognized (Prescott, 2004), but still poorly understood in this context. Savory foods, usually with higher amounts of umami, and sweet foods are often perceived as comforting, calming, and satisfying, while salty, sour and, especially bitter are very stimulating and alerting.

Many individuals demonstrate issues with registering or processing sensory information from food, such as the texture, temperature or taste, which can lead to difficulty eating. (Mari-Bauset, Zazpe, Mari-Sanchis, Llopis-González, Morales-Suárez-Varela, 2014)

For a hypersensitive individual, the more alerting textures such as firm, crunchy, or mixed consistencies can be overwhelming. Cold foods, or worse, alternating temperatures, can be actually painful. The more alerting tastes such as salty, spicy, sour, and bitter may cause his system to overload. Perhaps softer, bland foods served warm would be more comforting, rather than alarming, and therefore more acceptable.

On the other hand, for a person who is hyposensitive and has difficulty registering sensory input, more calming textures (liquid, puree, mushy, and soft), temperatures (room temperature and warm), and tastes (bland, savory and sweet) may have little impact on her system. A hyposensitive individual may overstuff, be unaware of the bolus in her mouth, and possibly lose control leading to aspiration. For her, we would look for crunchy foods, spike up the flavor with different herbs and spices, and alternate bites of warm and cool. Although mixed textures are actually the most alerting since the brain pays the most attention to novel or changing stimulus, foods such as chicken noodle soup or cereal and milk would not be a good idea. The hyposensitive person is more likely to have diminished awareness of the liquid portion in her mouth or not fully chew the solid portion and choke. Feeding therapy, provided in conjunction with a qualified Speech-Language Pathologist or Occupational Therapist, can often better normalize the registration and response...
to sensory input, making mealtime more enjoyable. An interdisciplinary approach is key. (Silverman, 2010)

Next in addressing safety, we determine whether or not a patient may have motor difficulties in tone or strength.

Tone and Strength

Tone is essentially the degree of tension in the musculature at rest. (Gale Encyclopedia of Medicine, 2008). If tone is too high, it can be difficult to get adequate range of motion. If it is too low, there may not be enough stability or endurance for accurate muscle contractions. Whether tone is too high, too low, or alternating, poor coordination of movements for chewing and swallowing are often the result of inadequate muscle tone. Even silent aspiration can hurt. In addition to tone, strength plays a major role in safe feeding. If a patient has reduced strength leading to poor manipulation of the bolus, the risk of aspiration increases. Refusing meat, the most difficult food to handle orally, is a key sign of reduced strength, and how a patient is able to move her body is a good indicator of how she will be able to move her mouth.

Feeding specialists can provide activities prior to meals to help normalize the tone, at least for that meal, and reduce the discomfort of poorly chewed food, food falling over the tongue and back uncontrolled, and the pain of aspiration. The fine motor movements of the lips, tongue, cheeks, and jaw are dependent on and often reflect the gross motor movements of the trunk and extremities. Activities to strengthen oral musculature, as well as trunk and core stability, are often very helpful. A feeding therapist can use oral sensorimotor activities to help improve the processing of sensory input and the coordination of the motor output to improve eating and reduce aspiration. However, sometimes there are less visible medical issues causing the aversion.

Medical Causes of Feeding Aversion

Individuals with intellectual and developmental disabilities often have concomitant health issues which may or not be related to the condition (Oeseburg, Dijkstra, Groothoff, Reijneveld, Jansen, 2011). Common medical conditions that can cause feeding aversion include gastrointestinal issues, drug side effects, and cardiopulmonary complications. Gastrointestinal issues top the list of “behavioral problem” look-alikes because they are uncomfortable and essentially invisible (Mukkada, Haas, Maune, Capocelli, Henry, Gilman, Petersburg, Moore, Lovell, Fleischer, Guruta, Atkins, 2010). Any condition causing slowed transit through the digestive tract (reduced motility, delayed emptying, constipation) or reverse flow (e.g., gastroesophageal reflux) can be painful, induce a feeling of nausea, or cause dyspepsia leading to reduced intake (Zangen, Ciarla, Zangen, Di Lorenzo, Flores, Cocjin, Reddy, Rowhani, Schwankovsky, Hyman PE, 2003). Medications may also be the cause of feeding aversion.

Many medications affect swallowing. Benzodiazepines such as Klonopin, a common anticonvulsant, and Xanax, an anxiolytic, may suppress brainstem swallow function. Reglan, an antispasmodic motility agent used to treat gastroesophageal reflux, can cause tardive dyskinesia. Antihistamines such as Zyrtec can cause xerostomia, or dry mouth, impairing swallowing and esophageal clearance. (Think of trying to swallow several crackers in a row without any water.) Risperdal, and other antipsychotics, may alter the sensory reception of taste and smell of food affecting appetite and enjoyment. Even asthma medications may cause reflux as a side effect. Very few medications have absolutely no side effects on the gastrointestinal system.

In addition to the previously listed causes, there are other examples of disease leading to feeding aversion. For example, patients with cardiopulmonary issues are often easily fatigued and need strategies to help with energy conservation and selecting foods that are easier to chew. And don’t forget the obvious: dental health. A painful tooth or ill-fitting oral prosthetics/dentures may not look any different at first glance, but can definitely affect one’s

ability or desire to eat. A thorough medical work-up can be very revealing when attempting to remediate a feeding aversion. As a last component of safety, we look at the environmental context of the meals.

The Eating Environment

Our patients do not exist in isolation. They are always within some sort of “family” context whether they are living with their biological family or in the care of others. Stress, depression, fear and confusion are common and negatively impact the feeding dynamic. Anxiety reduces appetite and GI motility through the activation of the sympathetic nervous system. Caregiver education and support are critical in facilitating a positive eating environment. When there are repeated negative experiences associated with eating, whether due to physical or environmental issues, one “learns” to avoid eating. That is why respect is so important.

