

## Psychotropic Drug/Food Interactions: What RDs Need to Know

By Dean Elbe, B.Sc. (Pharm.), BCPP

Due to the significant increase in usage of Second-Generation Antipsychotics over the past several years, most dietitians are well aware of the nutritional concerns surrounding these medications. However, food-medication interactions that can occur with other classes of psychiatric drugs may be less familiar, depending on your current practice setting and patient population.

The class of drugs known as benzodiazepines is used therapeutically for the treatment of insomnia and anxiety. These drugs also have muscle relaxant and anticonvulsant properties. Diazepam (Valium) is one of the oldest and best known drugs in this class. Other commonly used benzodiazepines include lorazepam (Ativan®), clonazepam (Klonopin®), alprazolam (Xanax®), oxazepam (Serax®), temazepam (Restoril®), triazolam (Halcion®) and midazolam (Versed®). Sedation, drowsiness, ataxia, fatigue, dizziness and other central nervous system effects occur with these drugs and the risk for these effects increases with concurrent alcohol intake.<sup>1</sup> Benzodiazepines are stored in fatty tissues, and can accumulate there in obese individuals. When a benzodiazepine is used for surgical anesthesia, the loading dose needs to be based on actual weight, and maintenance doses should be adjusted based on ideal body

weight.<sup>2</sup> All drugs in this class have the potential to cause physical and psychological dependence. Patients who take these medications in large doses or for long periods of time may require gradual, scheduled dose reduction (also called “tapering”) in order to safely discontinue their use.

Some, but not all benzodiazepines interact significantly when taken with grapefruit juice. Blood levels and total drug exposure increase with diazepam (Valium), triazolam (Halcion) and midazolam (Versed). It should be noted that grapefruit-drug interactions only occur with medications administered orally. When benzodiazepines or other drugs are given by injection, they are not subject to interaction with grapefruit.

Medications prescribed for Attention-Deficit/Hyperactivity Disorder (ADHD) generally fall into one of three categories: 1.) stimulant medications including amphetamine-type drugs, 2.) methylphenidate which is available in several different dosage forms, and 3.) agents with mechanisms of action similar to antidepressants (dopamine and/or norepinephrine reuptake inhibitors), such as atomoxetine (Strattera). Stimulants appear to affect central dopamine levels by blocking reuptake of dopamine and possibly by increasing dopamine release. Similar effects on norepinephrine may con-

tribute to the therapeutic effects of stimulants as well.

Stimulant medications are controversial, both due to the frequency with which they are prescribed, as well as the potential to affect growth with long-term usage. A recent meta-analysis<sup>3</sup> of stimulant use in children with ADHD showed a pattern of initial weight loss which was followed by eventual resumption of weight gain, and a slowing of the change in height by approximately 1 cm/year during the first three years of treatment. A meta-analysis<sup>4</sup> of the non-stimulant medication atomoxetine (Strattera) also showed significant effects on growth early in treatment, followed by a reduction of effects after two years of treatment.

What about the nutritional effects of the Second-Generation Antipsychotics? Are certain psychiatric medications more likely to cause weight gain, lipid disorders or lead to new-onset diabetes? To learn answers to these questions and more, I would like to invite you to attend the seminar I am presenting with your colleague, Zaneta Pronskey, RD, MS, FADA. We will be the Behavioral Health Nutrition (BHN) Priority Session speakers at the upcoming American Dietetic Association Food & Nutrition Conference & Expo in Philadelphia. Mark your calendars for Tuesday October 2nd from Noon to 1:30 p.m. (Session#

## From The Chair

Paula Kerr, MS, RD, CD



Fellow members, this is indeed an exciting time for all of us. It is my delight to be able to talk with you about our DPG name change and about meeting you at the American Dietetic Association's (ADA) Food & Nutrition Conference & Expo (FNCE) 2007,

Philadelphia, PA.

First, let me tell you about our name change. On August 13th our Executive Committee received confirmation from our Practice Team Manager, Frances Austin, RD, that our proposal for changing our name from Dietetics in Developmental and Psychiatric Disorders (DDPD) to Behavioral Health Nutrition (BHN) had been approved by the ADA Board of Directors. We are now officially Behavioral Health Nutrition (BHN)!

