

DevelopMental Issues

The Resource for Dietitians in Developmental & Psychiatric Disorders

A publication of *Dietetics in Developmental and Psychiatric Disorders (DDPD®)*

Spring Issue 2007

A dietetic practice group of the American Dietetic Association

Monkey See, Monkey Do

By April Hackert, MS, RD

I would like to introduce you to Amber. Her mother had her when she was 17. Her father was unknown and she was raised as a second generation child of her aging grandparents. Food was her best and only friend. She coated the pain of teasing and crude remarks at school with cake, ice cream, and video games. Slumber parties with friends were exchanged for breakfast adventures to McDonald's. Late night phone calls to friends were substituted with trips to the kitchen for her grandfather's hidden candy bars. Rewards for academic achievement were large [meat-lovers] pizzas rather than hugs. After 16 years, Amber weighed 297 pounds.

Children are unhealthier today than ever before. Type II Diabetes is no longer called adult-onset in order to accommodate the five-year-old children who have developed insulin resistance due to obesity and inactivity. On the other end of the spectrum, skeletal figures prancing down fashion run-

ways serve as the reference marker of an ideal body. The fame, notoriety, and promise of happiness from such role models lead children to unhealthy practices to achieve perfection.

As adults, we are responsible for the welfare of children. Personal reflections of our eating habits, verbal, and non-verbal cues, as well as food attitudes, are engrained into the developmental core of children. Without a better understanding of the implications of our actions and practical tools to change behaviors, the fate of future generations is dismal.

Model behavior

From diapers to diploma acceptance, the role of parents and primary caregivers (i.e., adults) on a child's nutritional habits and beliefs is undeniable. At birth the primary reflexes of rooting, sucking, and swallowing allow a child to obtain the nutrition required for growth (1). Throughout development, modeling and guidance from adults becomes increasingly more important. The American Dietetic Association (ADA) notes with an Evidence Grade I, the importance of parental training and family-based interventions for reducing overweight in school-age children (2).

As society continues to move at rapid speed, well-balanced nutritious meals are being replaced with

highly processed, grab-and-go food items. These substitutions are not without health consequences. Children as young as three- years-old are being influenced by parental health habits. When parents completed questionnaires about child feeding habits and self-reported anthropometric calculations were analyzed, the correlation between weight status of children, aged three-to-five years, and their parents was statistically significant (3).

The influence of parental attitudes on a child's eating habits continues throughout the college years. Examining the relationship between parent and child attitudes among college-aged men and women indicated the attitudes of the students was strongly related to the perception they had of their parents beliefs about weight and eating habits rather than the parent's actual report (4). As research continues to show how significant the personal beliefs and actions of adults are upon children, the implications become critical to understanding how to change a child's behavior.

Disinhibition

Without adult intervention, the health and nutritional habits of children will remain inadequate. The environmental influences of the media, advertising, and peer-pressure leave nutrition

INSIDE THIS ISSUE

From the Chair and Chair-Elect . . .	2
Mark Your Calendar	4
Practice Tips from Resource Professional Team	5,6
From the Editor	5
Call for Submissions	5
Practice Points	5,6,7
Officers	7
House of Delegates Fact Sheet . .	7,8

From the Chair and Chair-Elect

Sharon Wojnarowski, MA, RD and Paula Kerr, MS, RD, CD

Name Change Proposal

For the past 2 years, your DDPD Executive committee has been talking about changing the name of our practice group. Why? Here are some of the reasons:

1. People don't understand what we do. Exactly what is "*Developmental and Psychiatric Practice?*"
2. The language of consumers is changing. Disordered eating is replacing eating disorders. Is it developmental delays or disabilities? Where does Autism fit in? Is this client chemically dependent or simply abusing substances? Does **anyone** want the label "*psychiatric patient?*"
3. The language of health care is changing. Check your own insurance plan. Where are psychiatrists, alcohol counselors, eating disorder counselors, and behavioral therapists listed?
4. The language of ADA is changing. One element of ADA's Nutrition Care model is Nutrition Diagnostic Terminology, within which there is a category entitled **NB: Behavioral-Environmental** that includes:
 - **Disordered Eating Pattern**...including classic eating disorders as well as less severe similar conditions
 - **Harmful Beliefs/Attitudes About Food, Nutrition, and Nutrition-Related Topics** ...related to developmental or psychosocial problems... example pica
 - **Self-Monitoring Deficit** ...related to learning disability, neurological or sensory impairment...
 - **Excessive Exercise** ...evidence of addictive, obsessive or compulsive tendencies...e.g. anorexia nervosa, bulimia nervosa, binge eating, eating disorder NOS...
 - **Self Feeding Difficulty** ...poor lip closure, dropping cup... physical limitations
 - **Limited Access to Food** ...client history... mental illness
 - **Inability or Lack of Desire to Manage Self-Care** ...e.g. cognitive or emotional impairment
 - **Undesirable Food choices** ...e.g. mental illness
 - Note: Excessive Alcohol Intake is addressed separately in Bioactive Substance Intake.
5. The focus of ADA's *Standards of Practice and Standards of Professional Performance for Dietitians in Behavioral Health* is that group of dietitians working routinely with clients who have disordered eating, developmental disabilities, substance abuse problems, and/or a mental illness.