RESPECT for Patients

Many of our patients are unable to make their “no” understood or are under the belief that caregivers know what is best for them. A very important concept in feeding therapy is “Behavior is Communication.” If a patient is aversive to or refusing foods, feeding professionals need to ask why and try to address the actual problem, not merely reduce the problematic behavior. Show respect by abiding by the “Division of Responsibility” so well outlined by Ellyn Satter, MS, RD, CICSW, BCD (Satter, 2007). Satter explained the caregiver is responsible for the What, Where and When of a meal and the patient is responsible for Whether he eats and How Much. When attempting to control someone else’s eating, we invariably stop showing respect and most often make things worse. Respect can be provided by having predictable mealtime routines with realistic expectations given our patient’s age and/or cognitive and physical limitations. Caregivers should avoid pressuring, which can come in many forms including cajoling, threatening, or bargaining. Eating is supposed to be a fun time of exploration rather than a tense power struggle.

continued on page 5
Feeding Aversion in Intellectual and Developmental Disability... (continued from page 4)

Don’t Forget the FUN

Make meals FUN by encouraging enjoyment of the mealtime process and allowing slow acclimation over time to new or non-preferred foods. For example, we can facilitate exploration and practice by just looking at a food, taking pictures of it, smelling it, touching it, cutting it, stirring it, and so forth away from mealtime and away from any pressure. There are many steps between complete refusal of a food and eating it with sheer delight. Take time to work through these steps slowly, inviting patients to explore and form their own relationships with food. Meals can be made fun by always having at least one preferred food available as part of the meal and showing caregivers how to model enjoyment of various foods. Keep meals enjoyable and low-key. When eating is fun it becomes a self-reinforcing activity that will continue on its own, without our continued intervention.

Bearing all of this in mind, we must not write off a patient’s feeding aversion to simply being an expected part of the disability. As professionals, adhering to professional standards of practice (Cushing, Spear, Novak, Rosenzweig, Wallace, Conway, Wittenbrook, Lemons, Medlen, 2012), we are obligated to assess each person we serve, individually. While tube-feeding and/or texture modifications are helpful and at times necessary, professionals should not fail to address all of the factors involved with the goal of remediating them when possible. There is often much that can be done to improve intake through addressing sensory and motor issues, getting a medical consult and creating a positive environment where safety, respect, and fun are a mandatory part of the experience.

About the Author

Jennifer Meyer has nearly 25 years experience specializing in pediatric feeding disorders, working in Neonatal Intensive Care Units, developing inpatient dysphagia, neonatal and outpatient hospital-based feeding programs and serving as Assistant Clinical Professor at Texas Woman’s University and the developer and Clinical Coordinator of the Center for Assisting Families with Feeding and Eating (CAFFE). Through her private practice, Feeding and Dysphagia Resources, she continues to provide consultation and program development for Early Childhood Intervention Programs and Home Health Companies. Jennifer and her husband are the creators of Care to Collaborate, an online community of therapists dedicated to improving patient care through interdisciplinary cooperation and dynamic research-based education.

References


The Behavioral Health Nutrition DPG Nominating Committee is pleased to announce the slate of candidates for the 2015-16 officer positions:

Chair-elect – Diane Spear, MS, RD, LD
HOD Delegate – Cynthia L Burke, MS, RD, LDN, FAND
Treasurer – Kathryn Russell, MS, RDN
Nominating Chair-elect – Rachel Press, RD

Thank you,
BHN DPG Nominating Committee
Adapting Addiction Treatment Strategies to Binge Eating Disorder

Jessica Setnick, MS, RD, CEDRD

Regardless of your stance on whether or not eating “counts” as an addictive behavior, several addiction treatment strategies can be successfully adapted to help our clients with binge eating disorder. Particularly for patients who have struggled with an addiction and achieved sobriety, these concepts can feel familiar and build on the foundation of recovery that they have already achieved in another area. Transferring their skills to the management of eating can offer some confidence in their ability to change, rather than “starting over” or “starting from scratch.”

Strategy One: Abstinence

Abstinence is the cornerstone of addiction recovery, yet abstinence from food is not compatible with life. Your patient who is in addiction recovery may believe that the only way to stop binge eating is to avoid food altogether, or certain groups of foods. While this may be beneficial temporarily, when taken to extreme it can also become problematic, as avoiding food can also lead to binge eating.

There is an alternative to abstinence from food that can utilize your patient’s understanding of the need to refrain. Abstinence from destructive behaviors can become the foundation of binge eating disorder recovery. Review the behaviors that make up your patient’s eating disorder. Is there one or more that he or she could attempt to avoid until the next session? Even if they are unsuccessful they will gather information that will be useful in the next steps. Some examples of behaviors that a patient may consider abstaining from are eating out of a package rather than a plate or bowl, spontaneous purchases of foods not on their grocery list, eating seconds or thirds without waiting for food to digest, eating when experiencing strong feelings, eating while distracted or in the car, or giving in to peer pressure to eat. Help your patient choose a behavior that is not so challenging that it is impossible, like not bingeing at all.

Strategy One Patient Message: When the substance you abuse is food, abstinence is not an option. Yet the strategies you used in your addiction recovery can help you abstain from some of the behaviors related to your eating disorder.

Strategy Two: Managing Cravings

In our culture where unplanned encounters with food are impossible to avoid, managing cravings becomes essential. Job one is of course eating adequately throughout each day, since hypoglycemia is an undeniable trigger for binge eating. But relatively few of our patients binge eat only as a response to hunger. Uncomfortable situations, people, places and sensations can all be triggers, and identifying the underlying issue and how to solve it is a more advanced recovery skill. In the initial stage of recovery, we can’t expect a patient to be perfectly in touch with internal cues such as hunger and fullness and external triggers that lead them to binge. But we can help them start to withstand cravings for food between meals and snacks.

Ask your patients how they managed their cravings for their drug of choice. What did they do when tempted to drink, or use, or act out in another way? Did they read a book? Call their sponsor? Take a walk? Journal their thoughts? Attend a meeting? Take a nap? Could that behavior be recycled for use during a food craving? Or is there another activity that might be even more effective when used specifically related to food?

Strategy Two Patient Message: Applying the skill of managing cravings is slightly different when the substance of abuse is food, because of the necessity of using food without abusing it. You can’t simply ban it from your life. But you have learned to manage your cravings for your other addiction(s), and you can do something similar with your problem food behaviors.

Strategy Three: Identify Triggers

Any individual who has successfully maintained recovery from a drug, alcohol or other addiction has been trained to notice what incidents, cues or topics tend to precede a craving and then a lapse. Guide your patient in looking back over recent binge eating episodes to identify people, places, situations or feelings that may have triggered a desire to escape. How does the process start? What are the common threads? Only then can you try to avoid those events.