Your participation in our member survey was key in the decision process. Our BHN Executive Committee will continue to look to you for decision making. I find this process rather like redesigning our Practice Group's home office. Kathy Russell, MS, RD (Membership Chair) will be asking for your input on new colors and design styles for the BHN Web site. Melody Rankin, RD, LD, (our Newsletter Editor) will be asking you about a new look for our BHN newsletter. We are currently evaluating the visual representation of BHN. I hope you will join in the process of repainting and redesigning our Behavioral Health Nutrition home office. We want it to be a modern, user-friendly but comfortable place where we can all work together to promote the nutritional health of those we serve.

Second, I get to tell you about the events we have planned for you this fall at ADA's FNCE 2007. We have planned something for you every day. We want to meet you! Please introduce yourself to BHN officers. Our officers are making plans to be available to talk with you at each of these events:

**Saturday, September 29th, noon to 3 p.m.** will be our BHN Pre-FNCE workshop, titled **"Eating Disorders 9-1-1"**. All of us work with or will work with people who exhibit a disordered pattern of eating and who do not wish to change. Jessica Setnick, MS,

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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

Winter 2008 . . . . .	<b>January 10, 2008</b>
Spring 2008 . . . . .	<b>February 28, 2008</b>
Summer 2008 . . . . .	<b>March 31, 2008</b>
Fall 2008. . . . .	<b>June 30, 2008</b>

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Subscription cost for individuals not eligible for ADA membership is \$25.00. A check or money order should be made payable to ADA/DPG #12 and sent in care of the newsletter editor.

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## BHN Schedule of events at Food & Nutrition Conference & Expo 2007 (FNCE) Philadelphia, PA

- Saturday 12 p.m. -3 p.m. *Eating Disorders 9-1-1* workshop (J. Setnick presenter)
- Sunday 6 p.m. BHN Member Social – Marriott Downtown Philadelphia Lobby Lounge
- Monday 10:30 a.m.-1:00 p.m. DPG Showcase (Look for us in Booth #18)
- Tuesday 12 p.m. -1:30 p.m. BHN DPG Priority Session: Psychotropic Drug/Food Interactions: What RDs Need to Know
- ADA Foundation Silent Auction: BHN has donated a Laptop computer to help raise funds for ADA Foundation Student Scholarships. Put in your bids...

### **Session: M619**

#### **Eating Disorders 9-1-1**

A special pre-FNCE Workshop

*Conducted by: Jessica Setnick MS RD*

(Founder of “Eating Disorders Boot Camp”)

**When:** Saturday, September 29, 2007 12:00 p.m. – 3:00 p.m.

**Where:** Courtyard by Marriott, Philadelphia

**Room:** Juniper Room

**Complementary:** Jessica’s text “The Eating Disorders Clinical Pocket Guide”

**Buffet Lunch is included**

**CPEU Hours: 3.0 Level 2 Suggested Learning Needs Codes: 5200, 5320, 3000, and others that may apply to your ADA portfolio plan.**

#### **Learn:**

- How to design a meal plan for a patient with an eating disorder.
- How to convince your patients “it’s not about food.”
- How to make recommendations that your patients will want to follow.

**Early bird registration:** \$65 BHN members before September 20th, 2007

Register online at: [www.eatright.org/ddpd-fnce](http://www.eatright.org/ddpd-fnce)

**Late Registration:** \$75 BHN members After September 20th, 2007 register on-site at FNCE



About the presenter: Jessica Setnick, MS, RD/LD, is an internationally known pediatric dietitian in Dallas, Texas. In addition to training professionals around the country at Eating Disorders Boot Camp, Jessica meets with children and teens in her office or their homes to address a variety of weight and eating issues. An award-winning writer, Jessica has been recognized for her tireless efforts at communicating nutrition messages in an understandable way. Now recovered from her own eating disorder, Jessica’s passion is promoting a positive relationship with food and eating as a key component of a healthy and happy life.