A year ago your executive committee put this topic for discussion on the list serve and requested input via the Newsletter. This fall the Executive Committee, submitted to the ADA Leadership via our Practice Manager, a proposed name change. We are now waiting for our proposal to move through the ADA process of approval. We will keep you posted.

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Articles about successful programs, research interventions, evaluations and treatment strategies, meeting announcements and information about educational programs are welcome and should be sent to the editor by the next deadline.

Future Deadlines

Summer 2007. **March 25, 2007**
 Fall 2007. **June 15, 2007**
 Winter 2008. **September, 2007**
 Spring 2008. **January, 2008**

Please forward information or article submissions to:

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Monkey See Monkey Do

continued from page 2

fundamentals a luxury rather than priority. The disconnect between healthy adult and child eating habits stems from disinhibition. Children pick up on these behaviors and quickly assimilate them into their own psyche and attitudes towards food related behaviors.

Disinhibition is a psychological concept where once a *forbidden* food has been consumed; a person's level of restraint vanishes thus resulting in overeating. Simply think of a good food/bad food list. When a person eats a bad food item, they feel they have failed their current diet regimen. Since the initial plan of avoiding the bad food was foiled, why bother continuing to restrict? This creates a cycle of cognitive punishment as well as excessive caloric intake. The idea of hunger precipitating intake does not exist in someone with high levels of disinhibition.

The subtle verbal and non-verbal cues about personal weight status and food phobias are being transmitted loudly to children. An investigation of how parental levels of dietary restraint, disinhibition and perceived hunger effect the body fat levels of children supports this concept. A prospective observational study revealed that over six years, children's body fat increased linearly with increasing levels of self-reported parental disinhibition (5). Examining personal attitudes about food and body imagine is the first place to begin in the process of changing the health of children. Healthy modeling will lead to healthy behaviors.

Choosing to Change

It is a privilege to have the knowledge and opportunity to change nutritional attitudes. The environment is essential to creating a healthy modeling atmosphere for children. Key concepts of a healthy environment including access to nutrient-dense foods and beverages as well as limiting access to high-calorie items, avoiding excessive food restriction or using food as a reward, and starting the day off with breakfast (6). Children will eat what is around them. At first, there may be a battle; however, modeling the desired action will eventually lead to results.

A cross-sectional study comprised of 902 adolescents and their parent or guardians showed that among girls, the household availability of fruits and vegetables was positively related to intake and soft-drink availability was inversely related to dairy intake. Parental intake of dairy was positively related with boys and girls (7).

Eliciting change among children and teenagers requires patience and positive reinforcement. Meet the child where he or she is at and remember the key role of an adult: model the desired action. Knowing the feeding roles of both parent and child listed below will create the appropriate environment for success (8).

The Parents' Feeding Jobs

- * Choose and prepare the food
- * Provide regular meals and snacks
- * Make eating times pleasant
- * Show children what they have to learn about food and meal time behavior

- * Not let children graze for food or beverages between meals and snack times
- * Let children grow up to get bodies that are right for them

Children's Eating Jobs

- * Children will eat
- * They will eat the amount the need
- * They will eat an increasing variety of food
- * They will grow predictably
- * They will learn to behave well at the table

Amber made the choice to change during her sophomore year of high school. Each step was small and seemed challenging at first. After replacing sodas with fruit, starting to walk one block each night after dinner and most importantly, choosing journaling rather than food to express her pain she found hope. The combination of permanent, small, obtainable goals and an environmental overhaul allowed Amber to lose 150 pounds in a year-and-half.

It has been twelve years since Amber let her actions change her life and she has maintained her weight loss. There is no better time than now to examine your own life in order to better practice what you preach. Choose to let your actions speak louder than your words. The health of our children tomorrow is dependent on the choices you make today.

