BHN: Fuel Your Brain, Feel Your Best!

The Role of Nutrition Intervention for Improving Health and Outcomes in Patients with Alcohol Use Disorders: A Literature Review

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Introduction
Among the multitude of health consequences associated with alcohol use disorders (AUDs), many impact nutrient intake, metabolism and absorption. Medical nutrition therapy is an effective means by which to address the associated nutritional deficiencies and dietary needs. In addition to reversing physical consequences, a nutritionally adequate, balanced diet with meals spread throughout the day has been demonstrated to promote relapse prevention and psychological wellbeing, as has nutrition education during treatment and recovery. Nutrition intervention is a vital component of treatment for patients with AUDs.

Background
Approximately 17 million adults and 855,000 adolescents in the United States had an AUD in 2012. The Surgeon General has identified the prevention of excessive alcohol use among the top public health priorities for the United States, as outlined in the National Prevention Strategy (NPS). As registered dietitian nutritionists (RDNs), we are uniquely qualified to assist with this effort, as well as to promote healthy eating and active living, two additional public health priorities highlighted in the NPS.

Terminology and definitions associated with alcohol abuse and addiction were revised in 2013 with the publication of the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Historically, alcohol abuse and alcohol addiction were diagnosed as two separate disorders. After the publication of DSM-5, these two disorders merged under the umbrella of AUDs with specific criteria outlined for classification as mild, moderate and severe. Across the spectrum of AUDs, features may include loss of control with alcohol use, significant and recurrent adverse consequences, tolerance and withdrawal. For a comparison of DSM-IV and DSM-5 and information on specific criteria used to diagnose and classify AUDs, refer to the National Institute on Alcohol Abuse and Alcoholism 2013 publication entitled Alcohol Use Disorder: A Comparison between DSM-IV and DSM-5.

Risk factors for developing an alcohol use disorder are well recognized but not easily prevented. Individuals with a family history of AUDs are at increased risk due to both genetic pre-disposition and social conditioning through exposure to the behavior. Secondly, social environment, especially social isolation, is associated with AUDs. Alcohol can increase dopamine activity in the body, which in turn can boost mood. For this reason, it is common for people with mental health conditions, including anxiety and depression, to turn to alcohol and other drugs.

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From the Chair

Adrien Paczosa, RD, LD, CEDRD

Ready, set, GROW! This year BHN plans to continue on the path of growth and exploration. Your leadership team has been busy over the summer planning out the year of amazing events for you, and we look forward to seeing and hearing from ya’ll.

This IS the year to attend FNCE®, because BHN has some amazing things planned for each of you. Our Pre-FNCE workshop will truly be a life changing experience for you, your practice, and your clients. Brain Data and Dogma: Expanding MNT to increase fiscal reimbursement- October 3rd from 11:30 to 3:30 PM cost $129 for Members. During this workshop by the leading scientists, behavior change experts and lawyers in our field, you will learn and develop tools specific to your area of practice that you can use when you get home. Understand the sciences of nutrition and the brain, applicable tools for specific behavior change, and then how you and your place of work will best be reimbursed. This hands on, step by step workshop continues to be creating buzz throughout the behavioral health community nationally, and if you plan on attending I strongly encourage you to sign up today because seating is limited.

Saturday evening after kicking off FNCE® with our ground breaking Pre-FNCE workshop, BHN will be celebrating YOU! This year we are changing things up a bit, and our member reception will be October 3rd 8-10PM. Thank you Trovita Health Science for sponsoring our upcoming member reception at FNCE®. Those that attend the Pre-FNCE workshop will have VIP access (starting at 7PM) to the member reception, because our speakers will be at our reception to network. Come join the celebration of YOU!

Have you seen the BHN Track for FNCE®? Your leadership team went through all the sessions and chose the best of each day for all four practice areas to guide you at FNCE®. I hope to see everyone at BHN Spotlight session, Food For Recovery: Resolving Malnutrition and Disordered Eating Patterns in Addiction and Substance Abuse Populations. Make it a point in your FNCE® calendar to stop by the member showcase on Monday October 5th and meet your BHN leadership team at our booth. Plan on being blown away by this year’s booth, no hints you will have to stop by to find out! If you want to connect with any of us at FNCE® please tag @BHNDPG. For example, “What are all my @BHNDPG friends doing for breakfast today? #FNCE2015”

I look forward to meeting each of you at FNCE®. If you are not able to attend please follow along on social media to feel like you are there! After FNCE® don’t get too comfy. BHN has amazing webinars, factsheets, and so much more planned for you this year. Check In the Pipeline in our quarterly newsletter to see more! Your leadership team is here to help and support ya’ll, so please don’t hesitate to reach out.
Finally, AUDs are associated with increased muscle wasting. 4
AUD is also associated with liver disease, ranging in severity from fatty liver and alcoholic hepatitis to irreversible cirrhosis and encephalopathy or coma. 1,4-8 To illustrate the depth of nutrition-related medical conditions patients with AUDs experience, it is estimated that 45-70% of patients with AUD and liver disease also have pre-diabetes or diabetes. 4 Liver disease is also associated with night blindness due to the decreased ability of the liver to convert beta-carotene to vitamin A. As with all fat-soluble vitamins (vitamins A, D, E, K), caution should be taken when supplementing, due to risk for toxicity.

### Nutrition Assessment

When assessing a patient with alcohol dependence for nutrition risk, there are several factors that should be considered, outlined in Table 1.

Interviewing a patient to obtain information about their diet history can provide useful information. This is one time point at which an RDN should probe for alcohol intake patterns to aid the medical team in screening for potential AUDs. Any patient or client estimated to be consuming more than 20% of calories from alcohol should undergo nutrition assessment and intervention due to increased risk for malnutrition and nutrition-related consequences. 5 Individuals consuming more than 30% of calories from alcohol are at high risk for deficiencies that are otherwise very uncommon in the United States, including vitamin A and vitamin C deficiencies. 4,5 For patients determined to have an AUD, diet recall, in addition to laboratory results, should be thoroughly assessed for macro- and micronutrient adequacy. Given that deficiencies can contribute to low energy, depression and anxiety, correction is necessary for encouraging sobriety. 4

Obtaining a weight history to assess trends over time and calculating BMI are two measures, which can help to quantify the adequacy of caloric intake and nutrient absorption. In addition to these measurements, nutrition-focused physical exam can be a useful way to assess for evidence of muscle wasting, distribution of adipose tissue, and adequacy of dentition.

