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PSYCHOTROPIC DRUGS,
NUTRITIONAL AND WEIGHT
MANAGEMENT CONSIDERATIONS

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One out of five Americans may experience psychiatric illness, such as major depression, anxiety, panic attacks, eating disorder, neuropsychological illness, bipolar disorder, schizophrenia, ADHD (attention deficit hyperactivity disorder), OCD (obsessive compulsive disorder), JED (intermittent explosive disorder), ODD (oppositional defiant disorder), PTSD (post traumatic stress disorder), PMDD (premenstrual dysphoric disorder). Depression is diagnosed in 5-6% of the American population at any one time and at least 10% will suffer depression at some point in their lives. One percent will become ill with schizophrenia. Seventy-five percent of those develop schizophrenia between ages 16-25.

In October, 2003 The American Dietetic Association issued a position paper on "Integrating MNT and Pharmacotherapy". "It is the position of the American Dietetic Association that the application of medical nutrition therapy and lifestyle counselling as a part of the Nutrition Care Process is an integral component of the medical treatment for the management of specific disease states and conditions, and should be the initial step in the management of these situations. If optimal control cannot be achieved with medical nutrition therapy alone and concurrent pharmacotherapy is required, the Association promotes a team approach to care for clients receiving concurrent medical nutrition therapy and pharmacotherapy and encourages active collaboration among dietetics professionals and other members of the health care team." ADA Position Paper: J Am Diet Assoc, 2003;103:1363-1370 Authors: Mary Hager, PhD, RD and Andrea Hutchens, PhD, RD

Psychotropic drugs are defined as drugs that affect psychic functions, behavior or experience. They are generally divided into classes by indications (such as antidepressant) and/or structure such as Tricyclic antidepressant and/or by action, such as SSRI (selective serotonin reuptake inhibitor) antidepressant.

GENERAL CAUTIONS/ADVERSE EFFECTS

- Anticholinergic Effects: Dry eyes, blurred vision, increase intraocular pressure / glaucoma, dry mouth, constipation, urinary retention, rapid heart rate, cardiac arrhythmias, sedation, confusion, rare delirium.

- Anti-histaminic Effects: Sedation, drowsiness.

- Seizures: Some agents lower the seizure threshold and increase seizure risk in individuals predisposed to seizures.

- Mania / Hypomania: Any antidepressant may induce mania or hypomania particularly in individuals with bipolar disorder.

- Serotonin Syndrome: Precipitated by SSRI or the combination of serotonin elevating agents (i.e.: an SSRI and St John’s Wort). Symptoms include agitation, CNS irritability, motor weakness, shivering, muscle rigidity and altered consciousness.

SPECIFIC CAUTIONS and BENEFITS:


- Bupropion (Wellbutrin, Wellbutrin SR, Wellbutrin XL): Dose related seizures. Zyban for smoking cessation is the same as Wellbutrin SR. These products should not be combined. Bupropion is the only agent not associated with sexual dysfunction and generally non sedating.

- Neofazodone (Seroxene): Hepatotoxicity associated with nefazodone makes it an agent of last resort, in fact the brand name, Seroxene is no longer marketed.
From the Chair

Mary Emerson, MS, RD/LD

I was recently at a presentation on the University of New Hampshire’s Northeast Passage program which enables people with disabilities to have access to recreational activities. I was reminded once again of DDPD’s importance as a voice for individuals with disabilities. Our representation at the Public Policy Workshop by Lee Wallace, our incoming Chair, and Andrea Shotton, our Legislative Chair, this past March reminded me how important our voice is for people with disabilities.

DDPD continues to offer valuable services to our members, such as our FREE AV library (contact Joyce Lowe at Lowe@charter.net), our listerv (contact Sharon Lemons at lemons@prodigy.net), our speaker stipends of $400 each for those members supporting a speaker on a topic related to our area of interest (contact Lee Wallace at leesgoodfood@comcast.net), our resource professionals who are available to answer questions or provide guidance in their area of expertise, and of course our quarterly newsletter. We are now in the process of transitioning newsletter editors. I thank Melissa Altman-Traub for her service to DDPD over the past three years! I welcome aboard Joan Medlen who will be taking over as newsletter editor. Please drop Joan a line at joan@ipns.com if you are interested in either writing an article for the newsletter or would like to tell other DDPD members about programs/events in your area that would be of interest.

I am very proud to announce that DDPD has an active work group working on developing Standards of Practice for Behavioral Health Registered Dietitians. Standards of Practice are authoritative statements that describe a competent level of practice demonstrated through nutrition assessment, nutrition diagnosis (problem identification), nutrition intervention (planning, implementation), and outcomes monitoring and evaluation describing the responsibilities for which registered dietitians are accountable. They are not inflexible rules or requirements of practice and are not intended, nor should they be used, to establish a legal standard of care. They will help us to explain what medical nutrition therapy is in the various behavioral health settings that we are employed in. Have you ever been asked “What do you do as a dietitian in behavioral health?” Well this will help answer the question! I will keep you updated in future editions of the newsletter.

Whether we work in substance abuse, developmental disorders, eating disorders or psychiatric care, DDPD brings us together under one umbrella working together to be that voice for people with disabilities. It has been a privilege for me to serve as your chair and to be part of that voice. I know that as Lee Wallace takes over as your chair, DDPD’s voice will continue to be heard.

Looking Towards Next Year

Lee Shelly Wallace, MS, RD, LDN, FADA

The new fiscal year began on June 1, 2005. The Executive Committee was hard at work as always this past year, trying to provide services requested and needed by DDPD members.

Recent accomplishments include:
- DDPD Website - up and running with monthly updates
- Our listerv - we’ve had some great discussions and very helpful info shared!
- FNCE - not only a priority session, but also a breakfast meeting with CPE credit for members for the past two years. Hopefully this year as well - and a preconference workshop, too!!
- More DDPD business done on teleconference calls or over the internet, by email, listerv, or chat rooms. Training other than at FNCE is being provided on teleconference calls or Webinars. All of these new media options have reduced our overhead costs
- Publication - and debut at FNCE! - of the revised book Children with Special Health Care Needs

Other things we want to do in coming years include:
- Expand our ability to provide new tools for members - books, pamphlets, fact sheets, either written or downloadable.
- Expand the CPE available to professionals in our four specialty areas of practice.
- Provide needed information to our many members who are not exclusively employed in one of our four areas, but do work with individuals who fall in to one of the four groups.

To reach these goals, we will be expanding our publications committee, creating a fund-raising committee, and, as with many of the other DPG’s have, we will be raising our dues this year, for the first time in over 20 years. We want to continue to be able to provide the services, networking, and assistance YOU need to do your job to the best of your ability.

Be active! Get involved! Start by joining the listerv putting your name on our Membership Map in the public area of the website, so people can find YOU when they need a professional in your geographic region.

Please email me at leesgoodfood@comcast.net if you have comments, suggestions for projects, or want to volunteer.