**Sponsored by: Behavioral Health Nutrition (BHN) DPG #12**

# ADA's Regulatory Comments Update

Andrea Shotten, MS, RD, LDN  
BHN Public Policy Chair



Keeping up to date with The American Dietetic Association's (ADA) Regulatory Comments is

simple with internet access. Each ADA member can access the ADA web site, [www.eatright.org](http://www.eatright.org), and click on the Advocacy and the Profession tab to link to the Regulatory Comments Web site. Below is a quick summary of current ADA Regulatory Comments that should be of interest to our group:

## Comments on Early Intervention Program for Infants and Toddlers with Disabilities

The Department of Education published proposed rules in the Federal Register for the Early Intervention Program for Infants and Toddlers with Disabilities in May 2007. However, the proposed rules did not include the definition of nutrition services as defined in the current rules. ADA recommended that the Department of Education retain the current definition of nutrition services of the Registered Dietitian among the other types of services. In response to an action alert, ADA members also sent comments. The

majority of the comments received by the Department of Education supported the inclusion of the definition of nutrition services.

## FDA-proposed Gluten-free Label Claim

The Food and Drug Administration (FDA) published proposed rules for 'gluten-free' labeling in January 2007. ADA answered FDA's questions regarding the rules:

- Oats should not be listed among the prohibited grains.
- A disclaimer should be added if foods inherently 'gluten-free' may be exposed to gluten in processing and/or contain food additives that contain a significant amount of gluten.
- A disclaimer should be added to qualify the amount of gluten per gram of food to better inform consumers of the 'gluten-free' claim.
- A 'low-gluten' claim is not scientifically justified.

Overall, ADA believes that the FDA considered well a range of options available to food producers based on the best scientific and methodological data available to establish a definition for a 'gluten-free' claim.

BHN members are asked to submit their public policy concerns to the Public Policy Liaison for

collaboration: c/o Andrea Shotton, 6718 Durango Dr., Magnolia, TX 77354.

Additionally, ADA's Public Policy Workshop (PPW) is scheduled for February 4-6, 2008 at the Renaissance in Washington, DC. The agenda for the workshop has not been announced as yet. More information will be posted on the ADA Web site after Labor Day. PPW is designed to help attendees learn more about ADA priority issues before Congress and to get training on grassroots lobbying.

In addition, for those members who still need further education on the Coding and Coverage for Medical Nutrition Therapy (MNT), ADA is offering the following sessions at FNCE 2007 in Philadelphia:

- Optimize Your Claims – How a Billing Service Can Work For You
- Networking session for RDs participating in the RD Coding Network
- MNT Codes and Medicare Resources

For further information on these sessions access the ADA Web site, [www.eatright.org](http://www.eatright.org), and click on the Advocacy and the Profession tab to link to the Medical Nutrition Therapy Web site.

## What RD's Need to Know

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206). I look forward to seeing you all there.

### References:

1. Pronsky ZM. Food-Medication Interactions, 14th Ed. Birchrunville, PA: Food-Medication Interactions, 2005.

2. Casati A, Putzu M. Anesthesia in the obese patient: Pharmacokinetic considerations. *J Clin Anesth* 2005; 17: 134-45.

3. Poulton A. Growth on stimulant medication; clarifying the confusion: a review. *Arch Dis Child* 2005; 90: 801-6.

4. Kratochvil CJ, Wilens TE, Greenhill LL et al. Effects of long-term atomoxetine treatment for

young children with attention-deficit/hyperactivity disorder. *J Am Acad Child Adolesc Psychiatry* 2006;45: 919-27.

## Case Study In Substance Abuse

Ellen Tobias, MA, RD

When a nutrition consultation is ordered and time is limited, how you approach the consult may challenge both your skills and your knowledge. I have found that the majority of patients completing medical detoxification are not ready to discuss their medical or nutritional problems. What should I assess for? Should I initiate nutrition counseling? As the patient's dietitian, I usually have only one chance to determine the patient's nutrition care plan. What makes this consultation especially challenging is that the patient will be discharged within 5 days, the time-frame in which medical detoxification from drugs and/or alcohol is usually completed. I found that to be the case when I responded to the doctor's request for nutrition consultation with patient, "John".

**Medical Record Review:** "John" is a 35 year old man. He is able to speak, read and write English. He has a technical school degree beyond high school. This is his 10th known detoxification from alcohol and/or drugs. Last visit to Acute Substance Abuse Treatment Unit (ASATU) was 4 years ago. He is admitted for alcohol abuse and opiate dependence. He had been on Methadone for 4 years, but stopped 8 months ago. Methadone Maintenance Therapy (MMTP) will not resume until after discharge. John lives with his elderly father in his father's home.