Consider timing: What are the trends? Does it happen when you get home from work or school? Middle of the night? Weekends? After you put the kids to bed? When your wife is out of town?

Consider location: Does it happen at work? At home? At a restaurant? Any restaurant or a certain restaurant? When you are at the grocery store? What about when you’re on vacation or business trips?

Consider people: Does it happen when you eat with certain friend? After a phone call from your ex? When you are with your mother or dad?

Consider events: Does it happen when you get your grades? When you cash your paycheck? After a run-in with the law? A close call? Good news arrives? A doctor’s appointment?

Consider feelings: Does it happen when you are feeling down? Feeling like a failure? Feeling lonely, scared, or unloved? What about feeling sad, disappointed, ashamed or embarrassed?

Each trigger you identify with your patient will lead to alternatives that you can suggest. Pack a lunch instead of eating with your rude co-worker. Take a different way home from work. But there will be some triggers that simply can’t be avoided. A counselor can help your patient to cope with those parts of their life that simple won’t change.

Strategy Three Patient Message: No one successfully recovers from addiction without changing patterns. You can’t expect yourself to go to
Adapting Addiction Treatment Strategies to Binge Eating Disorder
(continued from page 6)
happy hour every day without ever taking a drink. To help yourself avoid the substance or activity that you are unable to control, you learned to avoid triggering situations and people that historically led to using. You can implement this same strategy for your eating disorder recovery.

Strategy Four: Practice Forgiveness and Self-Compassion

Your patient may be avoiding some of the pleasant parts of life because of fear that he or she will “make a mistake” with food. Or they may expect perfection and then feel terrible (and possibly trigger a binge) when they don’t eat “perfectly” all the time.

Teach your patient that perfect eating is an unrealistic goal. Remind them of the Desire Chip they received at their first 12-step meeting and ask how many people they know had a perfect recovery on the first try. Help them understand that although they feel ashamed or anxious when thinking or talking about eating, that you are not ashamed of them. Don’t let a patient call himself names in your office, like “stupid” or “hopeless.” Help your patient understand that their eating behaviors are helpful in a sense, because they serve as a bridge to take them away from difficult situations, people, events, and feelings.

Advise them to forgive themselves for not being perfect, and that perfection in eating is not a worthwhile goal. When a binge eating episode occurs, discuss what happened without shame or blame to learn what could be different next time.

Strategy Four Patient Message: You can forgive yourself for being an imperfect eater and look hopefully toward the future instead of hopelessly at your past. If shame is a trigger for you to eat, beating yourself up about eating can actually cause more bingeing to occur. You are deserving of healing. See if you can make the necessary changes out of love and care for yourself, rather than hate and shame.

As behavioral health RDs, we do not have the luxury of working in a well-researched area with decades of evidence-based interventions. At the same time, this allows us some freedom to explore new and creative ideas. As a dietitian who specializes in eating disorder treatment, I did not know much about addiction treatment until I became involved with Behavioral Health Nutrition (BHN DPG). The year I was BHN Chair, Kevin McCauley and Theresa Stahl spoke on addictions, and the more I learned, the more I detected many commonalities with eating disorders. I invited the foremost addiction therapist in the Dallas area, Mark Bird, to speak at Advanced Eating Disorders Boot Camp so that I (and other RDs) could learn more. I modified his addiction treatment strategies for my eating disorder patients, some who had experience with addiction recovery and some who didn’t. Many found them extremely helpful, particularly those who struggled with binge eating. The natural next step was to put together a presentation for dietitians on using those same strategies, and thus Adapting Addiction Strategies to Treat Binge Eating Disorder was born.

About the Author
Jessica Setnick, MS, RD, CEDRD, is a Senior Fellow at Remuda Ranch at the Meadows and a co-founder of the International Federation of Eating Disorder Dietitians. She looks forward to a day when no one feels ashamed to get help for their eating issues.
Breastfeeding Assists in Prevention of Neurodevelopmental Disorders

By Cynthia M. Johnson, BS, BA

The physical benefits of breastfeeding have long been known. Global efforts to increase the prevalence and duration of breastfeeding have been in place for years. The WHO and UNICEF Baby-Friendly Hospital Initiative (BFHI) has been in place since 1991 in order to “implement practices to protect, promote and support breastfeeding” worldwide (1). America’s Healthy People 2020 includes expanded breastfeeding objectives that include increasing employer-provided lactation-designated areas, and hospital facilities that promote newborn breastfeeding over formula feeding that dovetail nicely with the WHO’s BFHI (2). Research has shown that human development and immunity is benefitted by breastfeeding, citing benefits due to the bioactive compounds found in breast milk as well as the physical contact between mom and baby during breastfeeding. From the first drop of colostrum for the neonate to the mature milk for an older infant/toddler, breast milk is customized for a baby’s unique needs throughout different stages of development. The benefits are not just for baby, either. Physical benefits have been cited for mom as well: lowering the risk of certain cancers, aiding physical recovery from childbirth and allowing for optimal spacing of children to name just a few. However, is there research to support the role of breastfeeding in preventing neurodevelopmental disorders such as ADHD, ASD and even schizophrenia? Interestingly, research does show there are neurodevelopmental, mental/emotional and behavioral health benefits and, much like the physical ones, they are reaped by both mom and baby.

Postpartum Depression

Postpartum depression is a relatively common disorder among new moms, affecting between 10 and 20 percent, and can strike from a few weeks after giving birth to anytime within the first year (3). Research has shown that breastfeeding can reduce maternal stress and reduce depression-linked inflammation. Depression is thought to be associated with inflammation as the underlying factor due to an increased level of proinflammatory cytokines. Proinflammatory cytokines increase during a woman’s third trimester of pregnancy, and as a physiologic response to stress, such as may be experienced by new moms (4). According to a study by Groër and Davis (5), their data suggest that breastfeeding mothers may be receiving some cortisol and related proinflammatory cytokine attenuation due to breastfeeding, from which formula-feeding mothers do not benefit. Additionally, it is well-known that the hormones prolactin and oxytocin, released prior to and during breastfeeding, cause a relaxed and more positive feeling in the breastfeeding mother, which also can lower her risk of developing depression. Studies have confirmed the widely-accepted belief that baby benefits emotionally as well, which contributes to emotional security and bonding.