Member News

Congratulations to Joyce Lowe, our A/V librarian. Joyce has just retired after 18 years with the Department of Disability and Special Needs with the State of South Carolina. She now has a new email address: Lowe@charter.net
## A. Agents for the Treatment of Depression

### Tricyclic Antidepressants

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
<th>Anticholinergic Effects</th>
<th>Sedative Effect</th>
<th>Hypotensive Effect</th>
<th>Effect on Norepinephrine</th>
<th>Effect on Serotonin</th>
<th>Associated with Weight Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>amitriptyline</td>
<td>ELAVIL</td>
<td>Very High</td>
<td>Very High</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Very High</td>
<td>Yes</td>
</tr>
<tr>
<td>clomipramine</td>
<td>ANAFRANIL</td>
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<td>High</td>
<td>Moderate</td>
<td>Moderate</td>
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</tr>
<tr>
<td>doxepin</td>
<td>SINEQUAN</td>
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<td>Moderate</td>
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<tr>
<td>imipramine</td>
<td>TOFRANIL</td>
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<td>Moderate</td>
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<tr>
<td>trimipramine</td>
<td>SURMONTIL</td>
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<td>High</td>
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### Secondary Amines

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
<th>Anticholinergic Effects</th>
<th>Sedative Effect</th>
<th>Hypotensive Effect</th>
<th>Effect on Norepinephrine</th>
<th>Effect on Serotonin</th>
<th>Associated with Weight Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>desipramine</td>
<td>NORPRAMIN</td>
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<td>Low</td>
<td>Low</td>
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<td>Moderate</td>
<td>Possible</td>
</tr>
<tr>
<td>nortriptyline</td>
<td>PAMELOR</td>
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<td>Moderate</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
<td>Possible</td>
</tr>
<tr>
<td>protriptyline</td>
<td>VIVACTIL</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
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<td>Unlikely</td>
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</table>

### Selective Serotonin Reuptake Inhibitors

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
<th>Anticholinergic Effects</th>
<th>Sedative Effect</th>
<th>Hypotensive Effect</th>
<th>Effect on Norepinephrine</th>
<th>Effect on Serotonin</th>
<th>Associated with Weight Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>citalopram</td>
<td>CELEXA</td>
<td>Rare</td>
<td>Rare</td>
<td>Rare</td>
<td>Rare</td>
<td>Very High</td>
<td>Unlikely</td>
</tr>
<tr>
<td>fluoxetine</td>
<td>PROZAC</td>
<td>Rare</td>
<td>Rare</td>
<td>Rare</td>
<td>Rare</td>
<td>Very High</td>
<td>Unlikely</td>
</tr>
<tr>
<td>fluvoxamine</td>
<td>LUVOX</td>
<td>Rare</td>
<td>Rare</td>
<td>None</td>
<td>Rare</td>
<td>Very High</td>
<td>Unlikely</td>
</tr>
<tr>
<td>paroxetine</td>
<td>PAXIL</td>
<td>None</td>
<td>Rare</td>
<td>None</td>
<td>Rare</td>
<td>Very High</td>
<td>Possible</td>
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<tr>
<td>sertraline</td>
<td>ZOLOFT</td>
<td>None</td>
<td>Rare</td>
<td>None</td>
<td>Rare</td>
<td>Very High</td>
<td>Unlikely</td>
</tr>
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</table>

### Monoamine Oxidase Inhibitors (MAOIs)

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
<th>Anticholinergic Effects</th>
<th>Sedative Effect</th>
<th>Hypotensive Effect</th>
<th>Effect on Norepinephrine</th>
<th>Effect on Serotonin</th>
<th>Associated with Weight Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>phenelzine</td>
<td>NARDIL</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>tranylcypromine</td>
<td>PARNATE</td>
<td>Low</td>
<td>Low</td>
<td>Rare</td>
<td>-</td>
<td>-</td>
<td>Possible</td>
</tr>
<tr>
<td>isocarboxazid</td>
<td>MARPLAN</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>-</td>
<td>-</td>
<td>Yes</td>
</tr>
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</table>

### Miscellaneous Antidepressants

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
<th>Anticholinergic Effects</th>
<th>Sedative Effect</th>
<th>Hypotensive Effect</th>
<th>Effect on Norepinephrine</th>
<th>Effect on Serotonin</th>
<th>Associated with Weight Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>maprotiline</td>
<td>Generic Only</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Low</td>
<td>High</td>
<td>Rare</td>
<td>Possible</td>
</tr>
<tr>
<td>mirtazapine</td>
<td>REMERON</td>
<td>Moderate</td>
<td>High</td>
<td>Moderate</td>
<td>High</td>
<td>High</td>
<td>Yes</td>
</tr>
<tr>
<td>trazodone</td>
<td>DESYREL</td>
<td>Low</td>
<td>Very High</td>
<td>Moderate</td>
<td>None</td>
<td>High</td>
<td>Possible</td>
</tr>
<tr>
<td>bupropion</td>
<td>WELLBUTRIN, SR, XL</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Low</td>
<td>Rare</td>
<td>Rare</td>
<td>Unlikely</td>
</tr>
<tr>
<td>venlafaxine</td>
<td>EFFEXOR, XR</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>High</td>
<td>Unlikely</td>
</tr>
<tr>
<td>nefazodone</td>
<td>SERZONE</td>
<td>None/Low</td>
<td>Moderate</td>
<td>Low</td>
<td>Rare</td>
<td>Very High</td>
<td>Unlikely</td>
</tr>
</tbody>
</table>

### Cautions continued from page 1

- Venlafaxine (Effexor, Effexor XR): Has been shown to elevate diastolic blood pressure especially at higher doses. Use cautiously, if at all, in individuals with difficult to control blood pressure. Well tolerated, no anticholinergic effects, non sedating.
- MAO Inhibitors: Ingestion of foods high in pressor substances (tyramine, histamine, dopamine, phenylethylamine) while taking an MAO inhibitor may lead to a hypertensive crisis. These pressor substances are generally found in aging or decaying foods.
- Mirtazapine (Remeron): Appetite stimulant, may result in weight gain. Often useful for atypical depression associated with anorexia, particularly in geriatrics. Once daily dosing, sedating, lacks anxiety side effects, helpful for symptoms of insomnia.
**FDA APPROVED SSRI INDICATIONS:**

- **Fluoxetine (Prozac):** Depression, Obsessive Compulsive Disorder, Bulimia Nervosa, Premenstrual Dysphoric Disorder (Sarafem)
- **Paroxetine (Paxil):** Depression, Obsessive Compulsive Disorder, Bulimia Nervosa, Social Anxiety, Post Traumatic Stress Disorder
- **Sertraline (Zoloft):** Depression, Obsessive Compulsive Disorder, Panic Disorder, Post Traumatic Stress Disorder
- **Citalopram (Celexa):** Depression
- **Fluvoxamine (Luvox):** Obsessive Compulsive

**B. ANTIPSYCHOTIC AGENTS**

*Indicated for treatment of schizophrenia. Also used to treat acute manic episodes, psychotic features of dementia, intermittent explosive disorder and other disorders with psychotic features.*

### First Generation Agents - Low Potency

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
<th>Sedative Effect</th>
<th>Extrapyramidal Symptoms</th>
<th>Anticholinergic Effects</th>
<th>Hypotensive Effect</th>
<th>Weight Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>chlorpromazine</td>
<td>THORAZINE</td>
<td>High</td>
<td>Moderate</td>
<td>Moderate</td>
<td>High</td>
<td>Moderate</td>
</tr>
<tr>
<td>mesoridazine</td>
<td>SERENTIL</td>
<td>High</td>
<td>Low</td>
<td>High</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
<tr>
<td>thioridazine</td>
<td>MELLARIL</td>
<td>High</td>
<td>Low</td>
<td>High</td>
<td>High</td>
<td>Moderate</td>
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</table>

### First Generation Agents - High Potency

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
<th>Sedative Effect</th>
<th>Extrapyramidal Symptoms</th>
<th>Anticholinergic Effects</th>
<th>Hypotensive Effect</th>
<th>Weight Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>fluphenazine</td>
<td>PROLIXIN</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
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<tr>
<td>perphenazine</td>
<td>TRILAFON</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>trifluoperazine</td>
<td>STELAZINE</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>thiothixene</td>
<td>NAVANE</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
<td>Moderate</td>
<td>Low</td>
</tr>
<tr>
<td>haloperidol</td>
<td>HALDOL</td>
<td>Low</td>
<td>High</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>pimozide</td>
<td>ORAP</td>
<td>Moderate</td>
<td>High</td>
<td>Moderate</td>
<td>Low</td>
<td>Low</td>
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<tr>
<td>molindone</td>
<td>MOBAN</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>loxapine</td>
<td>LOXITANE</td>
<td>Low</td>
<td>Moderate</td>
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<td>Low</td>
</tr>
</tbody>
</table>