### **Axis III (2):**

- Hypertension (HTN)  
(non-compliant with meds)

- Hepatitis C
- History of Diabetes Mellitus (currently, no medication and a normal FBS as noted on admit labs)

Abdominal surgery for pseudocyst on pancreas 3 months prior to admission. John reportedly stopped taking prescribed Pancrease prior to admission due to lack of pain relief. He subsequently increased the use of alcohol and cocaine to relieve abdominal pain. John reported a "10" for abdominal pain on the "Nursing Admission Pain Assessment" form.

**Admitting Labs:** Metabolic Profile is within normal limits, except lab data confirming Hepatitis C.

**Anthropometric Data:** Height: 5' 9?". Weight: 162#. BMI: 23.8 kg/m<sup>2</sup> = Normal Weight. Usual Body Weight of 170 – 180#, with a reported history of 40# weight loss related to pancreatic cysts and abdominal surgery. (No documentation to determine validity of this information. Previous ASATU medical record and hospital record not available.)

**Vitals:** Blood Pressure (B/P) was elevated at admission and responded to an antihypertensive agent. B/P is maintained within normal limits with prescribed medication as noted on repeat chart review on day 3 of medical detoxification.

**Medications:** Norvasc for HTN; Nexium for abdominal distress. Norvasc was started at admission. Nexium was added on day 3 when MD requested a nutrition consultation. Antidiarrhea

agents were ordered at admission and daily adjustments were made by medical doctor.

**Diet Rx:** Regular (Detox Regular diet of ~2800+ kcals, 125+ grams of protein, three meals and an evening snack).

**Other Nutrition Related Information:** A nutrition consultation was requested on Day 3. The medical doctor's progress note reveals that diarrhea is continuing and not responding appropriately to antidiarrhea agents. Progress note reports continued abdominal pain and suggestion that John may have gastroesophageal reflux disease (GERD). John will have a follow-up appointment at the GI Clinic of the local hospital that treated him for pseudocyst to his pancreas 1 week after discharge from ASATU.

**Medical Nutrition Therapy:** John received nutrition therapy services from this Registered Dietitian (RD) on Day 4. John reported that he had stopped drinking milk and eating foods containing milk since age 30 due to lactose intolerance. It could not be determined if he was drinking milk or eating foods with lactose while in the Acute Substance Abuse Unit (Detox), as he declined to answer many of the nutrition related questions there. John reported that his usual meal pattern is two meals a day obtained from fast food establishments. He also reported that he had been prescribed nutrition therapy for pancreatitis, but that the nutrition consultation did not concur. John was offered a lactose-controlled, low fat meal plan dur-

## Case Study in Substance Abuse

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ing his stay on ASATU. He declined all nutrition interventions.

Due to multiple medical problems that could respond to nutrition therapy and the patient's anticipated discharge within two days, the RD must determine the appropriate nutrition therapy interventions that will help to relieve or decrease John's chronic abdominal pain, control his diarrhea, and resolve his symptoms of GERD while helping him to maintain sobriety. The "Lactose Controlled Diet" found in ADA Patient Education Materials, Supplement to the Manual of Clinical Dietetics, Third Edition" was utilized, along with the "Sobriety Nutrition Therapy Survival Skills" client education material from the current "ADA Web site Nutrition Care Manual." Nutrition education materials covering dietary modification to control HTN and symptoms of GERD were incorporated into John's instruction. The "Sobriety Nutrition Therapy" handout encouraged nutrition and lifestyle changes that may have a positive impact on blood pressure

control and may help alleviate John's symptoms of GERD. This RD usually does not provide two nutrition related handouts, however the lactose nutrition therapy handout listed foods that may cause distress, as well as foods allowed. His nutrition assessment revealed that John was lacking education on this topic.