Bonding and Emotional Security

A 2006 study by Britton, Britton and Gronwaldt suggested a link between emotional security and breastfeeding (6). Additionally, a more recent 2011 cohort study in the UK titled The Millennium Cohort Study followed over 10,000 mother-child pairs from the child’s age of 9 months through age 5, whereby a breastfeeding baseline was determined, and a Strengths and Difficulties Questionnaire regarding their child’s behavior at 9 months and again at 5 years was completed by parents. Most of the children in the study were term at birth, and among those children, the tendency to have fewer behavior-related problems as reported by their parents correlated with increased duration of breastfeeding in infancy (7).

Neurodevelopmental Disorders

An Australian cohort study of 14 years showed that breastfeeding for less than 6 months compared with 6 months or longer was “an independent predictor of mental health problems through childhood and into adolescence (8).” In the case of schizophrenia, an earlier study (2007) in the South African Journal of Psychiatry showed “significant difference in the duration of breastfeeding in patients versus controls,” as well as showing support for the theory that schizophrenia is a neurodevelopmental disorder. Researchers of the study concluded that “Breastfeeding seems to be protective against the development of schizophrenia,” having to do with essential fatty acids (EFA) and their role in brain development (9). Regarding EFAs, an Australian study that was published in 2014 titled Observable Essential Fatty Acid Deficiency Markers and Autism Spectrum Disorder gathered ‘observable fatty acid status’ and breastfeeding histories of participants with Autism Spectrum Disorder (ASD) and compared them to controls, which included “a measure of infant intake of fatty acid-rich colostrum immediately post-partum.” Results showed that “those infants not breastfed (with colostrum) within the first hour of life and who had a history of fatty acid deficiency symptoms were more likely to have an ASD diagnosis (10).” Similarly, studies show the same protective effect of breastfeeding duration against Attention Deficit Hyperactivity Disorder (ADHD). One recent study in Israel conducted on children aged 6-12 concluded that “Children with ADHD were less likely to breastfeed at 3 months and 6 months of age than children in the two control groups (11).” Finally, a study published in April 2014 showed social and developmental benefits of inhaled oxytocin on newborn monkeys, concluding that due to its social benefits on the monkeys, it may be useful in human ASD treatments, which could lead one to conclude that the oxytocin present in

continued on page 9
Breastfeeding Assists in Prevention of Neurodevelopmental Disorders (continued from page 8)

breast milk may confer similar benefits to a breastfeeding infant.

Based on the research cited here, it is clear that breastfeeding provides more than important physical and emotional benefits to mother and baby. It has been shown through research to contribute to preventing negative behavior in children, as well as neurodevelopmental disorders such as ADHD, ASD and schizophrenia. Since there has been an increase in these disorders in recent years, with ASD currently affecting 1 in 68 children according to the Centers for Disease Control, any help we can get in preventing this and other complicated disorders is crucial. However, it is equally important to keep in mind that these disorders are multifactorial in their development, as well as in their treatment. As of yet, there is no one single prevention or treatment, but with overwhelming research supporting the whole-person development and health due to breastfeeding (the longer the better), we would be wise to promote breastfeeding as the first best nutrition. Lactation consultants are adept at supporting breastfeeding efforts and troubleshooting complicated breastfeeding problems. They are available in hospitals and in the community at local WIC offices, and are often available to non-WIC participants. Le Leche League is a decades-old worldwide breastfeeding organization that offers breastfeeding support and resources.

About the Author

Cindy Johnson, BS, BA, is a graduate of University of Northern Colorado’s Dietetics Program. She has been trained as a WIC Lactation Consultant Assistant/ Breastfeeding Peer Counselor who currently works for Warmline Family Resource Center in Sacramento, CA. Cindy previously served as 2013-2014 Student Assistant Newsletter Editor for the BHN Newsletter. She can be reached at cindy.johnson1216@outlook.com.

References


Taking the Focus off Weight in the Dietetics Profession: A Path for New RDN’s

Carly Schott, Dietetic Intern and Lindsay Stenovec, MS, RDN

Introduction

Nutrition and dietetic students are often encouraged to evaluate health based on numbers. Whether it is waist circumference, body fat percentage, or BMI, it is taught that anthropometric measurements can determine if one is living a healthy lifestyle. Nutrition professionals may often find themselves telling patients that in order to improve their health, they must lower their weight by decreasing the number of calories they consume. Is the traditional emphasis on numbers and measurements the best approach for dietitians and their patients? What options exist for students and dietetic interns who believe their philosophies do not align with the weight-focused approach?

An Alternative to the Weight-Focused Approach

In contrast to our attention to the scale is the Health at Every Size® (HAES®) approach, which shifts the focus from weight control to health promotion by encouraging people to adopt healthy behaviors for the sake of health and wellbeing, regardless of their weight (1-5). The HAES® approach supports finding reward in moving one’s body through regular, enjoyable physical activity, and eating intuitively by honoring internal cues of hunger and satiety (2,3). Advocates of the HAES® approach put weight loss on the back burner, and instead learn to accept and respect the natural diversity of body sizes and shapes through the realization that good health can be achieved independent of body size (1-5).

Critics of HAES® principles argue that weight loss is essential to decrease disease risk in obese individuals (1,5). In fact, accumulating evidence suggests that treating obesity through diet-induced weight loss may actually predispose an individual to gain more weight (4,6-10). Diet-induced weight loss can cause compensatory changes in several biological pathways involved in the utilization and storage of energy, as well as in the regulation of appetite (4,6-10). This weight loss can also cause hormonal changes that collectively promote restoration of energy balance by increasing appetite, preferring high caloric foods, and the rewarding properties of food (4,5,9). Hormone changes can persist after the onset of weight regain, predisposing an individual to gain even more (4,5,9).

While it is true that obesity is associated with an increased disease risk, correlation does not equal causation. This association may be due to lifestyle and health aspects that often accompany obesity, such as increased inflammation from weight cycling or stress caused by weight stigma (1,11-13). Healthcare practitioners, including RDNs, also need to be aware of their own weight biases and how this negatively impacts patient care and well-being, particularly patients of higher weight (14-17). In contrast, evidence suggests that shifting the focus from weight loss to behavior change may have a greater impact on health (1,5,17,18). The HAES® approach has been associated with improvements in physiological measures, health behaviors, and psychosocial outcomes (especially related to self-esteem and eating disorders) (1,5,17,18). Studies on the efficacy of HAES® practices have reported improvement of dietary quality and eating behaviors, and, even without dietary restriction, no randomized controlled HAES® study has resulted in weight gain (1,5,17,18).