### Second Generation Agents (also referred to as “atypical antipsychotics”)

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
<th>Sedative Effect</th>
<th>Extrapyramidal Symptoms</th>
<th>Anticholinergic Effects</th>
<th>Hypotensive Effect</th>
<th>Weight Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>clozapine</td>
<td>CLOZARIL</td>
<td>High</td>
<td>Low</td>
<td>High</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>olanzapine</td>
<td>ZYPREXA</td>
<td>High</td>
<td>Low</td>
<td>High</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>quetiapine</td>
<td>SEROQUEL</td>
<td>Moderate</td>
<td>None</td>
<td>Rare</td>
<td>Moderate</td>
<td>Low</td>
</tr>
<tr>
<td>risperidone</td>
<td>RISPERDAL</td>
<td>Low</td>
<td>Low/Moderate</td>
<td>Rare</td>
<td>Low</td>
<td>Moderate</td>
</tr>
<tr>
<td>ziprasidone</td>
<td>GEODON</td>
<td>Moderate</td>
<td>Low/Moderate</td>
<td>Rare</td>
<td>Moderate</td>
<td>Rare</td>
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<tr>
<td>aripiprazole</td>
<td>ABILIFY</td>
<td>Moderate</td>
<td>None</td>
<td>Rare</td>
<td>None</td>
<td>Low</td>
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</tbody>
</table>

### Mechanism of Action

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
<th>Inhibits Sodium Channels</th>
<th>Enhances GABA</th>
<th>Inhibits Excitatory Amino Acids</th>
<th>Affects Neurotransmitters</th>
<th>Weight Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>lithium</td>
<td>Lithobid, Eskalith CR</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>High</td>
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<tr>
<td>divalproex</td>
<td>Depakote</td>
<td>X</td>
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<td></td>
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<tr>
<td>carbamazepine</td>
<td>Tegretol</td>
<td>X</td>
<td></td>
<td>X</td>
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<td>gabapentin</td>
<td>Neurontin</td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
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<tr>
<td>topiramate</td>
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</tbody>
</table>
First generation agents block dopamine receptors in the limbic system, the cortex, and the nigrostriatal area. All first generation agents block dopamine D-2 receptors and to varying degrees D-1 receptors. First generation agents effectively relieve positive symptoms of psychosis (delusions, hallucinations, bizarre behavior), but have little effect, if any, on negative symptoms (apathy, anhedonia, social withdrawal, flat affect, poverty of speech).

Clozapine (Clozaril) was the first second generation antipsychotic agent studied and marketed in the U.S. It significantly improved symptoms in about 40 to 50% of those schizophrenic individuals formerly labeled treatment resistant (about 10-20% of all schizophrenics). Clozapine was considered a major therapeutic breakthrough in the treatment of schizophrenia.

Second generation agents have greater affinity for dopamine D-1 receptors and a different ratio of D-1 receptor to D-2 receptor affinity. Affinity for dopamine receptors appears to be more specific to the limbic system than other areas of the brain as compared to older typical agents. This may account for a lower degree of motor impairment (e.g., dystonias, pseudoparkinsonism) with atypical agents. Second generation agents also have a greater effect as serotonin receptor antagonists which may explain their superiority in improving both positive and negative symptoms of psychosis.

**CAUTIONS / ADVERSE EFFECTS**

- **Extrapyramidal Symptoms** include: dystonias: torticollis, opisthotonos, oculogyric crisis. Severe muscle spasm locking various body areas in distorted positions; akathisia: subjective feeling of the need to keep moving, inability to sit still, severe restlessness.
- **Parkinson-like Symptoms**: rigidity, gait disturbances, mask-like face, drooling, tremor.
- **Tardive dyskinesia**: potentially irreversible, involuntary movement of the mouth, lips, tongue, head, neck. It can interfere with eating, swallowing, breathing.
- **Neuroleptic Malignant Syndrome** (NMS): a relatively rare but potentially life-threatening condition consisting of hyperthermia, muscle rigidity, altered state of consciousness, agitation.
- **Cardiovascular events**: orthostatic hypotension, arrhythmias, widening QT interval on ECG, sudden cardiac death.
- **Clozapine** (Clozaril) toxicity: Life-threatening toxicity agranulocytosis, a severe decrease in white blood cell count, danger of death by bacterial infection. Several deaths occurred in clinical trials. Individuals taking clozapine must register with the national clozapine registry. Once registered, the individual may receive only a 7 day supply of medication after having a WBC count which is within acceptable limits. Thereafter, WBC count must be done weekly in order to continue receiving a seven day supply of the drug. After six months without problems, the patient may be tested every two weeks. After a further six months, frequency of testing may be reduced to every four weeks. Once an individual experiences a low WBC count, he/she can NEVER be re-challenged with clozapine. A second reaction is usually rapid and more virulent often resulting in death.
- **Endocrine Effects**: Gynecomastia, galactorrhea, amenorrhea.
- **Weight gain**: Common to most antipsychotic agents, but more pronounced with several second generation agents. In descending order: clozapine (Clozaril), olanzapine (Zyprexa), risperidone (Risperdal), quetiapine (Seroquel).2 Unlikely with ziprasidone (Geodon) or aripiprazole (Abilify).
- **Diabetes/Insulin Resistance**: Most common with second generation agents. Now a class warning for all second generation (atypical) antipsychotics.
- **Hyperlipidemia**: Most common with clozapine (Clozaril) or olanzapine (Zyprexa).

**C. Anti-Manic / Mood Stabilizing Agents**


The following anticonvulsants are also used to treat Bipolar and Mood disorders. Only divalproex has an actual indication for treatment of acute manic episodes:

| Anticonvulsants | Divalproex (Depakote), carbamazepine (Tegretol), gabapentin (Neurontin), lamotrigine (Lamictal), topiramate (Topamax) |

**Cautions with the Use of Antimanic Agents**

Lithium (Eskalith, Lithobid) is a toxic agent with a narrow therapeutic range: 0.6 - 1.4 mEq/L. Adverse effects correlate with serum levels above 1.4mEq/L. It has definite teratogenic effects and is Pregnancy category D. Serum levels change rapidly in response to dehydration, changes in renal function, and dietary sodium intake.

Divalproex (Depakote) has been associated with a risk of hepatotoxicity and liver failure, particularly in children under the age of two years. It is a known teratogen, associated with neural tube defects; pregnancy category D.

Carbamazepine (Tegretol) has been associated with aplastic anemia and agranulocytosis. Do not use in any individual with a blood disorder. Monitor CBC at baseline, weekly for 3 weeks, monthly for 3 months then periodically.

Lamotrigine (Lamictal) may cause life-threatening rashes (including Stevens-Johnson Syndrome). This is associated with high levels of drug and rapid increase in dose. The drug is contraindicated in children younger than age 16 years. Use with divalproex or valproic acid increases the risk of rash development.

Topiramate (Topamax) may cause significant anorexia and weight loss. Paresthesias and tremors of upper and lower extremities and/or visual and speech disturbances occur in > 10% of patients.

**D. ANTI-ANXIETY AGENTS**

Benzodiazepines: Indicated for the treatment of anxiety, panic disorder, and as adjunct anticonvulsants, but may also be used for conscious sedation, as hypnotics, and pre-procedure sedation. These drugs have anti-anxiety, sedative / hypnotic, muscle relaxant and anticonvulsant effects.