### Table 1. Factors to Consider During Nutrition Assessment of a Patient with AUD

- Dietary history
- Physical assessment
- Weight history and body mass index (BMI)
- Laboratory values
  - Liver function tests (LFTs)
  - Measures of blood glucose control
  - Micronutrients
- Medications
- Gastrointestinal symptoms
- Socioeconomic status and support
- Other conditions, including combined drug use, immunodeficiency, psychiatric conditions, and/or eating disorders

Multiple laboratory values should be checked in a patient with a known or suspected AUD. These can be useful for assessing organ damage and micronutrient status. Studies have demonstrated that 50-70% of people with addiction are deficient in nutrients with vitamins D, C and A, and iron among the most common. 4 In addition to these values, LFTs, folate, vitamins B12 and E, methylmalonic acid, homocysteine, glycylated hemoglobin, lipid panel, hemoglobin, hematocrit, mean corpuscular volume, magnesium, and zinc can be useful for conducting a thorough assessment of micronutrient stores, anemia and liver function.

Many medications prescribed by physicians to help treat AUDs are known to have nutrition-impact side effects. RDNs can improve the comprehensiveness of nutrition therapy by being aware of, assessing for, and addressing these symptoms. Medications commonly used to treat AUD include Naltrexone (also called ReVia®, Vivitrol®, and Depade®), Disulfiram (also called Antabuse®), and Acamprosate (also called Camprall®).

Gastrointestinal symptoms can occur in people with AUD stemming from many etiologies. Excessive alcohol consumption can result in inflammation of the lining of the digestive tract,
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decreased digestive enzymes, and ulcers. Information should be gathered regarding gastrointestinal symptoms upon initial visit or admission for treatment and should be monitored over time. Many gastrointestinal symptoms resolve after detox with continued sobriety. However, if symptoms are persistent, further work-up and nutrition intervention should be provided. There are many other factors that should be considered when assessing a patient for nutrition risk and planning interventions. First, socioeconomic status, living conditions anticipated at discharge, and availability of a support system should be assessed and interventions should be tailored accordingly. Second, immune function can be compromised secondary to nutritional deficiencies associated with AUD. As a result, patients with concurrent health conditions that predispose them to a weakened immune system are at heightened risk for complications. Next, patients struggling with multiple addictions have been shown to have more varied and severe nutrient deficiencies, yet data suggests these patients generally receive less nutrition education relative to other patients. These factors can heighten health disparities between these groups. Finally, there is a high prevalence of eating disorders among patients with AUDs, with statistics estimating that 72% of women below the age of 30 years with an AUD have an eating disorder. It is key that disordered eating behaviors be identified and that nutrition intervention and behavioral counseling by other medical professions be tailored to address such behaviors.

Nutrition Intervention

Goals of medical nutrition therapy for AUD should be directed at specific outcomes, outlined in Table 2. Helping patients understand the ways in which nutrition can aid in achieving each of these goals can increase commitment to prioritizing good nutrition throughout recovery and sobriety.

The benefits that can be gained from regularly scheduled meals and snacks should not be underestimated. As soon as recovery from detox has occurred this should be a top priority for every patient. These meals and snacks should be nutritionally balanced with combinations of foods from each food group consumed over the course of the day and should be calorically appropriate to promote a healthy weight. This intervention can correct nutrient deficiencies, promote healing of impacted organs, and reduce cravings for alcohol. Regular, balanced meals combined with increased physical activity can also improve mood, promote stress management, and improve sleep quality, which can help to encourage ongoing sobriety.

Nutrient Prescription

Specific nutrients should be targeted in the diet prescriptions for patients with AUDs, as outlined in Table 3. There are significant psychological and neurological components involved in eating behavior during detox and treatment. It is highly important that

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### Table 2. Goal Outcomes of Medical Nutrition Therapy for Patients with an AUD

<table>
<thead>
<tr>
<th>Order of Priority</th>
<th>Outcome</th>
</tr>
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</table>
| First             | • Healing physical damage  
                   | • Preventing alcoholic liver disease or progression  
                   | • Correcting nutrient deficiencies |
| Second            | • Stress reduction  
                   | • Mood stabilization |
| Third             | • Reduce cravings |
| Fourth            | • Encourage self-care  
                   | • Healthful lifestyle |
| Fifth             | • Prioritize management for all co-occurring diagnoses |

### Table 3. Nutrient Prescription for Patients with AUDs

<table>
<thead>
<tr>
<th>Nutrient Prescription</th>
<th>Health Benefit or Concern</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encourage a diet high in complex carbohydrates and moderate in protein</td>
<td>• Reduces excess stress on liver</td>
</tr>
</tbody>
</table>
| Encourage nutrient dense foods, including fruits and vegetables, whole grains and healthy fats | • Reduce inflammation and cell oxidation, which is associated with improved treatment outcomes  
                   | • Omega-3 and omega-6 fatty acids have been demonstrated to reduce steatosis, fibrosis, and cirrhosis, while also reducing depression through increased neurotransmitter uptake, decreased inflammation, and improved integrity of cell membranes  
                   | • Polyunsaturated fatty acid supplements may be beneficial for reducing anxiety in patients with AUDs |
| Encourage adequate hydration and regular meal pattern to prevent hypoglycemia | • Reduces cravings, which is among the leading factors for preventing relapse |
| Avoid excess caffeine intake | • Reduces cravings, since caffeine triggers the same reward centers in the brain as alcohol  
                   | • When paired with smoking cessation, demonstrated to improve long-term sobriety |

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effort be made to identify and diagnose underlying mental health disorders, in addition to addressing the acute depression, aggression, and agitation observed during withdrawal and detoxification. Appropriate diagnosis and treatment of such disorders is necessary for successful treatment and promotion of long-term sobriety. Acute symptoms are attributed to decreased availability of neurotransmitters secondary to malnutrition and associated disruption on amino acid metabolism. As RDNs, we can help by educating patients about the role nutrition plays in brain chemistry. For example, patients can benefit from developing a greater understanding of the role carbohydrates play as the main source of energy used by the brain and their influence on serotonin production. Serotonin elevates and stabilizes mood and sleep patterns, whereas inadequate serotonin leads to irritability, depression, and cravings. Further, helping patients to understand that adequate protein intake is key, as amino acids are heavily involved in neurotransmitter availability. Consumption of a variety of protein-rich foods is advised in order to ensure exposure to the complete spectrum of amino acids. Dairy and meats for example are good sources of tryptophan, a key amino acid for serotonin production. On the micronutrient level, vitamins B12 and B6, folate, and iron should be checked and repleted, as indicated, given that deficiencies of these nutrients can elicit symptoms similar to those of mental health disorders, including depression, disrupted sleeping patterns, fatigue, and inability to focus. Additionally, these vitamins aid in the synthesis of serotonin from tryptophan. It is key that patients develop a healthy relationship with food and an understanding of the vital role different nutrients play in optimizing organ function and fueling our cells.