Recommendations for Implementing Health at Every Size®

With evidence suggesting that incorporating HAES® into dietetics practice could result in improved health outcomes for many, nutrition students and dietetic interns may consider adopting some or all of its principles. How do you implement a HAES® approach? Consider the guidelines set forth by HAES® advocates Linda Bacon, PhD and Lucy Aphramor, PhD, RD (1):

1. Interventions should focus on health, not weight, and should be referred to as “health promotion” rather than “obesity prevention.”

2. Interventions should seek to change major determinants of health that reside in inequitable social, economic, and environmental factors, including all forms of stigma and oppression.

3. Interventions should be constructed from a holistic perspective, where consideration is given to physical, emotional, social, occupational, intellectual, spiritual, and ecological aspects of health.

4. Interventions should promote self-esteem, body satisfaction, and respect for body size diversity.

5. Physical activity and eating should be delivered from a compassion-centered approach that encourages self-care rather than as prescriptions to meet expert guidelines.

6. Interventions should focus only on modifiable behaviors where there is evidence that such modification will improve health. Weight is not a behavior and therefore not an appropriate target for behavior modification.

The HAES® approach to wellness is a promising path for the dietetics profession that has yet to become a standard component of education and training for aspiring RDNs. Due to the present and ever-growing evidence for a health-focused approach, nutrition departments and internships may consider incorporating HAES® curriculum into coursework and practical rotations. For access to books, handouts, and free peer-reviewed HAES® curriculum, including slides and videos created by the Association for Size Diversity and Health® (ASDAH®), the National Association for the Advancement of Fat Acceptance (NAAFA), and the Society continued on page 11
Taking the Focus off Weight in the Dietetics Profession: A Path for New RDN's (continued from page 10)

for Nutrition Education and Behavior (SNEB), visit www.haescurriculum.com. Individuals are more than just body fat percentage, and a patient’s health is more than just a number on the scale. For the sake of health, it is time to try something new.

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About the Authors
Carly Schott, is a dietetic intern scheduled to complete her internship in the Fall of 2014. This article is one product of a 3-week elective rotation on eating disorders, intuitive eating, and the Health At Every Size® approach through the Dietetic Internship at California State University Fresno. Carly is a recent graduate of San Diego State University and currently resides in Clovis, California. She can be contacted at carlyschott@hotmail.com

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Resources

In the BHN Pipeline!

New BHN fact sheets on the topics of depression, ADHD and Autism were a great hit at the FNCE 2014 Showcase. These initial fact sheets are available on the BHN member website at www.bhndpg.org along with a list of topics in each of the 4 BHN practice areas for future fact sheets. There are currently 30 fact sheets in process and volunteers continue to be recruited for a growing number of topics. The fact sheets are downloadable and for education purposes only.

Two Types of Fact Sheets

1. Nutrition Fact Sheets for General Public
Fact sheets for the general public are available for download from the BHN website. The general public fact sheet will coordinate with the RDN fact sheet for like topic.

2. RDN Nutrition Fact Sheets
Fact Sheets for the RDN are available on the BHN website for members only. The fact sheet information will be integrated into the Nutrition Care Manual of the Academy of Nutrition and Dietetics website. The lead author will compile the information for both types of fact sheets for assigned topic. RDN Nutritional Fact Sheets will be updated at least every 5 years or as necessary.

Nutrition Fact Sheet Topics:
Fact sheets are based on one of two topic types.

1. Medical Diagnosis
Examples: Autism, Bulimia, Down syndrome, Cerebral Palsy, Bipolar Disorder, Addictions, etc.

2. Medical Condition or Issue
Examples: Dysphagia, Constipation, Lactose Intolerance, Achieving a Healthy Weight, Celiac Disease, etc.

Contributing Members:

1. Lead Authors: are leaders of BHN, practicing RDN’s, or researchers who oversee the development of the fact sheets and nutrition resources on a specific topic and coordinate the workgroup.

2. Contributing Authors: are practicing RDN’s, nutrition students or others who would like to contribute as a co-author. The contribution author assists the workgroup in understanding the current science and practice of dietetics in the subject area.

3. Reviewers: are experts in the field, possess critical thinking skills, writing ability, in-depth knowledge of the subject and current practice experience.

If you are interested in joining the growing group of author volunteers, contact Diane Spear, MS, RDN, LD at membershipchair@bhndpg.org.
In Search of Evidence

Vitamin B-12 and Mental Health in the News

Ruth Leyse-Wallace PhD, RD


A study from Kaiser reported that patients who took anti-acids/proton pump inhibitors (PPIs) for more than two years had a 65 percent increase in their risk of B-12 deficiency. Risk was dose-dependent: higher doses were associated with an increased risk. While PPIs and histamine-2-receptor agonists (H2RAs) are usually prescribed by physicians, some are widely available over the counter without a prescription. In 2012, about 15 million people received 157 million prescriptions for PPIs.

Proton Pump Inhibitors (PPI):
- Prilosec, Prevacid, Aciphex, Protonix, Nexium, Zegarid

Histamine-2-Receptors agonists (H2RA):
- Axd, Pepcid, Tagamet, Zantac


A rare case report of vitamin B-12 deficiency in an adolescent who was admitted for care was detailed. His history included absence of substance use, infections, stressors, or vegetarian diet habits. Biopsy revealed atrophy of the gastric mucosa with Helicobacter pylori colonization. Observations illustrate the importance of vitamin B-12, folate and homocysteine in carbon-transfer metabolism (methylation) required for the production of serotonin, other monoamine neurotransmitters and catecholamines.

Background:
The symptoms of vitamin B-12 deficiency may include agitation, irritability, negativism, confusion, disorientation, amnesia, impaired concentration and attention and insomnia. Psychiatric disorders that may be diagnosed in patients having B-12 deficiency include: depression, bipolar disorder, panic disorder, psychosis, phobias and dementia. In adult patients, the clinical picture may especially involve affective or psychotic symptoms.