This nutrition therapy intervention together with education materials that the patient took home with him can impact John's physical health, comfort, and his commitment to sobriety. John's situation is not uncommon. Deciding how to best help a patient admitted to the hospital for acute detoxification from alcohol or other substances requires a thoughtful assessment of the patient's physical health as well as his or her psychosocial situation. The RD needs to prioritize nutrition issues because of limited time, limited information, and the patient's motivation to learn and to change. Dietitians who lack education, training and/or experience in Behavioral Health practice may feel

that nutrition counseling on all medical nutrition issues should be addressed. Addressing all issues and utilizing multiple-nutrition handouts may not be practical. Limiting the number of handouts and the amount of written information for patients like John is suggested. Offering too much information can alienate rather than engage the patient. This RD used two handouts tailored to John's immediate medical and nutritional needs. The ADA Nutrition Care Manual\* has excellent nutrition information for a patient with lactose intolerance. A simplified two page handout was chosen instead of the three page version. This helped to engage John without overwhelming him and led to a productive counseling session.

John was discharged to home on Day 5. It is not known if he attended his follow-up medical appointment.

\*For information see the ADA Nutrition Care Manual (NCM), a publication of the American Dietetic Association (ADA) copyright 2007 [www.nutritioncaremanual.org](http://www.nutritioncaremanual.org)

## What's Eating Your Patients? How to Solve Emotional Eating from the Inside Out

*By Jessica Setnick, MS, RD/LD and Michelle Negri, RD/LD*

*This article is adapted with permission from Bariatric Times. Subscriptions to Bariatric Times are free to qualified individuals. To subscribe, go to [www.bariatrictimes.com](http://www.bariatrictimes.com) and follow instructions for subscription.*

The post-surgical patient is sitting in your office, tapping her foot and staring at you. She's flustered and angry because her weight keeps increasing. She seems to be getting bigger by the moment. Ever since she had surgery, she has

gone through a whole spectrum of moods – elated, happy, sad, angry, scared, and now... hysterical. She wants to know what YOU're going to do to make her stop gaining weight!

"Fix me!" she wails, leaning

desperately toward you.

You can't respond, your thoughts are a blur... How did I get here? What will I do? How will I help her? How can I escape?... and then with a start, you finally wake up. This time it was only a dream.

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# Gene Linked to Autism in Families with More Than One Affected Child

NIH News

National Institutes of Health

News release Tuesday, October 17, 2006

A version of a gene has been linked to autism in families that have more than one child with the disorder. Inheriting two copies of this version more than doubled a child's risk of developing an autism spectrum disorder, scientists supported by the National Institutes of Health's (NIH) National Institute of Mental Health (NIMH) National Institute of Child Health and Human Development (NICHD) have discovered. In a large sample totaling 1,231 cases, they traced the connection to a tiny variation in the part of the gene that turns it on and off. People with autism spectrum disorders were more likely than others to have inherited this version, which cuts gene expression by half, likely impairing development of parts of the brain implicated in the disorder, report Drs. Daniel Campbell, Pat Levitt, Vanderbilt Kennedy Center at Vanderbilt University, and colleagues, online during the week of the October 16, 2006 in the *Proceedings of the National Academy of Sciences*.

"This common gene variant likely predisposes for autism in combination with other genes and environmental factors," said Levitt. "It exerts the strongest effect detected thus far among autism candidate genes."

Autism is one of the most heritable mental disorders. If one identical twin has it, so will the other in nearly 9 out of 10 cases. If one sibling has the disorder, the other siblings run a 35-fold greater-than-normal risk of having it. Still, scientists have so far had only mixed success in identifying the genes involved.

While most previous studies had focused on genes expressed in the brain, Levitt's team saw a clue in the fact that some people with autism also have gastrointestinal, immunological or neurological symptoms in addition to behavioral impairments. They focused on a gene that affects such peripheral functions as well as the development of the cortex and cerebellum, brain areas disturbed in autism. Moreover, it is located in a suspect area of chromosome 7 that has been previously linked to autism spectrum disorders.

This mesenchymal epithelial transition factor (MET) receptor tyrosine kinase gene codes for a protein that relays signals that turn on a cell's internal machinery and is known to play a key role in both normal and abnormal development, such as cancer metastases (hence its name). Levitt's group and others had earlier found that impairing the receptor's signaling interferes

with neuron migration and disrupts neuronal growth in the cortex and similarly shrinks the cerebellum — abnormalities also seen in autism.