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
<th>Onset of Action</th>
<th>Half-life (Hours)</th>
<th>Active Metabolite</th>
<th>Associated with Weight Gain</th>
</tr>
</thead>
<tbody>
<tr>
<td>alprazolam</td>
<td>XANAX</td>
<td>Intermediate</td>
<td>Short</td>
<td>Yes (+/-)</td>
<td>Possible</td>
</tr>
<tr>
<td>chlor Diazepoxide</td>
<td>LIBRIUM</td>
<td>Intermediate</td>
<td>Short</td>
<td>Yes</td>
<td>Possible</td>
</tr>
<tr>
<td>clonazepam</td>
<td>KLOP0IN</td>
<td>Intermediate</td>
<td>Intermediate</td>
<td>Yes</td>
<td>Unlikely</td>
</tr>
<tr>
<td>clorazepam</td>
<td>TRANXENE</td>
<td>Rapid</td>
<td>Long</td>
<td>Yes</td>
<td>Possible</td>
</tr>
<tr>
<td>diazepam</td>
<td>VALIUM</td>
<td>Very Rapid</td>
<td>Long</td>
<td>Yes</td>
<td>Unlikely</td>
</tr>
<tr>
<td>lorazepam</td>
<td>ATIVAN</td>
<td>Intermediate</td>
<td>Short</td>
<td>No</td>
<td>Unlikely</td>
</tr>
<tr>
<td>oxazepam</td>
<td>SERAX</td>
<td>Slow</td>
<td>Short</td>
<td>No</td>
<td>Unlikely</td>
</tr>
</tbody>
</table>
CAUTIONS / ADVERSE EFFECTS OF BENZODIAZEPINES

- Addiction Potential: Agents are Schedule IV controlled substances which cause limited physical and psychological dependence and abuse potential.
- CNS: Sedation, drowsiness, incoordination, amnesia, paradoxical reactions, ataxia, poor mental concentration.
- Pregnancy: Category D; retrospective studies clearly show high rate of fetal malformation when benzodiazepines are ingested by pregnant woman in her first trimester. Chronic ingestion during pregnancy can lead to withdraw symptoms, lethargy, hypotonia in the infant after birth.

Buspirone (Buspar) is a non-benzodiazepine anti-anxiety agent and may act as a partial agonist at serotonin 5HT1A receptors. Buspirone does not exhibit muscle relaxant, sedative / hypnotic, or anticonvulsant properties. Buspirone take 3 to 6 weeks to exert a therapeutic effect. It is not effective for an acute anxiety episode. No abuse potential reported to date.

**CAUTIONS / ADVERSE EFFECTS**

- CNS: Dizziness, lightheadedness, headache, insomnia.
- Others: Infrequent nausea, dry mouth, constipation, diarrhea.
- No significant effect on appetite or weight.

E. Agents Commonly Used for the Treatment of ADHD (Attention Deficit Hyperactivity Disorder)

<table>
<thead>
<tr>
<th>Amphetamine Stimulants</th>
<th>Non-Amphetamine Stimulants</th>
</tr>
</thead>
<tbody>
<tr>
<td>• dextroamphetamine</td>
<td>• methylphenidate CI</td>
</tr>
<tr>
<td>• amphetamine mixture</td>
<td>• Ritalin Tablets, Ritalin SR Tablets</td>
</tr>
<tr>
<td>Dextro</td>
<td>Adderall</td>
</tr>
<tr>
<td>Capsules: prompt and extended release</td>
<td>Concerta Tabs: prompt release with extended release core.</td>
</tr>
<tr>
<td>Capsules: prompt and extended release</td>
<td>Cykert Tabs (The brand name Cykert was just withdrawn from the market in 2005)</td>
</tr>
</tbody>
</table>

Non-Stimulants

- atomoxetine
- desipramine
- bupropion

Stimulants appear to affect central dopamine levels by blocking reuptake of dopamine and possibly by increasing dopamine release. Similar effects on noradrenaline may also contribute to the therapeutic effects of stimulants as well.

Atomoxetine (Strattera) is a selective presynaptic norepinephrine reuptake inhibitor; how this mechanism contributes to decreasing the symptoms of ADHD is uncertain.

Cautions with the Use of Agents for ADHD in Children

- Growth suppression has been reported with long-term use of stimulants in children. This appears to be a condition unrelated to the anorexiant effects of these agents. "Catch up growth" has been reported when children are given a drug free period (i.e. summer breaks). Atomoxetine (Strattera) has been shown to inhibit weight gain and growth in children as compared to placebo. With both groups of agent children's weight and growth should be monitored closely.
- Neither stimulants nor atomoxetine (Strattera) should be used in individuals with cardiovascular or cerebrovascular disease. A black box warning was recently added to atomoxetine (Strattera) due to two cases of severely elevated liver enzymes.
- Pemoline (Cykert) has been associated with hepatotoxicity including elevation of liver enzymes, hepatitis, jaundice, and fatalities from acute liver failure. A minimum of twice monthly liver function studies must be completed while child is on this drug.
- Stimulants may worsen behavioral disturbances in psychotic children and/or may precipitate Tourette's and other tic disorders.

Common Adverse Effects of Stimulants

- CNS: Nervousness, anxiety, insomnia, headache, irritability, seizures (uncommon), facial dyskinesia (pemoline and amphetamines), rare psychotc episodes with hallucinations.
- G.I.: stomachache, anorexia, weight loss, nausea.
- C.V.: palpitations, tachycardia, hypertension (amphetamine).

Common Adverse Effects of atomoxetine (Strattera)

- Decreased appetite / weight, nausea, vomiting, dry mouth.
- Headache, dizziness, mood swings, irritability, insomnia, somnolence.
- Urinary retention, constipation.

F. COMBATING WEIGHT GAIN

Weight Gain is much more than a cosmetic problem. Medical consequences are well known, such as higher rates of cancer, diabetes, and/or cardiovascular disease. Less emphasized, but often more immediately limiting are joint problems, particularly in the lower extremities and skin problems, such as cellulitis.

Psychological/Behavioral concerns include poor self image, depression and reluctance to participate in social or physical activities. These psychological problems can counteract some of the beneficial effects of psychotropic drugs by creating new problems (such as depression or anxiety due to weight gain).

Financial - Following is a statement from WebMD on obesity related health care costs in 1998. The cost of lost work time is not included, nor is the cost of clothing, which becomes significant in cases of large weight gain over short periods of time.

Possible Mechanisms of Weight Gain due to Psychotropic Drugs

The hunger associated with psychotropic drug induced appetite stimulation is “a need to eat/ Inability to feel full”, not true increased hunger, (no crambling stomach).

Possible mechanisms of weight gain are:

- Leptin Resistance: Leptin is a hormone produced by adipose tissue. Leptin is an appetite suppressant. Antipsychotics generally cause elevated leptin levels, indicating leptin resistance. Insulin stimulates leptin production. Drug induced hyperinsulinemia may contribute to problem.5,5
- Insulin resistance which leads to increased insulin release, hyperinsulinemia, greater glucose uptake and therefore weight gain.49
- Histamine H1 Receptor Blockade: Stimulation of CNS H1 receptors in rats causes decreased food intake, thus blockade causes increased food intake.
- Serotonin type 2C Receptor Blockade: Mice genetically altered to be devoid of Serotonin type 2C receptors become obese. This may explain why blockade of these same receptors leads to weight gain.
**Behavioral Approaches to Combat Weight Gain**

Emphasis on lifestyle changes, rather than "diet" is often most successful, particularly for individuals combating mental illness. Avoid negatives, such as "you can't have".

**Awareness of an individual's diagnosis** is essential to design a successful program to combat weight gain. An individual with a diagnosis of ODD requires a very different approach than one with a diagnosis of ICD.

**Obesity Expenses Tax States**

| Obesity not only puts a strain on America's health, it's also taking a toll on our wallets. A new study shows that obesity-related health-care costs reached an estimated $75 billion in 2003, and taxpayers foot the bill for about half of those expenses through Medicare and Medicaid. Researchers found total obesity-related health-care costs varied greatly from state to state, ranging from a low of $87 million in Wyoming to a high of $7.7 billion in California. Taxpayer-funded Medicare and Medicaid expenses attributed to obesity were highest in California and New York, respectively, with a combined price tag of more than $5 billion. |

Oppositional clients generally will respond much better to "diets" if THEY feel that they are in control, while those with impulse control problems may need more imposed limitations.

Many problems, such as learning disabilities, make it difficult for individuals to cooperate with any regimen that involves making choices. OCD is especially a challenge since a client may become obsessive about a suggested change to the point of self harm or exaggeration (such as eating an entire 12 pack of corn cakes at one sitting because "the dietitian" suggested this as a "good" snack).