Laboratory evaluations:
- Vitamin B-12 was 166 pg/mL and two subsequent tests after 6–8 hours of fasting were normal (197–400 pg/ml).
- Folate and transcobalamin levels were normal.
- Hemoglobin was found to be 10 g/dL (Normal 14–18 g/dL)
- MCV was 98 fl (Normal 80-100 fl)
- Bone marrow examination did not reveal megaloblastic changes.

Diagnosis:
Mood disorder with mixed psychotic features due to vitamin B-12 deficiency.

Treatment:
Risperidone 0.5 mg/day and intramuscular vitamin B-12 500 mcg/day along with referral for treatment of H. pylori.

Progress:
- Week two: no psychotic features. Risperidone was stopped and parenteral vitamin B-12 treatment continued with monthly injections for 3 months.
- One month: Follow-up endoscopy and biopsy demonstrated eradication of H. pylori.
- Six months: Psychiatric symptoms had not recurred at the time of last evaluation.

Limitations of the evaluation:
Reported as lack of evaluation of small intestine with levels in serum of patient, evaluation of homocysteine levels and testing for mutations in folate-dependent enzyme methylenetetrahydrofolate reductase (MTHFR) and methyl-malonylcoAmutase, celiac antibodies and anti-parietal cell titres.


Elevation of Homocysteine (Hcy) in Depressed Patients with Bipolar Disorder:
Assays of serum concentrations of Hcy, vitamin B-12, folic acid, markers of endothelial function (E-selectin and intracellular adhesion molecule-1 (ICAM-1)), and hyperhomocysteinemia (>15 mM), found hyperhomocysteinemia in 50 patients (45% of population), and significantly more frequently in male (67%) than in female subjects (39%).

Authors stated the prevalence of hyperhomocysteinemia in bipolar depressed patients during an acute episode corroborates the correlation between increased concentration of Hcy and lower level of vitamin B-12 and folic acid reported in this group.


Multiple genetic variants within the folate metabolic pathway contribute to negative symptoms of schizophrenia, which suggests the utility of folate supplementation in these patients. Four variants, MTHFR 677T, MTR 2756A, FOLH1 484C, and COMT 675A, emerged

continued on page 13
Vitamin B-12 and Mental Health in the News  
(continued from page 12)

as significant independent predictors of negative symptom severity, accounting for significantly greater variance in negative symptoms than MTHFR 677C>T alone.

In another report by the same author, folate plus vitamin B-12 improved negative symptoms significantly compared with placebo group.

Negative symptoms of schizophrenia may include:

- Lack of social contacts
- Lack of initiative
- Socially awkward behavior
- Loss of energy or motivation
- Decreased emotional displays
- Discomfort when interacting with other people.

The Potential Role of B12 Supplementation in Dementia and Cognitive Function

Ruth Roberts, LPC, LDN, RDN

B12 is a vitamin that is available in different forms. The two most preferable forms are hydrocobalamin and methylcobalamin while cyanocobalamin is the most widely available and is the form that serum levels are measured. (7) B12 is found only in animal products unless it is fortified in foods, but it is most extensively found in animal foods. Vitamin B12 levels below about 170–250 pg/mL (120–180 picomol/L) indicate a vitamin B12 deficiency in adults. Low folate levels can also contribute to low B12 levels and when increased B12 levels should be reevaluated. (7) B12 is usually determined by serum or plasma and might not accurately reflect intracellular concentrations. A more accurate indicator of vitamin B12 status is elevated serum homocysteine level (>13 micromol/L). This indicator has poor specificity because it is influenced by other factors, such as low vitamin B6 or folate levels. (1) The National Institutes of Health’s Office of Dietary Supplements lists a few foods that are high in B12.(1)

The symptoms of cobalamin deficiency often present as weight loss, lack of appetite, fatigue, constipation and difficulty maintaining balance. B12 deficiency can occur when the body does not get or pernicious anemia in which the body is unable to absorb the appropriate amount of the vitamin the body needs. Older individuals often no longer have the taste for animal protein. Often people over 50 as well as those that have had gastrointestinal surgeries and digestive disorders such as celiac and Crohn’s disease may lose the ability to absorb B12 from the foods they eat. Atrophic gastritis is a condition touching

<table>
<thead>
<tr>
<th>Foods High in B12</th>
<th>Serving size</th>
<th>Vitamin B12 content (micrograms [mcg])</th>
<th>% Daily Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clams, cooked</td>
<td>3 ounces</td>
<td>84</td>
<td>1,402</td>
</tr>
<tr>
<td>Beef liver, cooked</td>
<td>3 ounces</td>
<td>70.7</td>
<td>1,178</td>
</tr>
<tr>
<td>100% fortified cereal</td>
<td>3 ounces</td>
<td>6</td>
<td>100</td>
</tr>
<tr>
<td>Rainbow trout, cooked</td>
<td>3 ounces</td>
<td>5.4</td>
<td>90</td>
</tr>
<tr>
<td>Light tuna, canned in water</td>
<td>3 ounces</td>
<td>2.5</td>
<td>42</td>
</tr>
<tr>
<td>Cheeseburger and bun</td>
<td>1 sandwich</td>
<td>2.1</td>
<td>35</td>
</tr>
<tr>
<td>Haddock, cooked</td>
<td>3 ounces</td>
<td>1.8</td>
<td>30</td>
</tr>
<tr>
<td>25% fortified cereal</td>
<td>1 serving</td>
<td>1.5</td>
<td>25</td>
</tr>
<tr>
<td>Top sirloin beef</td>
<td>3 ounces</td>
<td>1.4</td>
<td>23</td>
</tr>
<tr>
<td>Low-fat milk</td>
<td>1 cup</td>
<td>1.2</td>
<td>18</td>
</tr>
<tr>
<td>Low-fat fruit yogurt</td>
<td>8 ounces</td>
<td>1.1</td>
<td>18</td>
</tr>
</tbody>
</table>

A thorough review of indicators, assessment, and monitoring of patients for B-12 deficiency and response to treatment.

References


About the Author

Dr. Leyse-Wallace retired from clinical practice and has published three books: Linking Nutrition To Mental Health and Nutrition and Mental Health as well as a reader-friendly version of her doctoral dissertation The Metaparadigm of Clinical Dietetics: Derivation and Applications. She lives in Alpine, California in San Diego County and has three adult children and five grandchildren.