To explore this possible connection, the researchers looked for associations between the brain disorder and nine markers in the MET gene, sites where letters in the genetic code vary among individuals. They tested two samples: the first, 204 families, including 26 with more than one child with autism spectrum disorders, the second, 539 families, including 452 with such multiple affected children.

One marker, the C version, emerged as over-transmitted at "highly significant" levels in people with autism spectrum disorders in both samples. Moreover, this association held only for families with more than one affected child and was strongest in a sub-sample of those with more narrowly-defined autism. The C version was significantly less prevalent in a group of 189 unrelated controls than in the individuals with autism or their parents.

In cell culture tests, the researchers determined that the C version is weak at making the MET receptor protein, resulting in a two-fold reduction in gene expression compared to the other

## Gene Linked to Autism

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common G version of the gene, with presumably adverse consequences on brain development. Inheriting two copies of the C version boosted risk for autism spectrum disorders 2.26-fold, while inheriting one copy of C and one of G increased risk 1.54-fold.

“Since autism likely involves complex interactions between many different genes and other factors, common genetic predisposing factors are likely more influential in families with multiple affected members,” explained Levitt. “Some cases in families with only one affected member more likely stem from rarer genetic glitches or other sporadic events. Hence, finding the link with the MET gene variant only in the former ‘multiplex’ families strengthens its candidacy.”

The researchers propose that in

some individuals with autism spectrum disorders who also develop digestive and immune system or non-specific neurological problems, the MET gene variant might play a role in impairing both brain and peripheral organ development.

“We know that autism is the most heritable of neuropsychiatric disorders, but, thus far, we have not identified genes that consistently are associated with this developmental brain disease,” said NIMH Director Thomas Insel, M.D. “This new finding is an important clue, which if replicated in an independent sample, will take us closer to understanding the genetic basis of autism.”

Also participating in the study were: Daniel Campbell, James Sutcliffe, Philip Ebert, Vanderbilt University; Roberto Militerni, Carmela Bravaccio, University of

Naples (Italy); Simona Trillo, Associazione Anni Verdi; Maurizio Elia, Oasi Maria SS; Cindy Schneider, Center for Autism Research and Education; Raun Melmed, Southwest Autism Research and Resource Center; Roberto Sacco, Antonio Persico, University Campus Bio-Medico and Fondazione Santa Lucia.

The research was also supported by The Autism Genetic Resource Exchange (AGRE), Cure Autism Now, the Marino Autism Research Institute, Telethon-Italy, National Alliance for Autism Research, Foundation Jerome Lejeune, and NARSAD. For more information about autism spectrum disorders see: <http://www.nimh.nih.gov/healthinformation/autismmenu.cfm>.

## What’s Eating Your Patients?

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But your professional nightmare could easily happen, if your patients have unidentified emotional eating.

Emotional eating is a non-technical term that describes eating in response to emotions rather than hunger (1). When emotional eating becomes that severe, it is given the name “binge eating disorder” (see change to Table 1 for symptoms).

For the purposes of this article, emotional eating refers not only to clinically diagnosable patients, but also to those who don’t meet full

criteria. Emotional eating includes patients who are eating out of pain, whether current or past, and eating to feel better, numb out, or feel worse. They are eating to help solve, prevent, or distract themselves from problems. They may have been traumatized in the past, either because of, or unrelated to, their weight. They may eat in public to please others, or eat in private to avoid criticism. Emotional eating may lead to overweight or obesity, leading an emotional eater to seek medical help for weight

loss (3,4,5).

When looking into bariatric surgery, an emotional eater may be consciously optimistic, but unconsciously terrified. If surgery is their “last resort,” the additional stress can actually cause weight gain. The emotional eating may not be identified during assessment, because the patients themselves may not recognize their eating behaviors as emotional. They may classify their eating as abnormal, but assume that surgery will “fix it.” Most dangerous of all, patients



## What's Eating Your Patients?

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may welcome the inability to emotionally eat, without realizing that they will then be forced into facing certain emotions that they are used to relieving with food. For all of these reasons, bariatric practitioners must be increasingly alert to detect emotional eating issues in order to prevent the devastating consequences that otherwise can result.