**Education** about drug effects should always be part of education about an individual's medication. But, too much emphasis on appetite stimulation leading to weight gain may "back fire". It is not uncommon for a client to state "It's not my fault I'm gaining the weight too because I'm taking-- medication for my weight loss. Why? What, Where, When? Why is the client eating excessive calories? True hunger or other reasons for eating, such as boredom, peer pressure, parties, eating out, etc. What is he/she eating? Excess amounts of well-balanced meals or "junk" foods? Some individuals do well keeping a food intake record/diary, but, for many, this is a "turn off". Frequent clients agree to keep diaries, but either do not do so, or simply record those items which are on their meal plan and fail to record those they know will meet with disapproval.

**Where is he/she eating?** Only at the dinner table versus in front of the TV, in vehicles, at the movies, bowling, etc. Does the client live in an apartment, parent's home, group home or residential treatment facility?

**When is he/she eating?** Timing of meals and snacks needs to be reviewed. A snack too close to a meal may result in poor intake of a balanced meal, but an appetite for further snacking later in the evening. Behavioral approaches can be tailored to address specific problems, such as the perception that watching a movie "must" include a large soda, box of candy and popcorn! Or that there **"must"** be a high calorie snack offered upon coming home from work at 4, even though dinner is at 5:30.

**Exercise** and increased activity level needs to be encouraged as realistic. To expect a "couch potato" to immediately begin exercising an hour a day is unrealistic. Suggestion of such a goal will usually be rejected. Five to ten minutes a day three times a week might be a first step and may involved simply getting off the couch and walking around the house.

**Group** approaches such as weight loss programs (Weight Watchers, LA Weight Loss, YMCA groups, etc.) may work for some individuals or a group of individuals such as a number of clients who live together in a group home. "Meal club" or "supper club" have been successful in some settings, as opposed to the terms "weight loss group" or "diet".

**NAMI** — National Alliance for the Mentally Ill (www.nami.org) has a new support program. "Hearts and Minds" program which debuted in February, 2004. **Hearts & Minds** is a new educational undertaking to promote awareness and reduce risk of cardiovascular disease among people with mental illness. **Hearts & Minds** focuses on four main health areas weight gain and reduction, exercise, smoking, cessation and diabetes risk. The program consists of a 12 minute videotape and 26 page workbook. In select locations, the program will be presented by a live speaker.

**Nutritional Approaches**

**Nutritional assessment/history**, including diagnosis & special diet history are first steps to determine the best approach. Assessment should include the individual’s education level, learning ability and reading level. Nutritional knowledge and preconceptions about weight control and dietitians also need to be determined. Many well spoken, educated people cannot state which foods are "high fat", for instance, or many believe that dietitians "just put people on diets".

Start simple and individualize with emphasis on:

- **Basic Nutrition** - What are Calories, Carbohydrates, Fats and Proteins?
- **Portion Control** - What is a "normal" portion?
- **Snacks** and "filler" foods - Emphasize low calorie and "free" foods.
- **Healthy Eating Approach** or Meal Plans rather than "DIET".

Set realistic goals, starting with short term, achievable goals. 5 - 10% weight loss is much more realistic and achievable than 100 lbs. Failure is often due to unrealistic goals - "No, you will not lose 20 lbs in a week, and probably not in a month." "Yes, you're doing very well - you've lost 5 pounds this month." In some cases, cessation of weight gain is a first goal! Stabilization of weight, even though obese, may be an accomplishment with many clients.

**Involve family and/or staff as appropriate**. Weight loss success is often a function of menu and lifestyle changes. Obese clients in a group home that adopted a "healthful lifestyles" approach have successfully lost weight, after literally years of sporadic results when just some of the individuals had low calorie diet orders. Follow up with scheduled consultation sessions.

**Pharmacologic Approaches**

If you and your client feel appetite stimulation may be the reason for weight gain, suggest consideration of change of the psychotropic drug. As illustrated above, appetite stimulation is more common with clozapine (Clozaril), olanzapine (Zyprexa), quetiapine (Seroquel) or risperidone (Risperdal) than with ziprasidone (Geodon) or aripiprazole (Abilify).

**Anti-Obesity Drugs**

Sibutramine (Meridia) and phentermine (Adipex-P, Ionamin) are centrally acting appetite suppressants structurally related to amphetamine. They are for short term use, with a reduced calorie diet and exercise. These drugs are indicated for obesity (BMI greater than 30) or in overweight individuals (BMI greater than 27) with additional risk factors, such as hypertension, diabetes or hyperlipidemia.

A major side effect is hypertension. They are also contraindicated with severe renal or hepatic problems, with cardiac disease or seizures. Phentermine is not indicated for anyone under 16 and may be habit forming with long term use, which generally prevents its use in anyone with a history of drug abuse/dependency. GI problems, such as dry mouth and constipation, are common.
Orlistat (Xenical) is a lipase inhibitor, peripherally acting in intestines to reduce absorption of fat by binding to lipase. It is not an appetite suppressant and MUST be used with a low fat diet of not more than 30% of calories from fat, spread evenly throughout the day. Because fat is not absorbed, fecal fat excretion is increased, leading to the possibility of fecal spotting, oily stools, increased fecal urgency and even incontinence.

Topiramate (Topamax) is an anticonvulsant, also used to treat bipolar disorder. Appetite suppression and weight loss have been reported in more than 20% of patients.20

Zonisamide (Zonegran), also an anticonvulsant, has also been used with some success.11

**Nutritional Considerations Other Than Weight Gain**

The primary focus of this paper concerns weight gain as a result of appetite stimulation, but some drugs can suppress appetite, leading to weight loss. For instance, the antidepressant SSRI drugs fluoxetine (Prozac) has been reported to cause weight loss at least with initial use.22 Anti-ADHD drugs methylphenidate (Concerta/Ritalin) or amphetamine mixtures (Adderall) can cause anorexia, weight loss and poor growth in children.

Metabolic effects are also a concern. A drug may cause or exacerbate glucose intolerance and cause or aggravate diabetes. Particularly, antipsychotics olanzapine (Zyprexa) or clozapine (Clozaril) affect glucose regulation leading to impaired glucose tolerance or new onset diabetes, even without weight gain.33 Ketonacidosis, usually rare with Type 2 diabetes, has been reported with these agents.11-12 This effect has also been reported with other second generation antipsychotics, prompting the FDA to recently issue a class warning.

Hyperlipidemia, elevated cholesterol and/or triglycerides, has been reported with many antipsychotics such as chlorpromazine (Thorazine), clozapine (Clozaril) or olanzapine (Zyprexa). Weight gain further exacerbates the problem.11

SIADH (Syndrome of Inappropriate Anti-Diuretic Hormone Secretion) has been reported with Tricyclic antidepressants, SSRIs, such as citalopram (Celexa) and MAOIs, as well as anticonvulsants valproic acid (Depakote) and carbamazepine (Tegretol). SIADH leads to hypotension, edema, inability to produce and excrete dilute urine, increased extracellular fluid volume.

Some medication affect nutrient kinetics. If a drug decreases the metabolism of nutrients, higher blood levels may lead to toxicity. A well known example is the effect of monoamine oxidase (MAO) inhibitors tranylcypromine (Parnate), phenelzine (Nardil) and isocarboxacid (Maryland). These antidepressants prevent the breakdown of presynaptic agents (tryptamine, dopamine or histamine) from aged, fermented or spoiled foods. Pressor agents are vasoconstrictors that can cause a hypertensive crisis, even leading to death.

Examples of Foods that must be avoided with MAO Inhibitors: aged cheeses and meats • Miso soup • tap beer, Korean beer • salami or mortadella • fava beans • concentrated yeast extracts (Marmite) • air-dried sausage • snowpea pods • banana peel • soy sauce • broad bean pods • casseroles, pizza made with aged cheese • soya bean, soya bean paste • sauerkraut • tofu/fermented bean curd • kim chee

A drug may increase the metabolism of nutrient(s) resulting in higher requirements and danger of deficiency. Anticonvulsants phenobarbital and phenytoin (Dilantin) increase the metabolism of folate acid, vitamin D and vitamin K leading to deficiency and bone disorders such as osteoporosis.