Vitamin B-12 and Mental Health in the News

(continued from page 12)

difference, -0.33 change in SANS score per week. Change occurred when genotype was taken into account but not when genotype was excluded. An interaction of the 484C>T variant of FOLH1 (rs202676) with treatment was observed (P = .02), where only patients homozygous for the 484T allele demonstrated significantly greater benefit. The author concluded treatment response is influenced by genetic variation in folate absorption. These findings support a personalized medicine approach for the treatment of negative symptoms in schizophrenia (1).
The Potential Role of B12 Supplementation in Dementia and Cognitive Function
(continued from page 13)

10 to 30 percent of older adults that prevents the absorption of B12 in the body from occurring (3). Vegetarians or individuals who follow a vegan diet should try to eat foods that are fortified with B12.

The body goes through four stages when it is becoming deficient in B12. The body does not develop neurological symptomology until stage 2, at which time the neurological symptoms are reversible. At stage three, the symptoms are potentially reversible but at stage four the neurological damage becomes irreversible. (2)

Dementia can begin mild and then progress to a more severe state. However, it usually begins with symptoms such as forgetfulness. Other issues that can occur are problems with language, emotions or personality, memory, perception, and thinking and judgement (cognitive skills). The deficiency of cobalamin may cause cognitive shortfalls and dementia as well. Some case studies and research studies are beginning to show evidence that, when there are B12 deficiencies, dementia can be improved in several areas such as concentration, visuospatial performance, executive function, and overall cognitive function. In one case study (3), described in an article written by Norbert Goebels, MD and Michael Soyka, MD, a 64 year old presented with serious cognitive impairments and signs of B12 deficiency, as well as, weight loss and lack of appetite. The patient was given vitamin B12 and his cognitive function improved five weeks into the treatment. In another case study, an 87 year old woman presented to a clinic with confusion, agitation and memory decline for about two years. She had a B12 deficiency and she was administered several B12 injections and her overall cognitive functioning improved dramatically (3). There are other research studies that describe effective B12 treatment regimens that improve symptoms of dementia. This study reports after one year of treatment that 12 of the 19 patients with dementia improved with B12 treatment. The group that improved with treatment had initially more problems with psychosis and more deficits in concentration, visuospatial performance and executive function. However, they did not show improvement in language problems and ideomotor apraxia. These findings suggest that B12 deficiency when treated can be reversed in elderly dementia patients (4).

There are specific markers to determine B12 levels and one of these markers is formulating the methylmalonic acid and homocysteine levels. These levels are linked with poorer B12 deficiency, episodic memory and perceptual speed. Researchers are claiming that there is a link between the accumulation of homocysteine in the blood and the lack of B12. The importance of homocysteine in this process of the relation of B12 to cognition is thought to be the inability of the body to metabolize neurotransmitters. In this particular study homocysteine levels were associated with decreased total brain volume and cognitive performance (4).

B12 helps maintain healthy nerve cells and deficiency can cause memory loss and other cognitive problems. B12 is an essential vitamin that at times is not absorbed or is not adequately consumed due to decreased protein intake particularly with animal protein. If treated early, 75 percent of dementia caused by B12 can be reversed. B12 does not treat all dementia; however, with these results it would be a valuable worthwhile clinical assessment approach and a possible inexpensive treatment (5).

There are different forms of B12 and it depends on if a patient is taking it orally, parenterally or intramuscularly. The oral supplement is present as cyanocobalamin form that the body easily converts to the active forms methylcobalamin and 5-deoxyadenosylcobalamin. The intramuscular and parenteral forms are also administered as cyanocobalamin and occasionally hydroxocobalamin as a prescription (1).

About the Author
Ruth Roberts is a Registered Dietitian Nutritionist and a Licensed Professional Counselor. She is the Assistant Editor for Behavioral Health Nutrition (BHN) Newsletter. BHN is a DPG of The Academy of Nutrition. She has her B.S.H.E. and her M.A. in Community Counseling. She has been in the Nutrition and Behavioral Health for about 15 years both working in an inpatient and outpatient setting. She has experience with providing nutrition education in Diabetes self management, meal management, weight management, healthy eating, and renal disease. She has assisted with ensuring the compliance requirements for Medicaid and JCAHO for both Dietetics and Behavioral Health Facilities. Ruth has worked with treatment teams, managed staff and managed budgets. She has assisted in developing, communicating, and overseeing a training program for staff while working in behavioral health.

References
Have you considered increasing your Business and Management Skills to promote your career path as a dietitian? Are you a preceptor for dietetic students; have you considered becoming one?

These were the mega issues discussed during the House of Delegates (HOD) meeting this year at the Food & Nutrition Conference & Expo™ (FNCE®). It was an extremely full session and one filled with lively discussion. Although I am your elected representative for Behavioral Health Nutrition Dietetic Practice Group (BHN-DPG), there were additional BHN- DPG members there representing their states, other DPG’s or simply auditing.

The HOD meeting started on Friday morning and the first day was devoted to dialogue on Mega Issue 1: Business and Management Skills. The purpose of this session was for meeting participants to:

- Identify benefits and successful outcomes of utilizing business and management skills
- Expand members’ awareness, utilization and development of business and management resources.
- Develop strategies to utilize, expand and sustain business and management skills.
- Apply business and management skills in all areas of practice
- Recognize, seize, and create business and management opportunities.

Prior to the actual dialogue session, which occurred at 15 tables of delegates and auditors, brief presentations were given by 5 expert panel members who have utilized business and management skills in achieving their current positions.

Beverly Girard-PhD, MBA, RD: Director of Food and Nutrition Services for the School Board of Sarasota County, Florida. This is a school district of 42,000 students in 40 public schools and 8 charter schools.

Catherine Broihier, MS, RD: Food and Nutrition Communications specialist, recipe developer and menu consultant, web content development, cookbook author.

Cheryl Koch, MS, RD, FAND: Vice President of Facilities and Support Services at the Johns Hopkins Bayview Medical Center in Baltimore, Md. She oversees all support services at the Medical Center, facilities engineering, design and construction, and service excellence. She is also responsible for the Clinical Nutrition Department in the Johns Hopkins Health System, Academic Division.

Stacey Antine, MS, RD: Founder of HealthBarn USA, the leader in proven hands-on healthy lifestyle education for children and their families.