Special Dietary Needs
The diet prescription may need to be adjusted in order to accommodate other dietary needs, such as those to address problems with dentition, altered gastrointestinal function, or metabolism. Patients with AUDs are at increased risk for central adiposity and obesity, impaired glycemic control, hyperlipidemia, hypertension, and metabolic syndrome, which is characterized by a combination of these conditions. As RDNs, we are familiar with the diet prescription for optimizing heart health, weight management, glycemic control, gastrointestinal symptom management, and modified consistency needs, and it is important that these guidelines also be worked into individualized counseling and recommendations. Caution must be taken to ensure the patient is not overwhelmed with competing nutrition messages and with pressure to make too many major lifestyle modifications at once. Readiness to change should be assessed and accounted for throughout the duration of nutrition intervention.

Enteral and Parenteral Nutrition Support
If a patient is unable to take adequate nutrition orally, enteral tube feeds or parenteral nutrition support may be indicated. Just as with most other patient populations, enteral nutrition is the preferred route due to the relatively lower infection risk and known benefits of gut stimulation. Formulas containing glutamine should be avoided due to association with increased ammonia levels. Contrastingly, formulas containing taurine may help to maintain sobriety, as this amino acid has been associated with repression of the reward system in the brain triggered by alcohol.

Early Intervention and Patient Education
It is recommended that more acute deficiencies and nutrition-impact symptoms should be prioritized first, followed by long-term lifestyle modification and optimization. However, it is also important to recognize the impact that nutrition education early in the treatment process can have on fostering a healthy relationship with food. Cowan and Devine published a report from a qualitative study they conducted to better understand the perspectives of men recovering from substance addiction as relates to food, eating patterns, and weight shifts. They discovered that dysfunctional eating patterns and struggles with weight gain were widespread and that the relationship shifted considerably between early and mid to late recovery. Initially, food is viewed as a substitute for alcohol use with frequent food hoarding and binge eating to satisfy cravings, boredom, and mood. Over time, concerns over rapid weight gain and efforts to lose weight develop. Later in the recovery process, food is viewed as a way to provide structure to the day, which recovering addicts rely upon for maintaining sobriety. These findings, in conjunction with those of Hauser & Iber who concluded that increased awareness of and involvement in nutritional status helps people “embrace better eating patterns,” support a need to intervene early with nutrition education and a healthy eating environment. Further supporting this is a study published by Grant, Haughton, and Sachan, which demonstrated that nutrition education is positively associated with substance abuse treatment outcomes.

Nutrition education has been demonstrated to significantly increase 3 month sobriety success rates. Specific topics which may be most beneficial to this patient population, include education on the role of nutrition in promoting and maintaining sobriety, strategies for grocery shopping and preparing meals that are healthy and balanced, resources available for healthy recipe ideas, and emphasis on avoiding triggers, such as avoiding any alcohol-containing ingredients. Additionally, education about hunger and satiety cues and portion control can help patients to better understand the quantity of food needed to fuel their bodies and to recognize times when they are experiencing craving, as opposed to true hunger. Budget-friendly tips and consideration for limited kitchen equipment should always be incorporated, given the high prevalence of limited resources among patients with AUDs.

Weight Management
Secondary to true biochemical changes, as well as situational conditions, it is common for patients to gain weight during addiction treatment. Patients often replace their substance of choice with excessive food
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intake during treatment. Additionally, biochemical shifts increase appetite and cravings for highly palatable foods and reduce awareness of hunger and satiety cues. While weight gain may be an appropriate goal for some patients with evidence of underweight or protein-calorie malnutrition, weight gain in other patients may increase risk of metabolic syndrome. Further, increase in weight during treatment has been associated with increased LFTs, suggesting that rapid weight gain could result in stress on an already compromised liver. Finally, weight trends should be monitored throughout treatment and nutrition intervention should be adjusted, as indicated, to promote only gradual trends in weight in the desired direction.

Micronutrient Supplementation

Micronutrient supplementation should also be a highly prioritized intervention for patients with AUDs. Prescription of a general multivitamin and thiamine supplement upon initiation of treatment can be a safe way to improve micronutrient intake with minimal risks, as thiamine is a water-soluble vitamin and therefore its supplementation is unlikely to result in toxicity. Thiamine deficiency is common in patients with AUDs due to its role in the detoxification of alcohol in the body and increased excretion secondary to the diuretic effect of alcohol. Risks of the deficiency are high, as it can lead to Wernicke-Korsakoff’s syndrome, which is a serious neurological disorder characterized by ataxia, vision changes, confusion, memory loss, confabulation, and hallucinations. Other micronutrient supplements should be added based on assessment of laboratory values and clinical presentation. For example, patients with low serum vitamin A levels and reported night blindness should be prescribed 2 mg vitamin A per day for several weeks, along with zinc supplementation due to its role in vitamin A metabolism. However, it is important that nutrition education be provided about preference for nutrients to come from foods, as is outlined by the 2015 Dietary Guidelines for Americans. Collaboration with Other Healthcare Providers

Interdisciplinary collaboration is also a vital piece of successful AUD treatment. RDNs can work with recreation therapists and physical therapists to encourage safe, appropriate increases in physical activity and to provide hands-on experience related to healthy cooking. Social workers can assist in providing community resources for improving access to and affordability of healthy foods and safe, alcohol-free living environments. Psychotherapists can help to treat eating disorders or other mental health abnormalities that may be limiting a person’s ability to successfully implement nutrition-related behavior change. Nurses can be a great resource for report of observed behaviors.

Conclusion

For many patients with AUDs, learning reasons and ways to channel prior negative energy spent on drinking into healthy diet and lifestyle practices can significantly contribute to positive treatment outcomes. RDNs can play a role in helping patients with AUDs discover how to fill time with planning and eating healthy, balanced meals spread throughout the day, a sleep routine promoting 7-9 hours of sleep per night, and participating in activities they associate with positive emotion, especially those involving physical activity. Each of these interventions can help to reduce known triggers of relapse by reducing excess free time, encouraging positive social interaction, reducing cravings, encouraging change in routine, and increasing positive emotions. The improvement in mood and cognitive function associated with adequate sleep, regular exercise, and restoration of macro- and micronutrient stores is essential.