Phenothiazines, such as chlorpromazine (Thorazine), increase excretion of riboflavin.39

**Physiologic Effects**

Drugs with antiobolinergic effects (antipsychotics, tricyclic antidepressants, antihistamines):

a) impair salivary flow causing dry mouth, taste changes, dysphagia, increased curries, stomatitis.

b) slow intestinal peristalsis causing constipation, possibly impaction.

c) cause cognitive problems such as confusion, delirium.

d) cause orthostatic hypotension, urinary retention, dry eyes/blurred vision, tachycardia.

Tricyclic antidepressant amitriptyline (Elavil), antipsychotic clozapine (Clozaril), or antihistamine diphenhydramine (Benadryl) have strong antiobolinergic effects.

Drug induced gastro-intestinal problems such as stomach irritation, esophageal reflux, dyspepsia, nausea/vomiting or GI bleeding. SSRIs (Anti-Depressants, OCD Treatment) fluoxetine (Prozac) or fluvoxamine (Lavox) are reported to cause GI upset, dyspepsia and, rarely, upper GI bleeding.18

**Effect of Food on Psychotropic Medications**

Nutrients may alter the renal excretion of some medications. Lithium (Eskalith) and sodium are reabsorbed at the same sites in the kidney. High sodium intake increases sodium excretion and thereby lithium excretion. Low sodium intake causes sodium retention and lithium retention. Dietary sodium intake must be consistent in order to keep lithium levels stable.

Certain foods or food additives which exhibit effects similar to those of a medication can enhance or counteract the effects of a medication. Foods or beverages high in caffeine can increase the adverse effects of central nervous system stimulants such as methylphenidate (Concerta/Ritalin) or counteract the effects of anti-anxiety drugs such as diazepam (Valium).19

Dietary changes may affect drug Pharmacokinetics. A high fiber diet may decrease the absorption of tricyclic antidepressants such as amitriptyline (Elavil) and therefore reduce effectiveness of drug therapy.

Grapefruit, Seville oranges and grapefruit hybrids (tangelos) are CYP 3A4 inhibitors. They slow metabolism of CYP 3A4 metabolized drugs and increase serum levels of drugs to toxic range.

Grapefruit should be avoided with bupropion (BuSparr) and ziprasidone (Geodon).

Grapefruit should be used with caution with carbamazepine (Tegretol), quetiapine (Seroquel), clomipramine (Anafranil), diazepam (Valium), midazolam (Versed), triazolam (Halcion).

Psychotropics which have been tested with grapefruit and shown to have no significant interaction are alprazolam (Xanax), caffeine, clozapine (Clozaril), haloperidol (Haldol), phenytoin (Dilantin).

References:


13. Pisto JT, Ralfin RS. "Drugs That Promote Cessation of Riboflavin" 1987 Drug Nutr Inter 5:143-151


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Rosalind M. Wilkins Receives First Life Time Achievement Award

Rosalind M. Wilkins was awarded the First Life Time Achievement Award from the Missouri Dietetic Association. The Award was given in recognition of Wilkins’ professional work as a dietitian that has spanned thirty-three years. The Life Time Achievement Award recognizes Wilkins for her professional contributions of experience, long-practice as a dietitian of the American and Missouri Dietetic Associations, and to acknowledge her contribution to professional practice, to mentoring activities, and professional and community volunteer work.

A registered dietitian with the American Dietetic Association, Commission on Dietetic Registration, and a licensed dietitian with the State of Missouri, Division of Professional Registration, Wilkins began her early formal education in the Webster Groves, Missouri school system. After graduating from high school, Wilkins enrolled at Tennessee State University (TSU) and completed her B.S. degree in Foods and Nutrition. While at TSU she was a charter member and first president of Beta Sigma Chapter of Kappa Omicron Phi, National Home Economics Honor Society; elected Third Vice-Chairman (a statewide office) of the Tennessee Home Economics Association Student Member Section; and served as president and parliamentarian of the TSU Home Economics Association. Wilkins was the recipient of several honors while at TSU including the Lady of the Lamp Award, in recognition of her outstanding service and leadership in the field of Home Economics; served as a University Counselor; was a Dean’s List honoree; and was award the Twenty Pearl Award by Alpha Psi Chapter, Alpha Kappa Alpha Sorority, Inc., for dedicated member service and outstanding leadership.

Wilkins earned a M. S. degree in Dietetics from Saint Louis University and completed an accredited Dietetic Internship at Saint Louis University. Her work experience began in St. Louis where she was employed with the Human Development Corporation’s WIC Program and at the Yeatman Union-Sarah Medical Health Centers as a Clinical Dietitian. Her state level work included the Missouri Department of Elementary and Secondary Education, the Missouri Department of Mental Health, and the Missouri Department of Health and Senior Services. Wilkins recently retired from the State of Missouri after twenty-five years of service.

Wilkins was sited for her mentoring experience and promotion of the field of nutrition and dietetics. This included serving as the Dietetic Internship Director at the Department of Health and Senior Services; supervising the Dietetic Internship program at the Department of Mental Health; Adjunct Instructor Department of Animal Science, Foods and Nutrition, Southern Illinois University-Carbondale; Adjunct Instructor, Dietetic Education, University of Missouri -Columbia; Youth Motivational Taskforce at TSU; and coordinating public health nutrition experience and establishing a joint public health dietetic internship program between Saint Louis University and the Department.

Professional activities include: member of the American Dietetic Association, Commission of Dietetic Registration Appeals Panel; ADA Dietetics in Developmental and Psychiatric Disorders Practice Group Executive Committee member; 70th Annual Meeting of ADA Poster Session abstracts reviewer for Community Dietsetics/Nutrition Education/Public Relations; Nominating Committee, Specialization Committee, and State Networking Coordinator - Public Health Nutrition Practice Group; State Network Coordinator, Pediatric Nutrition Practice Group and Nutrition Education for the Public Practice Group; Nominating Committee Member, Chair of Legislative Information and Public Policy Committee of Central Missouri Dietetic Association; State Chairman of Legislative Committee, Missouri Dietetic Association; Missouri representative to the Association of State and Territorial Public Health Nutrition Directors; member of Legislative Committee and State and Local Liaison Committee; National President, Nutrition and Dietetics Division of the American Association on Mental Retardation. Wilkins was a recipient of the State of Missouri Governor’s Award for Productivity and Quality in 1990.

Recognized community service over the past thirty years included: licensed foster parent with the Missouri Division of Family Services, volunteer JCTV-3 Public Access Television, charter member of the St. Louis Chapter of Coalition of 100 Black Women, board member of The Sickle Cell Anemia Association of Metropolitan St. Louis, volunteer with Hope for Caribbean Kids and Have a Heart for Kids Foster Parent Association, media coordinator and new member class teacher - Refreshing Spring Church, and charter member of Delta Sigma Chapter National Sorority of Phi Delta Kappa (Education Honor Society). Wilkins has also been active in Christian mission and received training at Beulah Outreach Ministry in North Carolina. She traveled and ministered in Belize with the International Association of Missions and is planning on traveling to Haiti in June with Hope for Caribbean Kids and New Missions.

Attend and Learn

- FNCE - Food & Nutrition Conference & Expo
  2005 - St. Louis, October 22 - 25. Register at http://www.eatright.org/fnce
  2006 - Honolulu, Hawaii, September 16 - 19...
  The Call for Proposals begins June 1 with a submission deadline of July 20, 2005.

Read and Learn

ADA members can earn up to four units of CPE at no additional charge beginning with the March 2005 issue by reading specified self-study Journal articles and taking the accompanying test. Stay current in practice and build your portfolio with a new ADA members only benefit.

Need to update your Counseling Skills? Earn 2 hours of CPE at a time and location convenient to you with “Working with Challenging Clients - When Giving Information Isn’t Enough”, a Self-study Guide. Go to http://www.eatright.org/Public/ContinuingEducation/96_12013.cfm for product details, objectives and member pricing.

Seeking Spanish Language enhancement and resources for yourself and your team? One of the highest rated teleseminars, “Survival Spanish for Foodservice and Dietetics Professionals” is available as an archived audio CD - order at https://www.krm.com/regonline/amdvcreg5.nsf/a/md8607-0. Use this as a group CPE learning event and purchase the new ADA publication, “Spanish for Nutrition Professionals” at http://www.eatright.org/Public/ProfessionalDevelopment/SearchableProducts/04_21737.cfm.