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continued on page 4

Monkey See Monkey Do*continued from page 3*

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Share Your Talent!**Good with Numbers?**

Do you have any experience in accounting or bookkeeping?

Do you know how to use Microsoft Excel? Our DDPD Executive Committee needs your help.

Contact Paula Kerr at pkerr6818@charter.net for details.

Want to learn about publishing?

Help with the communications tasks of DDPD including *DevelopMental Issues*, the DDPD web page and more!

Contact Joan Medlen for more information: joan@downsyndromenutrition.com



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New Resource in Development: Call for Submissions

DDPD Members Sarah Thompson and Paula Cushing are working together on a project to produce a CD containing teaching tools and resources that will assist dietitians working with individuals with Intellectual and Developmental Disabilities (IDD).

For this tool to be successful and useful, we need your help. Do you have tools and resources you have used that would assist dietitians in working with this population that you would like to share? Some

examples include assessment tools, education tools, clinical guidelines, websites, books, publications, nutrition presentations and curriculums.

You will of course be given credit for the materials you have developed. For more information, contact:

Paula Cushing:

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Brentwood, TN 37027

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Fax- 615-884-4405

Practice Points from our Resource Professionals

Intellectual and Developmental Disabilities

Tips for Positive Interactions

Paula Cushing

1. Praise and patience: be kind, show you care, and be positive toward the smallest accomplishment
2. Progress may require baby steps: one step at a time, one change at a time
3. Use easy to understand language. Ask questions in a way the person will understand.
4. Tailor educational materials to each person's learning style:
 - Provide concrete, clear, "black and white" guidelines
 - Keep it simple. Find one or two foods that the person might choose to replace with healthier choices
 - Use pictures of food, video tapes, and food models
 - Use materials with lots of colors and pictures such as colored copies of the food pyramid.

From the Editor

Joan Guthrie Medlen, RD

Welcome to our Winter Edition of DevelopMental News. Each issue is always a work of art. I am constantly amazed by the talents of the people involved in the DDPD practice group and their willingness to share with you, our members. This issue is no different as you will see when you read the many tips and strategies for enhancing your practice.

As we begin to cull our talents to share, it is essential that information be shared in a manner that encourages learning and growth for everyone in our practice group. To do this well, we need more help. If you would like to assist with the newsletter and communications area of DDPD, I would like to hear from you! Please email me at joan@downsyndromenutrition.com for more information.

Did you know, that articles in this Developmental News are approved for .5 CPE? Each newsletter is peer-reviewed by three members before it reaches you. This means that it qualifies for professional reading in your portfolio for .5 CPE.

I look forward to expanding our communication team and services over the next year to bring you new, creative ideas and Continuing Education opportunities each year. In the mean time, remember to send us your ideas, articles, or a list of those topics you would love to see covered in Developmental News!

Practice Points

continued from page 5

- Practice learning what food groups and which foods go into each group.
 - Use visual tools: charting minutes of exercise, number of servings of fruits and vegetables consumed, steps per day, or number of sodas consumed (with a set limit).
5. Give the person your full attention. Include staff and family in providing diet education, but work with the individual to help him or her understand why it's important to make changes. Be prepared to repeat this many times.
 6. Assist with problem solving. Talk about choices to resolve a problem. Use role plays to work through trouble areas.

Eating Disorders

Jessica Setnick

Practice Tip for Eating Disorders Counseling from Molly Kellogg, RD, LCSW, a DDPD Member

To maximize cooperation from your clients offer choice. At each visit find some way to give choices even if it's just which food record form to use or which topic to talk about first. Before giving specific advice, ask permission. Almost every time they will grant you permission and this allows the client a sense of control.

This is one of many tips you will find in Molly Kellogg's new *Counseling Tips for Nutrition Therapists: Practice Workbook*, available at www.mollykellogg.com.

Psychiatric Disorders

Linda Venning, MS, RD

Recently in a session at Hawthorne Children's Center in Northville, MI titled *Evidence-Based Child/Adolescent Mental Health Treatment*, Michael Butkus PhD discussed treatments for child therapy in aggression/delinquency, ADHD, depression, and anxiety/fears. Her shared a clinician based child therapy model to employ:

- 1) talk/play with child

- 2) talk with parents
- 3) listen reflectively/show empathy
- 4) build a warm relationship
- 5) be flexible/spontaneous
- 6) be supportive/encouraging and be able to deal with multiple problems/issues.

This model is a helpful tool for dietitians using evidenced base guidelines for nutrition care plans.