About the Author

LT Kelly A Verdin, MPH, RD has worked as a Registered Dietitian for the last 6 years, with nearly 5 of those years as a Clinical Research Dietitian at National Institutes of Health.

References:

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CPE Questions for The Role of Nutrition Intervention for Improve Health and Outcomes in Patients with Alcohol Use Disorders: A Literature Review

1. Which of the following is associated with improved treatment outcomes?
   a. Balanced, regular meals and snacks spread throughout the day
   b. High protein, low carbohydrate diet
   c. High dose vitamin E supplementation
   d. All of the above are associated with improved treatment outcomes

2. Which of the following conditions are irreversible?
   a. Pre-diabetes
   b. Cirrhosis
   c. Fatty liver
   d. None of the above

3. A patient with an alcohol use disorder that is going to require nutrition support via tube feeds should be provided with a formula that does NOT contain which nutrient?
   a. Glutamine
   b. Omega-6 fatty acids
   c. Taurine
   d. Vitamin A

4. What percentage of women below the age of 30 years with an AUD have a co-occurring eating disorder?
   a. 12%
   b. 31%
   c. 72%
   d. 84%

5. Which of the following combinations of interventions can all patients recovering from an alcohol use disorder benefit from?
   a. High-dose fat-soluble vitamin supplementation, individual nutrition counseling, group nutrition education
   b. High-dose supplementation of vitamins A, C, E, zinc, and iron, individual nutrition counseling
   c. Multivitamin supplementation, thiamine supplementation, group nutrition education
   d. Multivitamin supplementation, vitamin A supplementation, individual nutrition counseling

Take Your Passion for Behavioral Health Nutrition to the Next Level

This is a great opportunity to expand your professional network and contribute to the growth and impact of BHN. We are in the process of putting together our Executive Committee ballot for the 2016-2017 year. We are looking for BHN members for the positions of:

**Officer nominations needed:**
- Chair Elect
- Secretary
- Nominating Committee

**Volunteers are needed for:**
- Event Coordinator

*Deadline for officer nominations is October 10, 2015*
The Psychology of Nutritional Decision-Making: The Case for Mindfulness

Bryn Wilkin, RD

Introduction

When it comes to making healthy food choices, individuals are quick to label foods as “good” or “bad.” If you were to ask a person to identify the healthier option between French fries and a tossed salad, the response would most likely be a “no-brainer.” However, the American fast food industry still sells millions of orders of French fries on a daily basis. Even in an increasingly health-conscious world, people struggle to sort through the mixed messages of the media, their own desires, and foods labels to create balanced meals and lifestyle choices. The science of decision-making confirms that a mix of emotions, societal norms, and brain chemistry muddles the nutritional decision-making process for all American consumers.1

Gaining Control of Decisions

Healthful decisions are aided by nutrition education, but are heavily influenced—positively or negatively—by social and personal psychology. Everyone has experienced social influences on decisions when eating with a group of friends in a food court. A well-placed food display or colorful advertisement in the grocery store can quickly lead to an “impulse buy.” Confusing food labels or nutritional claims on product packaging may lead you to simply pass by a potential healthy choice in favor of choosing a familiar brand name. Each of these situations have different outcomes based on current nutritional knowledge and on the amount of cognitive resources consumers are willing to activate in order to make a healthy purchase. Cognition, when considered by dietitians, can be valuable in understanding the bigger picture of a patient’s day-to-day food and nutrition choices. If the individual is also aware of this interaction, he/she can use new information to combat the sometimes misleading and confusing external influences to make better decisions for themselves and their families.

One such strategy for gaining control of the cognitive and subsequent decision-making process is mindfulness. Mindfulness can be defined as “a moment-to-moment awareness of one’s experience, without judgment.”2 When applied, mindfulness slows down an individual’s daily experiences. Rather than answering emails between meetings at work, that time could be spent noticing the sights and sounds surrounding his or her workplace or noticing how one deep breath affects the body, mind, and thoughts. This concept can help with stress reduction, focus, cognitive flexibility, relationship satisfaction, and even strengthening an individual’s immune system. When its components are put into practice, mindfulness education has been found to reduce an individual’s stress and increase psychological well-being.2 In order for these benefits to be recognized, an individual must have some degree of self-efficacy and motivation to complete a change. Mindfulness can then help to propel individual goal achievement. When applied to eating behaviors, the principles of mindful eating include: awareness, observation, being in the moment, being mindful of the environment, being nonjudgmental, letting go, and acceptance.3 Eating mindfully allows an individual to slow his or her pace during mealtimes, taking time to savor each flavor in a food item. This heightened eating awareness allows time to enjoy food and encourages creating a favorable mealtime environment where there are few distractions from the television or electronics, which drastically contrasts with fast-paced, emotional, and distracted eating patterns that saturate the typical American household.

Understanding the intersection of cognition and mindfulness is critical to properly identifying clients who will benefit most from the principles of mindful eating. This identification process begins with assessing client goals, and evaluating those goals against current mindful eating literature, while also understanding the cognitive and social barriers to mindful eating success.

Effectiveness of Mindful Eating

Mindful eating has been utilized as an intervention in a variety of research studies. One study showed that mindful eating is an effective intervention in controlling obsessive thinking and automatic relations between urge and reaction, as related to food. As a result, participants were able to control and significantly reduce their strong food cravings over a seven-week period of group intervention.4 When applied to weight loss programs, mindfulness principles were shown to help individuals achieve significant weight loss and greater levels of physical activity.5 In all studies that report successful weight loss with mindful eating, the participants also reported that they were intentionally applying mindful eating habits at the majority of meals during a given week. Another study reported that mindfulness can successfully increase an individual’s psychological well-being and self-efficacy, while supporting weight loss goal achievement.5,6

The psychology of decision-making incorporates one’s cognitive functioning as well as brain chemistry. Something as simple as a food label triggers a decision bias in the amygdala. The amygdala is recognized as the emotional center of the brain—processing memories and creating immediate emotional responses that are translated into behavioral reactions. During one experiment, researchers showed mildly hungry participants pictures of food, each with an advertisement emphasizing either taste or health-related food properties.7 Functional MRI results, performed on each participant, showed significant decision bias triggered by the amygdala in response to the health-related advertisements. When continued on page 9
Bandwagon Effect