Writing Opportunity

We are beginning a new graduate level textbook titled Nutrition in the Lifecycle-an Evidence-based Approach (Jones & Bartlett Publishers) and are looking for a pediatric disability section author. All interested authors can contact us at this email address (sari.edelstein@simmons.edu). Thank you.

Sari Edelstein, PhD, RD, Assistant Professor, Simmons College, Boston, MA Phone 617 521-2713

Web page update

DDPD’s web page can be found at www.ddpd.org. The web page has undergone a few changes in the last few months. I encourage you to take a look if you haven’t looked at it recently. Since we now have a members only section all the recent past newsletters have been posted. A page of those members wishing to be listed for the public to access has been added.

One of the most valuable benefits of belonging to DDPD is the ability to belong to the listserv. This gives you the ability to ask your colleagues questions that come up in your practice. The members of the listserv represent a wide range of experience and are always willing to help when they can. Any member wishing to join the listserv can email slemons@prodigy.net to be added.

Career Resources now online! Members can now find tools and references to showcase and enhance their management and leadership skills as free links at http://www.eatright.org/Member/ProfessionalDevelopment/76_20896.cfm
Instructions for Receiving Continuing Professional Education Credit

Members only of the Dietitians in Developmental and Psychiatric Disorders DPG may receive 2 Level II CPE credits for successful completion of the following questions. Recommended learning codes are 3070 and 5320.

1. After reading the article, “PSYCHOTROPIC DRUGS, NUTRITIONAL AND WEIGHT MANAGEMENT CONSIDERATIONS” answer the questions by writing down the correct answers.

2. E-mail your answers, along with your name, CDR registration number, address, phone number, and whether you are an RD or DTR to Mary Emerson at emersonm@springharbor.org. If you do not have e-mail, you may send this information to Mary at:

3. Only current DDPD members may submit answers for CPE credit. There is no fee.

4. Submit answers by September 30, 2006 in order to receive the approved 2 hours of CPE credit.

5. Fill out the Certificate of Completion on page ___ to keep for your records.

Note: The certificate of completion is not valid until the information requested in instruction #2 above has been submitted to and recorded by DDPD/ADA. You will be notified ONLY if 2 CPE hours have NOT been approved. You MUST keep a record of your continuing education for your Professional Development Portfolio. Please record this hour on your Learning Activities Log, and retain the certificate of completion in the event you are audited by CDR.

1. It is estimated that depression will be experienced by what percentage of Americans at some point in their lives?
   a. 1
   b. 6
   c. 10
   d. 25

2. Patients taking amitriptyline (Elavil) should be asked about the common adverse effect of:
   a. diarrhea
   b. dry mouth
   c. joint pain
   d. weight loss

3. Which antidepressant is a Monoamine Inhibitor (MAOI)?
   a. Tranylcypromide (Parnate)
   b. fluoxetine (Prozac)
   c. clomipramide (Anafranil)
   d. sertaline (Zoloft)

4. Which medication is approved by the Food and Drug Administration for patients with bulimia nervosa?
   a. paroxetine (Paxil)
   b. fluvoxamine (Luvox)
   c. chlorpromazine (Thorazine)
   d. venlafaxine (Effexor)

5. Which statement is correct about children’s development if taking atomoxetine (Strattera)?
   a. pediatric obesity is common
   b. the medication should be given through the summer to prevent growth problems
   c. they have an increased risk for Type 2 diabetes
   d. growth must be monitored closely.

6. Which weight loss strategy may be effective for an individual with learning disabilities?
   a. carbohydrate free diet
   b. exchange list plan
   c. food guide pyramid
   d. planned menu of healthy meals and snacks

7. Patients on this antipsychotic medication need their white blood cell counts monitored closely:
   a. Clozapine (Clozaril)
   b. haloperidol (Haldol)
   c. fluphenazine (Prolixin)
   d. thioridazine (Mellaril)

8. How should a client taking lithium (Lithabor or Eskalith) be instructed regarding their diet?
   a. avoid sodium
   b. consume consistent amount of sodium daily
   c. consume less than 2 gm of sodium daily
   d. lightly salt food

9. If an individual is taking ziprasidone (Geodin), they should avoid _________ to prevent a dangerous drug-nutrient interaction.
   a. aged cheese
   b. caffeine
   c. Seville oranges
   d. salty foods

10. What preexisting medical condition would you expect may be exacerbated by an atypical antipsychotic?
    a. asthma
    b. cancer
    c. renal disease
    d. type 2 diabetes

DDPD Election Results

Thank you to all the members who voted!

For 2005-06:
Sharon Wojnaroski is Chair-elect
Lynn Grieger is Nominating Committee Chair
Melissa Altman-Traub and Ann Overmeyer are on the Nominating Committee
CERTIFICATE OF COMPLETION

PSYCHOTROPIC DRUGS, NUTRITIONAL AND
WEIGHT MANAGEMENT CONSIDERATIONS

Title of Program

Date of Completion

DDPD
Commission on Dietetic Registration CPE Accredited Provider

AM003
CPE Provider Accreditation Number

Participant’s name

Has successfully completed __2__ CPEU. CPE level __II__.

in the city/state of

Melissa Altman-Traub

Signature of CDR CPE Accredited Provider

Date

Submit this copy to state licensure board, if applicable.

CERTIFICATE OF COMPLETION

PSYCHOTROPIC DRUGS, NUTRITIONAL AND
WEIGHT MANAGEMENT CONSIDERATIONS

Title of Program

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Participant’s name

Has successfully completed __2__ CPEU. CPE level __II__.

in the city/state of

Melissa Altman-Traub

Signature of CDR CPE Accredited Provider

Date

Retain this copy for your records.
DDPD Goes to Washington

Lee Wallace, MS, RD, LDN, FADA (DDPD Chair Elect) and Andrea Shotton, MS, RD, LDN (DDPD Legislative Chair) joined approximately 400 of their ADA colleagues from around the United States in Washington, D.C., March 1-3rd at ADA’s Public Policy Workshop (PPW). Although Lee and Andrea were somewhat intimidated as first time PPW participants, the Workshop hosts (Legislative and Public Policy Committee of ADA) gently provided the guidance, support and leadership training necessary for becoming a high quality effective nutrition and health policy advocate.

Held annually, the PPW provides participants with an understanding of the legislative and regulatory processes that are key to influence ADA’s food, nutrition and health initiative priorities. Three priority issues are identified for the next congressional session:

- Expansion of the Medical Nutrition Therapy Medicare benefit
- Reauthorization of the Ryan White CARE Act
- Reauthorization of the Older Americans Act

While understanding the legislative priorities for ADA is critical, so is the implementation of the grassroots skills obtained to deliver important messages to Senators and Representatives. The PPW participants gave these messages to their respective state’s Senators and Representatives:

Expansion of the Medical Nutrition Therapy Medicare Benefit

“Please support improving the health care of Medicare patients while reducing the cost of providing proper nutrition counseling by co-sponsoring the Medicare Medical Nutrition Therapy Act of 2006. This bill gives the Center for Medicare & Medicaid Services (CMS) the authority to expand the medical nutrition therapy benefit to any disease, disorder, or condition deemed medically reasonable and necessary.” CMS will then make their decision for MNT coverage using evidence-based research for cost-effectiveness. Contact Ron Smith, Director of Government Relations, at (202) 775-8277 or rsmith@eatright.org for more information.

Reauthorization of the Ryan White CARE Act

“Please support amendments to the current Ryan White CARE Act and provide funding to strengthen the role of Medical Nutrition Therapy (MNT) and the registered dietitian in programs funded by the Act. Currently, MNT is not a required service in all titles of the Act. Therefore, patients and families served by these programs have limited, if any, access to life-saving MNT by a registered dietitian. Questions may be directed to Mary Lee Watts at (202) 775-8277 or mwatts@eatright.org.”