Margaret Tate, MS, RD: Retired after 33 years in public health (state Level) and is currently a consultant in leadership development/coaching, meeting planning, group facilitation, not-for profit Board training, consumer education, and development of written policy briefs and grant applications.

Alex Pezzullo, MPH, RD: Senior Vice President of Growth Strategy for Network and Population Health Consulting. Alex has many specialty areas including care delivery model strategy and performance, growth strategy, reimbursement, medical cost optimization, and quality improvement.

Discussion followed these presentations with delegates reflecting on their personal needs to be in a position of influence and the business and management skills needed to be successful. In another session, the discussion centered on what the Academy provides currently and what additional resources could be provided along with what the DPG’s, Affiliates, and MIGs, might consider developing and providing.

A series of guiding principles were identified related to the dialogue and actions needed. These included 10 action steps that can be taken, but a summary resolution was developed that will be voted on in November.

The resolution: **Be it resolved that the HOD requests that the HOD Leadership team establish a task force to review all of the HOD input from the dialogue session to determine a plan to assist members and students with building, enhancing and utilizing skills and knowledge related to business and management. The plan will need to minimize impact on the Academy’s budget. The plan will be reviewed by the HOD in May 2015.**

Mega-Issue 2: Current Practice Issues: Preceptors and Supervised Practice Positions.

Despite efforts on the part of the Academy, Accreditation Council for Education in Nutrition and Dietetics (ACEND), and Nutrition and Dietetic Educators and Preceptors (NDEP) the number of supervised practice positions continues to lag behind demand, leaving many qualified graduates unable to complete their education to become a RDN. This has been discussed multiple times but now it presents in crisis mode as approximately 2,000 graduates a year cannot obtain supervised practice required for registration eligibility. ACEND accredited Individualized Supervised Practice Pathways (ISPP) in January, 2012 for those not matched for an internship, however a shortage of preceptors and supervised practice positions remains a barrier.

The HOD meeting this year was designed to conduct a dialogue on this issue. The purpose of the dialogue was for the delegates to:

1. Brainstorm solutions to increase supervised practice experience positions, especially in non-hospital setting.
2. Brainstorm solutions to increase the number of preceptors.
3. Promote the CDR Online Dietetics Preceptor Training Course for use by all new and current preceptors.
4. Streamline the process to establish new sites and preceptors.

continued on page 16
HOD Delegates Report
(continued from page 15)

5. Explore the use of non-traditional practice settings for supervised practice experiences.
6. Identify current simulations available and identify gaps to determine future needs.
7. Communicate alternative options to students that do not match to a supervised practice site to understand other options: Pathway 3 (for NDTR) and Independent Supervised Practice Program (ISPP).
8. Promote the ACEND Find-a-Preceptor Database to be fully utilized by preceptors, program directors and students.

This is a critical issue for dietetics as a profession and one that DPG's such as ours should embrace, encourage our members to consider and promote within the agencies where we provide nutrition.

The resolution: the Speaker of HOD will communicate all of the input generated by the delegates to ACEND, CDR, and NDEP for their consideration in addressing these two issues facing the profession. They will report to the HOD on their progress in spring and fall 2015.

If you as a BHN-DPG member have questions, concerns or comments on either of the issues addressed during FNCE, please email them to me so that I can send them to the HOD leadership team. Consider being a preceptor and send your name to the Academy website or to me. Harriet Cloud, MS, RD, FAND. Harriet.h.cloud@gmail.com

BHN Awards
Congratulations to the following BHN award winners.
Awards were given at the Member reception at FNCE® on October 21, 2014

Excellence in Practice – Mental Health
Linda Venning, MS, RD
Linda has a long history of serving clients in the Mental Health arena. She worked at Northville State Hospital in Michigan serving adults with chronic and severe mental illness. Currently she is the only dietitian working at the Hawthorne Center in Michigan, which is the state’s only children’s mental health hospital. She works with children with severe mental health conditions providing compassionate nutrition care while working to educate the children and their parents on the role of good nutrition therapy in healthy living. Linda works diligently to provide menus that the children will eat while at the same time encouraging good and healthy eating habits.

Linda has been an active member of BHN serving as our Resource Professional for Mental Health. In this role she has provided many BHN members with information and support for dietitians working in mental health settings.

Eating Disorders
Rebecca Bitzer, MS, RD
Rebecca has lead the way in the field of eating disorders by establishing and maintaining a group practice before it was a common practice. She is known for her strong work ethic, her ability to work well with others, and her willingness to take risks. In addition to serving on the boards of many Eating Disorder related groups she has been involved with other Academy practice groups.

Intellectual and Developmental Disabilities
Andrea Shotton, MS, RD, LD
Andrea has been an advocate for this population for many years. She has worked in a variety of settings and has worked with inborn errors of metabolism and conducted research on epilepsy and the ketogenic diet. In addition, Andrea has been an active member of BHN and has served as the practice group Chair where she was instrumental in developing the group’s strategic plan to advance BHN members in their areas of practice. Most recently she has worked with the publications team providing continuing education credits for newsletter articles and webinars.

Distinguished Member
Dr. Carin Kreutzer, EdD, MPH, RD
Carin is currently an Assistant Clinical Profession at USC Davis School of Gerontology and USC Keck School of Medicine. She completed her Bachelor’s degree in nutrition and dietetics at California State University Fresno, followed by a dietetic internship at the Massachusetts General Hospital in Boston. She received a master’s degree in Public Health, Health Services Management and Administration from the University of Washington, Seattle. She recently completed a doctorate degree in Urban Education Leadership at the USC Rossier School of Education.

Dr. Kreutzer has been a practicing registered dietitian/ nutritionist since 1982 primarily serving the at-risk and underserved pediatric populations. In October 2013 she accepted a new position in the USC Davis School of Gerontology to develop a Master’s Degree, Distance, Coordinated Program in Nutrition and Dietetics, focused on Nutrition, Healthspan and Longevity. In addition to her current position she has been teaching nutrition on the graduate and undergraduate level at California State University Northridge and USC.

Cary has been an active leader in nutrition and dietetics. She has held local and national elected positions and has mentored numerous students throughout her career as a registered dietitian/ nutritionist. She has been a member of BHN for over 27 years. She has held numerous positions during this time including Chair, Treasurer, and member of the Nominating Committee.
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Contribute an article or topic for future BHNewsletter issues!

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

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: http://www.eatright.org