Two important aspects of the decision-making process in a social setting include descriptive and injunctive norms. A 2013 study by Mollen et al. was interested in how one’s social environment (descriptive norm) and one’s opinion regarding what is considered a socially appropriate action (injunctive norm) would affect their lunchtime food choices. The study was conducted as a field experiment within a college food court. Four different messages were conveyed to students by way of banners posted in the food court: healthy descriptive norm, healthy injunctive norm, unhealthy descriptive norm, and no message (experimental control). The healthy descriptive norm read, “Every day, more than 150 students have a tossed salad for lunch here.” The healthy injunctive norm read, “Have a tossed salad for lunch!” The unhealthy descriptive norm read, “Every day, more than 150 students have a burger for lunch here.” Each day, researchers would record the number of burgers and tossed salads purchased. The results showed that students responded with a healthy decision most significantly when presented with the healthy descriptive norm. The injunctive norm was also effective in increasing healthy decisions, although not significantly. These results suggest that people’s behavior is significantly influenced by the “bandwagon effect.” In other words, if students know that others are making healthy choices, they want to be a part of the crowd.

Emotional Ability Training

While the bandwagon effect may be influential in group settings and individual decisions, it may not be as effective when it comes to inspiring permanent behavioral and lifestyle changes. Recent research has introduced the idea of providing “emotional ability training” (EA) to individuals as a way to increase the impact of mindful eating on everyday decisions, and making that decision-making strategy a permanent behavior, with an ultimate goal of providing a framework by which consumers can become more mindful of their food choices on a daily basis. Emotional ability includes four dimensions, which help to facilitate mindful thinking in eating and food decisions. The first dimension measures a person’s ability to be aware of and recognize various emotions that impact decisions. The second dimension measures a person’s ability to understand how their individual emotions develop, blend, and progress over time. The third dimension measures a person’s ability to learn and know which emotions are relevant in various food consumption settings, while the final dimension of EA measures the ability to regulate emotions – whether those emotions are individual or group oriented.

Kidwell et al. used emotional ability training in conjunction with mindful eating teaching in several ways that allowed them to tap into the cognitive resources of the average consumer. Their findings revealed that consumers have individual heuristics that they rely upon in choosing foods. For example, a more restrained eater/dieting client may have a cognitive heuristic that favors choosing foods that are packaged in smaller containers, perceiving those smaller containers as a healthier option. By addressing the emotions and heuristics of individuals, researchers found that consumers were significantly more likely to change their eating and food choice behaviors over an extended period of time. In fact, Kidwell et al. found that when compared with only nutrition education, emotional ability training was significantly more effective in achieving long-term (3 month) behavior change, resulting in weight loss for several clients. The study was limited by the fact that the nutrition counseling/education provided to individuals was not delivered by a registered dietitian. However, the emotional ability component, combined with mindful eating principles, could become a useful tool for registered dietitians in achieving long-term behavior change.

Corporate Wellness Opportunities in Mindful Eating

The bulk of research on mindful eating has been applied in areas such as weight loss and disease management. However, the application of mindfulness and emotional ability can be of benefit to the average consumer. A recent study trained hospital employees to use mindfulness when ordering lunch. During a four-week trial period, employees were provided with mindful eating education and the opportunity to pre-order lunch on a daily basis. Participants were given financial incentives in the form of lunchroom vouchers and encouraged to make mindful food choices. After the intervention, researchers followed participants, measuring how often they decided to pre-order lunch, without a financial incentive. Results showed that employees began to make healthier lunchtime choices, as measured by total kilocalories and grams of fat consumed daily over four weeks. Post-intervention, participants were moderately likely to pre-order lunch using mindfulness principles and a majority were interested in having the pre-ordering option available in the future. Throughout this intervention, dietitians were not utilized in teaching mindfulness principles or nutrition education. This model suggests an opportunity for corporate wellness dietitians, who could develop similar intervention, education, and accountability programs for employees.
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Conclusion
Every day, dietitians assume the role of nutrition educators—whether they are providing one-on-one counseling, managing a kitchen, or working within a supermarket to promote healthy living. As dietitians begin to research and utilize the interaction and strong influences of one’s brain chemistry, social norms and factual knowledge, they have the potential to inspire true and long-lasting lifestyle changes.

About the Author:
Bryn Wilkin graduated from the Cleveland Clinic’s Dietetic Internship in July 2015. She graduated from Miami University with a B.S. in Nutrition and Dietetics and a B.A. in Psychology. Bryn can be reached via email at bryn.wilkin@gmail.com

Resources:

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**BHN Collection of Case Studies**
Ruth Leyse-Wallace, PhD, RDN

Case Studies are valuable for teaching and a means of sharing experience among colleagues and can demonstrate both classical and unusual conditions. A case study is a clinical chronicle, not a scientific paper. It is written at the conclusion of treatment and can relate the lessons learned from the case. It is generally written in narrative form and should report only references used to support the case study. Relevant photographs may be included. Some guidelines call for case studies to be 500-1500 words. The word limit for the *J Acad Nutr & Diet* is 2,000 words. Reports should contain de-identified data and be accompanied by a consent form signed by the patient or legally responsible person.

Elsevier and the Academy list the following outline for Case Studies:
(1) an introduction and general description of the pathophysiology of the disease or disorder and its nutritional relevance;
(2) a brief but thorough description of the clinical case (eg, patient profile, presenting symptoms, relevant past medical/surgical history, hospital or treatment course, laboratory results, tests or procedures) with utilization of the Nutrition Care Process, International Dietetics and Nutrition Terminology, and using de-identified data to protect the patient or patients’ right to privacy;
(3) the interventions and medical nutrition therapies and evidence-based guidelines employed;
(4) a discussion and conclusion, which includes outcome data (if available), lessons learned for the subsequent management of similar cases and emphasis on future directions for applicable research.


Journals, books, and collections of case studies are available online. The *J of Med Case Reports* [http://www.jmedicalcasereports.com/](http://www.jmedicalcasereports.com/) is an open access, peer-reviewed journal. The *Brit Med Jour case studies*, [http://casereports.bmj.com/](http://casereports.bmj.com/) covers all disciplines with more than 10,000 articles. Nutrition is included under the categories of Nurses>Nutrition & Metabolism>Diet>Vitamins and Minerals.