Reauthorization of the Older American Act (OAA)

“Annually, about 250 million congregate and home-delivered meals are served to approximately 2.6 million older adults. However, millions more would benefit from nutrition services if they were more broadly available. Participants and caretakers of older adults served by OAA should have access to meals, nutrition screening, nutrition education and counseling by a registered dietitian.”

The new Dietary Guidelines for Americans 2005 were also a primary focus. Two presentations on the dietary guidelines were given to participants as well as a Toolkit for Health Professionals with resources for using the guidelines in each participants’ local community. ADA provided input to the Department of Health and Human Services and the US Department of Agriculture during the development of the dietary guidelines and partnered with them in the development of the toolkits. For more information see website: www.healthierus.gov/dietaryguidelines.

Contact your state’s local officials and congressmen to speak about ADA’s priority issues. For a detailed ADA Advocacy guide go to: http://www.eatright.org/Member/Files/advocacy_guide5.16.03.doc

Andrea works as a Metabolic Dietitian with the University of Tennessee, Boiling Center for Developmental Disabilities. Current job duties include providing nutrition education and management for the Inborn Errors of Metabolism Clinic, nutrition assessment and evaluation for the Developmental Disability Clinic, education to graduate/intern trainees in developmental disabilities, technical assistance in nutrition and Developmental Disabilities, as well as assisting in nutrition grant proposal/writing. Additionally, Andrea serves on the Child Nutrition Task Force as a member for the Tennessee Dietetics Association and President-Elect for the Memphis Area Nutrition Council along with Legislative Chair for DDPD, an ADA practice group. Andrea can be reached at 901.448.6523

ADA NEWS

- The American Dietetic Association (ADA) recently adopted the Nutrition Care Process and Model (NCP). NCP consists of four distinct steps: nutrition assessment, nutrition diagnosis, nutrition intervention and nutrition monitoring and evaluation. Nutrition diagnosis, the use of nutrition diagnostic terminology, and nutrition diagnostic statements written in problem, etiology and signs/symptoms format (PES) are new concepts for some RDs. ADA is seeking qualified members for a newly created Peer Network for Nutrition Diagnosis (PNND) to help implement and refine the Nutrition Care Process, Nutrition Diagnoses and Nutrition Diagnostic Terminology. This volunteer network will be made up of ADA members from various work settings from seven U.S. regions. Peer Network for Nutrition Diagnosis members will be required to:
  - Serve as a network member for a two year term
  - Attend training offered by ADA (either face-to-face or webinars)
  - Participate in pilot implementation program supported by ADA
  - Attend at least one workshop training in their city/facility after the NCP/Nutrition Diagnosis is effectively implemented
  - Serve as a mentor to setting-specific on-line community of interest
  - Attend FNCE workshop and Dietetic Practice Based Research Network (DPBRN) meeting and reception at least once during their 2 year term and provide an oral presentation and/or one page summary of experiences. Travel expenses for FNCE and 1-2 nights hotel will be provided by ADA.
  - An ADA appointed committee will review the applications, select the most qualified candidate using established criteria, and submit candidate’s names to the ADA House of Delegates for review. The deadline for application is April 21, 2006. The American Dietetic Association (ADA) recently adopted the Nutrition Care Process and Model (NCP). NCP consists of four distinct steps: nutrition assessment, nutrition diagnosis, nutrition intervention and nutrition monitoring and evaluation. Nutrition diagnosis, the use of nutrition diagnostic terminology, and nutrition diagnostic statements written in problem, etiology and signs/symptoms format (PES) are new concepts for some RDs. ADA is seeking qualified members for a newly created Peer Network for Nutrition Diagnosis (PNND) to help implement and refine the Nutrition Care Process, Nutrition Diagnoses and Nutrition Diagnostic Terminology. This volunteer network will be made up of ADA members from various work settings from seven U.S. regions. Peer Network for Nutrition Diagnosis members will be required to:
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  - An ADA appointed committee will review the applications, select the most qualified candidate using established criteria, and submit candidate’s names to the ADA House of Delegates for review. The deadline for application is April 21, 2006.
  - If you would like to apply go to www.eatright.org and log in with your membership number. Click on “Research” in the left hand column and go to the heading: “Peer Network for Nutrition Diagnosis” then, click on “Peer Network for Nutrition Diagnosis Application Form.” Complete the form then click on “Submit.”
True Story:
How your DDPD representatives and ONLY your DDPD representatives had their photos taken with the Senate Majority Leader and former Presidential Candidate at the PPW in Washington in March

All attendees at ADA’s PPW visit their Congress and Senate members on the last day of the Workshop. These visits are coordinated by the state Legislative Network Coordinator (LNC) of the state they live in. By chance, both of DDPD’s representatives, Andrea (our Legislative Chair), and Lee (who received a scholarship to go), were from Tennessee!

Our Tennessee LNC did a great job coordinating those appointments for Thursday morning, and also found out about “Tennessee Tuesday”, a breakfast hosted by the two TN Senators for anyone from Tennessee who is visiting Washington. Their office staff and assistants are always in attendance, but the Senators’ attendance, of course, varies with their schedules. But the week of the PPW this year was the first week of the legislative session, and both Senators were there! We (and over 225 other folks from Tennessee) had a chance to meet, shake hands, and get a photo taken with both of our Senators!

We are pleased to have as our two senators from Tennessee, the current Senate Majority Leader and a former presidential candidate. Both have supported nutrition legislation in the past, and we encouraged them to continue to do so!

**DDPD Advertising Policy**

The Dietetics in Developmental and Psychiatric Disorders Dietetic Practice Group accepts advertisements for our newsletter, *DevelopMental Issues*, under these guidelines:

- Advertisements will be limited to products and services that are of interest to our members, consistent with the goals for the dietetic practice group, and which promote sound nutrition of the patients we serve.

We reserve the right to evaluate all statements in advertisements and to refuse to accept any copy that does not follow guidelines established through the American Dietetic Association.

We require the following disclaimer in each issue of the newsletter: "The publication of an advertisement in *DevelopMental Issues* should not be construed as an endorsement of the advertiser or the product by the American Dietetic Association or this dietetic practice group.

Rates: $2500 to sponsor an entire issue (which includes recognition at our Annual Meeting, a full page ad, a recognition notice, and one year complimentary subscription)

$  500 for a full page
$  350 for a half page ad
$  250 for a quarter page
$  125 for an eighth page (business card size)

Dietetic Practice Group members are entitled to a 20% discount.

Advertisements may be submitted any time and advertisers will receive notification of acceptance within 30 days of submission, at which time scheduling for placement will be arranged.

Advertisements must be received in camera-ready form by the designated deadline for publication along with payment in full made payable to The American Dietetic Association/DPG #12 and sent to: Melissa Altman-Traub, Newsletter Editor, Nutrisolutions@aol.com, 1556A Stoney Lane, Philadelphia, PA 19115. Phone: 215-969-0652.
2005-2006
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Resource Professionals
Do you have a professional question you need help with?
Contact the appropriate Resource Professional today!

CPE Answer Key
3. A 7. A
ForMyDiet.com: helping people with metabolic disorders manage their diets better.

ForMyDiet.com is a new website designed to make living with and managing a metabolic disorder diet a whole lot easier!

ForMyDiet currently features many informative and useful tools, such as an informative center with medical information about specific orders, message boards with a range of forums that fit different interests, and online food list and nutrient calculations that allow for searching, sorting, and retrieval of disorder-specific nutritional values.

ForMyDiet is currently working on a metabolic disorders diet management application that will be available through its website, and will provide patients with tools to securely track dietary intake, medication, medical formula, blood levels, and more. The application will allow for added accuracy, and will eliminate many of the tedious management tasks that individuals with chronic disorders need to complete each and every day.

In addition to patient tools, the ForMyDiet diet management application will include healthcare professional tools that will give healthcare professionals the ability to monitor their patient's diet more closely, and allow for increased patient-professional communication. In addition, healthcare professionals will have visual representation of their patients' data and will be able to aggregate data by professional or clinic.