Tip for everyone from our Chair-Elect

Paula Kerr

Have you used your SOP/SOPP lately? Mine came in handy just last week. I was questioned about why I was inquiring into the timing of a patient's psychotropic medications. My response: I need to assess this patient's mealtime lethargy. When asked if I was qualified to do so, I invited this coworker to examine my printed copy of SOP/SOPP for Dietitians in Behavioral Health. Have you used yours lately? It may just save you some time:

Standards of Practice for Registered Dietitians in Behavioral Health Care

STANDARD 1: NUTRITION ASSESSMENT

The Registered Dietitian in Behavioral Health Care obtains adequate information in order to identify nutrition-related problems.

Rationale: Nutrition assessment is a systematic process of obtaining, verifying, and interpreting data in order to make decisions about the nature and cause of nutrition-related problems. It is initiated by referral and/or screening of individuals or groups for nutritional risk factors.

Nutrition assessment is an ongoing, dynamic process that involves not only initial data collection, but also continual reassessment and analysis of client's or community's needs. Assessment provides the foundation for the nutrition diagnosis at the next step of the Nutrition Care Process. [http://](http://www.eatright.org/ada/files/Behavioral_Health_SOP_SOPP_3_2006.pdf)

www.eatright.org/ada/files/Behavioral_Health_SOP_SOPP_3_2006.pdf

House of Delegates Fact Sheet

PUBLIC POLICY and ADVOCACY

BIG QUESTION: WHAT IS NEEDED FOR DELEGATES AND MEMBERS TO PARTICIPATE MORE EFFECTIVELY IN ALL ASPECTS OF PUBLIC POLICY AT THE FEDERAL, STATE AND LOCAL LEVELS?

DILEMMA

* Less than 5% of registered dietitians (RDs) and dietetic technicians, registered (DTRs) invest their time and efforts to improve the profession through advocacy and public policy.

* RDs and DTRs are greatly affected, perhaps to a greater degree than many other professions by changes in public policy because food and nutrition affect so many people.

* There is continuous criticism by non-RD administrators that following the Food Guide Pyramid in planning and preparing meals is difficult and should be set aside.

* The key issue ADA has to address is if MNT and other nutrition services are cost-effective and efficacious when they are provided by a registered dietitian.

* ADA's Public Policy Priorities are aging, child nutrition, food and food safety, health literacy and nutrition advancement, medical nutrition therapy and Medicare/Medicaid, nutrition monitoring and research, and obesity/overweight/healthy weight management.

* When members, staff and political action come together to deliver the right fact-based message, at the right time, in the right place, important things can happen. But when any single component of the triad is weak or missing at the critical time or place, an association's effectiveness in representing the members' interests will suffer.

* ADA staff and committees, while effective, do not make half the impression that thousands of ADA members are able to make individually. ADA's grassroots program is now under review.

* ADA's grassroots program is now under review. The new approach is intended to maximize ADA's effectiveness. ADA's new grassroots program will be disseminated to the House of Delegates in advance of the March 17-18th, 2007 HOD meeting.

WE WANT TO KNOW

1. What bills or legislative activities are being addressed by your district/affiliate/DPG related to food, nutrition and health?
2. What threats and opportunities exist with your district/state or DPG related to food, nutrition and health public policy issues?
3. What is the involvement of your district/state

continued on page 8

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continued from page 7

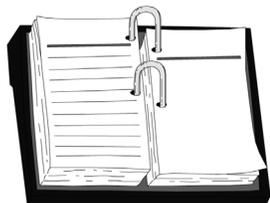
association or DPG (both organizational units and members) in public policy advocacy activities?

Provide responses to your delegate.

DELEGATE CONTACT INFORMATION

Marolyn Steffen, RD, CD is the delegate for our DPG and can be contacted at 4601 Kingsdale Drive, Valparaiso, IN, 46383 or marolynrd@comcast.net. Your comments are appreciated.

For more information on this topic, visit "HOD Backgrounder: Public Policy and Advocacy" using the following link www.eatright.org/HODBackgroundersSpring2007.



Make a Date with DDPD in Philadelphia!!

*Save the date for the exciting first annual DDPD pre-FNCE Workshop! We are lucky to have noted expert Jessica Setnick as a member of our practice group and our inaugural pre-FNCE workshop presenter! Plan to arrive in Philadelphia a few hours early to join us for **Eating Disorders 911** - the eating disorders practice update you can't afford to miss! DDPD members and non-members welcome. Cost: \$90 for 3 CPEs. More details to follow!*