The BHN DPG is starting a collection of case studies drawn from the practice of RDNs who belong to any of the four subgroups of BHN: Alcohol and Substance Abuse (ASA), Eating Disorders (ED), Intellectual and Developmental Disabilities (IDD) and Mental Health (MH). A suggested form is available to assist in gathering and reporting typical, unusual or especially interesting cases. A Consent Form is also available. The forms include space for all recommended sections of the guidelines although additional material may be added by the RDN. A practitioner may submit the completed form with the narrative written, or without the narrative for collaboration on writing the final case study report. BHN Case Studies may possibly appear in the newsletter or on the website, or may be submitted to *J Acad Nutr & Diet*.

Additional Resources:
- Himmelfarb Health Sciences Library. Study Design 101. [https://himmelfarb.gwu.edu/tutorials/studydesign101/casereports.html](https://himmelfarb.gwu.edu/tutorials/studydesign101/casereports.html)
Harriet Cloud, MS, RD has been at the heart of the BHN DPG since its beginning. She has most recently passed the torch as our House of Delegates (HOD) representative to Cynthia Burke, MS, RDN, LDN, FAND.

I was pleased to share a conversation with Harriet about her years as our delegate and a charter member of BHN DPG. Here are some of her memories, experiences and views on the subject of representing BHN in the HOD and dietetics today.

**What do you feel was the most important achievement of the HOD during your time there?**

“I think that the recent issue with the corporate sponsorship that came about from Kraft Cheese was very important. The HOD, with the Academy’s blessing, brought that issue out into the open and let it be discussed, and this opened up the need for transparency. Corporate support is a very big issue at the affiliate and national level. The practice groups have been receiving support from corporations for some time and they may need to continue, but some kind of ethical framework is needed.

The second issue addressed by the HOD, that I think is very important is the education of our RD’s in the future. Though education has recently been addressed, the work continues. We have a Future’s Committee. They do continue to meet which is a good thing. A lot of these commissions are still talking and examining the issue and reporting to the HOD.”

Harriet went on to say that the topic of education has dominated meetings this year for the HOD. She cites the fact that it continues to be very difficult to get an internship. Meanwhile, colleges continue to recruit nutrition students. In addition, the Academy is calling for more preceptors to ensure students have a pathway to the RD/RDN career.

She spoke of one of the undergraduate students who has been working with her for 2 years. Her student was counseled that she needs to keep her grades really high and her extracurricular experiences as extensive as possible or she might as well forget about being an RD since getting into an internship is so competitive.

**Can you compare your own educational experience with what you see happening now?**

“I think my training as an undergraduate at Kansas State, Manhattan, was very good. There was a huge emphasis on Food Service Production and much more hands on experiences. I had an externship just prior to my senior year at the University of Kansas Hospital. It provided a preview of what the internship would be like and what dietetics as a profession would be. When I went to my internship at John’s Hopkins it was a 12 month program. I graduated from that program with self-confidence from so much ‘hands-on’ training.

Now I sit on the Dietetic Internship Selection Committee for the University of Alabama at Birmingham. Some days I think ‘I wouldn’t have gotten in today’. It is an amazing process! The expectations are so much higher. You always expected to have a good GPA and letters of recommendation, but not GRE’s of 1200! The expectations of our young RD’s are so much higher. Now everyone needs a Master’s degree. I waited for 20 years to get my Master’s. I had been working for the Department of Public Health and I had an idea of what I would enjoy."

Harriet notes she spent 25 years at the Sparks Center working with at least 40 trainees who had to get their Master’s. “Sometimes I would hear someone say ‘I just want to get it done’. So they may not have had a chance to know what options they might enjoy.

Some internships would benefit from redesign. Does the student need to know every diagnosis and treatment out there? What he/she needs is to learn is what information is out there and how to creatively find and use it.” She feels that the salary expectations for new graduates should be higher, but that the graduates also have to be competent.

**What do you feel is most important for our members?**

Harriet talked about soft skills. She cited several times in her career where, face to face meetings with other RD’s and healthcare professionals made the difference between developing programs, getting grants, and being empowered to make effective change.

“The most difficult meetings for me in the HOD were the Virtual Meetings. There you are, on the phone and the computer for 3 hours. You don’t know who you are speaking with, you can’t make eye contact, and you can’t read their body language.”

She went on to say that every year BHN has a special transition meeting for the Executive Committee. “Our meeting in Austin this year was so important. I roomed with our new House of Delegate’s representative, Cindy Burke. We had a chance to really talk about some issues and to get to know each other. She will be great!”

Harriet went on to say that some might feel that the important ideas and information can be transmitted by Facebook, Twitter, and virtual meetings; however, she thinks along with these, there is incredible value in sitting face to face to address challenges and develop new ideas. Harriet is a proponent of technology in Clinical Nutrition and in Marketing and Programming for our DPG. She thinks that the more we learn how to use it effectively, the more advances we will make in Nutrition as a whole. But, she says “I don’t want the technology to replace the human interaction.”

**About the BHN, she had this to say:**

“We started this DPG as the Dietetics in Developmental and Psychiatric Disorders (DDPD), which addressed the 4 areas in Behavioral Health. These include Developmental Delays, Psychiatric Disorders, Addictions and Eating Disorders.

Early on, Developmental Disorders (DD) was the major focus of the group. The RD’s that worked in Nutrition for Psychiatric populations had a real problem with this. They were not afraid to be vocal about it. So, because of that, changes were made.

continued on page 12
BHN Member Spotlight
continued from page 11

Balance was achieved. Currently, the focus has shifted to Eating Disorders and Addictions. I think these are important but that the other areas are just as important. Keeping balance in our DPG is very important. If we cannot stay balanced with attention to each area, we will lose members.

It will be important to continue strategic planning for balance, and for support of areas that need help. Right now, DD has taken a hit legislatively. Many programs that involved RD’s working with programs for this population have been cut. The problem is there are more patients coming into this population. Autism is an example along with children born prematurely who require Early Intervention and Special Education in preschool and elementary school. BHN members and leaders need to support these areas. A lot of hard work has been done, but more help is needed.

What has been the best advice that anyone has given you during your career?

“I was in a management training course at the Sparks Center. It was a small group of 2 men and 2 or 3 women. The instructor said ‘Why is it that you don’t view yourself as the men who are sitting in the room? You need to build your self-confidence, your self-esteem. If you believe in yourself and have positive self-esteem you will see yourself in a leadership position.’” Harriet thinks this is good advice for any RD in their career. I asked her if she would share some personal moments in her career and life:

When you think back on all of your experiences as a RDN, what is the one that brings you the most joy to remember?

“I have always enjoyed working in this field and with students and many activities in the Academy, but it was special when I won the Copher Award” she answered. Harriet was the recipient of the Academy’s highest honor, the Copher Award in 2004. She also expressed great happiness at having been the first RD to enter the Alabama Healthcare Hall of Fame last summer.

What is next for you, Harriet?

“Well, I am leaving the HOD position, but I am still in the BHN DPG. At the transition meeting I asked them, ‘Why don’t we have a Speaker’s Bureau’ and they thought I would be the person to start that so, I will be bringing some ideas for the group at FNCE this fall.”

What do you like to do in your spare time?

“Well, you know, I have 8 kids, 15 grandchildren and 7 great grandchildren. I like to see them, have them over for dinner and visit. I like to play tennis and bridge.”

How have you balanced it all, Harriet?

“I take a lot of Centrum Silver and I recently added some Vitamin B12.”

I am sure I speak for all of us when I say Harriet, you are amazing! Thank you Harriet!

In Search of Evidence in Behavioral Health and Disabilities

Research has indicated that people who have intellectual and developmental disabilities (IDD) appear to be more vulnerable to having a co-existing psychiatric diagnosis. This study examined Medicaid 1915(c) Home and Community-Based Services (HCBS) waiver applications for people with IDD to determine the mental/behavioral health services proposed. We found that a large variance exists across states in projected spending for services, spending per participant, annual hours of service per participant, and hourly reimbursement rates. Moreover, compared to overall funding we found a general lack of state commitment to mental/behavioral services. States must shore up the capacity of their HCBS 1915(c) waivers to support people with behavioral challenges in addition to IDD in order to assure that services continue to be delivered in the least restrictive environment appropriate.


One in five U.S. adults (More than 53 million) reported a disability in the 2013 Behavioral Risk Factor Surveillance System (BRFSS) survey conducted by the Centers for Disease Control (CDC) and Prevention. CDC analyzed data from the 2013 BRFSS to assess overall prevalence of any disability, as well as specific types of disability among noninstitutionalized U.S. adults. Five questions were included in the survey to identify disability in vision, cognition, mobility, self-care, and independent living. Since disability among adults is associated with disparities in behavioral risk factors for health (e.g., smoking and physical inactivity), more specific information on disability and disability types will inform public health researchers and program planners to better understand the relationships between disability, demographic factors, and health status to identify and address barriers to more effective interventions. Across all states, disabilities in mobility and cognition were the most frequently reported types. A higher prevalence of any disability was generally seen among adults living in states in the South and among women (24.4%) compared with men (19.8%). Prevalences of any disability and disability in mobility were higher among older age groups. These are the first data on functional disability types available in a state-based health survey. Understanding the prevalence of disability is important for public health programs to be able to address the needs of persons with disabilities.

In the BHN Pipeline!

Please Join BHN at FNCE® 2015!

Pre-FNCE Workshop

*Brain Data and Dogma: Expanding MNT to Increase Fiscal Reimbursement*

**Speakers:** CAPT Joseph R Hibbeln, MD USPHS; Ralph Carson, PhD RD LD; Lisa Kantor, JD

**Saturday, October 3, 2015 from 11:30 am-3:30pm**

**Session #356 Music City Center Room 104**

- Dynamic hands-on workshop by international leaders in the field of Behavioral Health Nutrition
- In collaboration with the Academy Center for Professional Development
- Connect nutritional neuroscience, behavioral modification, and your wallet

**Information:** [http://www.eatrightfnce.org/FNCE/content.aspx?id=6442484881](http://www.eatrightfnce.org/FNCE/content.aspx?id=6442484881)

**Register at:** [https://www.compusystems.com/servlet/ar?evt_uid=512](https://www.compusystems.com/servlet/ar?evt_uid=512)

Member Reception & Celebration Event

**Saturday, October 3, 2015 from 8:00pm-10:00pm**

Omni Hotel Broadway Ballroom J

- Free to BHN members
- Pre-FNCE Workshop Attendees receive early entrance at 7:00pm
- Watch your e-mail, BHN’s social media to register

BHN at the DPG/MIG Showcase

**Monday, October 5, 2015 from 9:00am–12:00pm**

- Clarify the Complexity of Nutrition with BHN
- Receive a complimentary brain education Map and *Explore Your Brain!*
- Preview the BHN Starter Kit *Treasure Box*

BHN Spotlight Session

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

**Speakers:** Steven Karn, DO, FACN and Megan Kniskern, MS, RD, CEDRD

**Monday, October 5, 2015 from 3:30pm-5:00pm**

Music City Center / Grand A

- Determine specific dietary deficiencies associated with chronic substance abuse, how they manifest over time, and why they are often overlooked in traditional treatment
- Identify prescription and street drugs abused and their impact that leads to disordered eating patterns
- Explore nutrition interventions for acute and long term recovery support

Visit [www.bhndpg.org](http://www.bhndpg.org) for a list of FNCE® sessions presented by BHN members and suggested sessions on BHN-related topics.

NEW Webinar!

Mark your calendars for the upcoming October 27th webinar: “Medication Interactions and Possible Nutrient Deficiencies from Common Medications”. CEU approved. Look for details in an upcoming email and social media.

BHN Factsheets:

BHN continues to work aggressively on new factsheets in multiple areas of clinical practice, in each of our four practice groups. If you would like to review a collection of topics, suggest an additional topic or would like to author or review individual fact sheets, please contact Mary Kuester, MA, RDN at: publicationchair@bhndpg.org or Ruth Roberts, LPC, LDN, RDN at ruthsfa2@yahoo.com. More information can be found at: [http://www.bhndpg.org/bhn-call-for-authors-for-nutritional-fact-sheets-and-resources/](http://www.bhndpg.org/bhn-call-for-authors-for-nutritional-fact-sheets-and-resources/)

CDR Approval of CEDRD Credential


Academy Quality Management

Scope/Standards Workgroup Update

AND’s Quality Management Scope/Standards Workgroup recently submitted a report to the Academy regarding the current needs and progress of Scope of Practice and Standards of Professional Practice papers (SOP/SOPP). Due to the overwhelming amount of papers that are in need of revision and those that have been proposed, the workgroup has placed a “hold” both updates and new papers. They will continue to update the Scope/Standards of Practice for RDNs and focus areas at this time. Further information can be reviewed regarding cost to review/update each paper, value added, frequency of use as well as recommendations and requests by the workgroup to manage the process effectively to meet appropriate standards and future work in the Academy Program: Scope/Standards of Practice Report.

Social Media

Looking to keep up with the latest BHN webinars, events, programs? Perhaps just awesome information you can “share”, “retweet”, “regram” or Pin for your own followers? Follow BHN and promote the work of all Behavioral Health RD/RDNs!

- Twitter: @BHNDPG
- Facebook: [https://www.facebook.com/BHNDPG](https://www.facebook.com/BHNDPG)
- Instagram: bhn_dpg
- Pinterest: [https://www.pinterest.com/bhndpg/](https://www.pinterest.com/bhndpg/)
Policy and Advocacy Leader (PAL)
Legislative Update
Carol Bradley, PhD, RDN, LD, BCBA • BHN PAL

How do you feel about Action Alerts? I hope you understand how important they are to our ability to practice our chosen profession. The Academy has a great team in Washington DC who follow legislative issues related to practice and reimbursement. WE are the stakeholders so let’s make sure we get behind the Academy’s efforts. New information is that the Academy will track DPG’s engagement in Action Alerts and ANDPAC Participation over this budget year, i.e. percentage of Executive Committee/PAL leaders participating in action alerts. Action Alerts mean that a critical piece of legislation needs your urgent attention – even if you have taken action on that issue before. You know the old saying, “It’s not over till it’s over.”

Nancy Farrell, MS, RDN of the Academy, Vice-Chair of the Academy’s Political Action Committee (ANDPAC) and National Media Spokesperson contacted BHN Chair, Adrien Paczosa, RD, CLD, CEDRD and myself. Ms. Farrell wants to encourage all to support ANDPAC. The purpose of ANDPAC is to solicit donations from Academy members and in turn contributes to the campaigns of candidates for political office whose stance on legislation related to nutrition, food, and health support Academy goals. ANDPAC also works with the Academy’s Legislative and Public Policy Committee (LPPC) to educate dietetics professionals in the political process and encourage their participation through outreach and other efforts. See http://www.eatrightpro.org/resources/advocacy/andpac.

Here is how we can all help:

Support ANDPAC by joining the High Five Club - a $5 monthly donation to help protect food and nutrition policy efforts on Capitol Hill, and hence their livelihood as RDNs, go to http://www.eatrightpro.org/resources/advocacy/andpac/donate-to-andpac (under Donate Now - select the High Five Club campaign). I am a member of the President’s circle this year based on two donations I was able to make.

Both Nancy and Pepin Tuma of Academy Regulatory Affairs want us to stay attune to nutrition public policy issues such as Medicaid Prevention Services and on States Expansion of Medicare/Medicaid Act. The Academy wants DPG input on implementing nutrition program regulations. These issues identified by Regulatory Affairs could be ones of specific interest to you, our members including TeleHealth with clients.

If you are interested in giving input and/or are an expert on the above, please let us know.

Thanks for your support!

Carol Bradley, PhD,
RDN, LD, BCBA

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Academy of Nutrition and Dietetics

FNCE® 2015
Food & Nutrition Conference & Expo™

Music City Center | Nashville, TN | October 3-6, 2015
This year the House of Delegates (HOD) will meet on October 2-3 2015 in Nashville, Tennessee. At this meeting the Mega Issue to be discussed will be Malnutrition. A survey was sent early in September to BHN member to gather information that will be included at this meeting. In addition, there will be a membership issue discussion with a report by Sponsorship Advisory Task Force Report.

The Mega Issue question is: **How do we empower RDN’s to be leaders in management of malnutrition (identification, diagnosis, and intervention)?**

The discussion will address the following questions:

1. What do we know about the needs, wants and expectations of members, customers and other stakeholders related to this issue?
2. What do we know about the current realities and evolving dynamics of our members, marketplace, industry and the profession that is relevant to this decision?
3. What do we know about the capacity and strategic position of the Academy in terms of its ability to address this issue?
4. What ethical/legal implications, if any, surround the issue?

The Meeting Objectives are that participants will be able to:

1. Recognize the magnitude, contributing factors and consequences of malnutrition in the United States.
2. Expand awareness of the impact/outcomes of managing malnutrition (identification, diagnosis, intervention) across all dietetic practice settings.
3. Affirm and promote the role of and the opportunities for RDNs and NDTRs in management of malnutrition.

The Academy of Nutrition and Dietetics has a vested interest in addressing malnutrition and teaching members how to identify, document and treat malnutrition. Various resources have been developed, and partnerships have been formed to further the Academy’s vision of optimizing health through food and nutrition. Resources, partnerships and research currently is available on the Academy Website including, but not limited to, information on reimbursement, practice tools and resources, Alliance to Advance Patient Nutrition, Malnutrition Quality Improvement Initiative, Malnutrition Resource Center and Nutrition Focused Physical Exams.

Early identification, assessment, and nutrition intervention of the malnourished individual or individual at risk for malnutrition is important in improving outcomes. As the nutrition expert, the RDN can and should be involved with the complete spectrum of addressing and managing malnutrition.

Background information and a fact sheet for this issue is available at eatrightpro.org or use this link: Malnutrition (http://www.eatrightpro.org/resource/leadership/house-of-delegates/mega-issues-and-backgrounders/an-overview-of-mega-issues-and-backgrounders)

**Member Issue Discussion**

**Sponsorship Advisory Task Force- Update**

The Academy Sponsorship Advisory Taskforce (SATF) met in Washington DC on June 18-19th to review the important feedback provided by the Academy’s Spring House of Delegates meeting. This feedback became the cornerstone as they continued to develop guidelines for Sponsorship that align with the Academy’s vision to optimize health through food and nutrition.

The SATF plan is to report on proposed guidelines to the HOD at FNCE for input and comment. This will be the HOD’s membership issue discussion on Saturday, October 3. HOD’s input will be used to develop a formal report for the BOD in early 2016. In addition, SATF plans to develop a strategic communication plan to foster transparency in the guidelines themselves as well as in the rollout of this document. The guidelines will cover endorsement, evaluation of products, promotion of RDNs, and the harmonization of sponsorship across all Academy units.

An update of the outcomes of this HOD meeting will be provided.

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**The First Fifty: A Pictorial History of the Academy of Nutrition and Dietetics, 1917–1967** documents six eras in the Academy’s history in black-and-white and color photographs that chronicles the origins of the Academy of Nutrition and Dietetics and the profession it represents.

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Contribute an article or topic for future BHN Newsletter issues!
Contact newslettereditor2@bhndpg.org or one of the BHN leaders listed in this newsletter.

BHN: Fuel Your Brain, Feel Your Best!

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/