If a patient became obese by eating in response to emotions he/she could not express, surgery may leave him/her vulnerable to the same feelings, but with no way of relieving them (6,4).

Messages in our culture tend to suggest that weight loss is a cure-all. But any emotional distress that a patient incorrectly attributed to obesity - perhaps loneliness, social phobia, depression, or shame - will linger during and after weight loss is achieved. So in addition to the original distressing emotions, a patient may begin to experience depression, disappointment, or anger, accompanying the realization that surgery didn't "fix" emotional issues. (4,7,8).

If a patient finds ways around post-surgery dietary guidelines and returns to inappropriate or emotion-related eating after surgery, he/she may begin to gain weight, which in turn would be expected to cause more negative feelings (7,9,10). Realizing that even bariatric surgery is not "enough" can be profoundly depressing. Psychiatric centers are anecdotally reporting increasing numbers of

post-surgery patients with depression, anxiety, and other psychological distress. Professionals report that routinely these patients were unaware of the beneficial purpose of their emotional eating in bolstering their brain chemistry, and therefore developed no skills to compensate for its loss. A detailed history often reveals one or more unprocessed traumas, from childhood abuse and abandonment to miscarriage, divorce, and family deaths (9,11,12).

After treating emotional eaters pre-surgery through the Ai Pono Eating Disorders Program in Honolulu, Dr. Anita Johnston describes these as "frozen" traumas locked in an iceberg. "Once the ice begins to melt," she says, "you find all kinds of things buried there." In other words, as our patients move forward after bariatric surgery, their eating behaviors no longer serve to numb them from past pain. The cracks underneath begin to be revealed, but the patient has no skills to cope with what they may find. In many cases, patients need surgery, regardless of their emotional eating status. But they also need the additional support of psychological care and to know where they will get help before there's a crisis.

### **Emotional Eating: Why aren't we identifying it in pre-surgery assessments?**

First of all, we don't always ask. You may not feel comfortable asking a patient, "Do you ever eat out of depression or shame?" And it

may not feel comfortable to them to answer. If questions are asked in a written survey format, patients may be reluctant to indicate their emotional eating, not knowing who will ultimately read their answers. On the other hand, many patients don't identify with the terms "bingeing" or "emotional eating" and therefore don't equate what they're doing as such. Sometimes it's a "don't ask, don't tell" situation, since patients may fear certain confessions will prevent or delay their surgery. Dr. Johnston points out that a lot of our patients don't recognize the events of their lives as trauma, so it's impossible for them to realize the connection with their eating.

Finally, often no one person on the pre-op team takes responsibility for assessing emotional eating. Is it a nutrition issue? A psychologist's topic? Irrelevant? When team members are working out of different locations or not working together at all, it is more difficult to build the rapport necessary to encourage disclosure. If assessments are brief or perfunctory, or worse, only focus on post-surgical instructions, disordered eating habits may not be picked up.

### **Emotional Eating: Why don't we notice emotional eating after surgery?**

At a post-surgery support group that feels like a pep rally, the patient who's stress-snacking, bingeing, night-eating, or all of the above, may not speak out. If they're not doing well, they may

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## From the Chair

*continued from page 2*

RD, will help us to work in a way that our clients will appreciate, and that will promote healthy change. Don't miss this one! A buffet lunch, a copy of Jessica's text "The Eating Disorders Clinical Pocket Guide," and 3 CPEU come with the cost of registration. You need to register on-line before September 20, 2007 for the best deal. Go to: [www.eatright.org/ddpd-fnce](http://www.eatright.org/ddpd-fnce).

**Sunday, September 30th at 6:00 p.m.** we invite you to join us in the **Lobby Lounge** at the **Downtown Philadelphia Marriott Hotel** for our very first BHN member social. We will have a special gift for the first 10 BHN members to arrive and introduce themselves. Come for the conversation. Come for the fun. Just come!

**Monday, October 1st 10:30 a.m. to 1:00 p.m.** is our Dietetics Practice Group **Showcase**. BHN officers will be in **Booth #18** to answer your questions, record your suggestions, get your input on redesign of our BHN Web site and newsletter. We will have Psychiatric Manual CDs for sale and BHN give-aways. And if you have a friend who needs to become a BHN member, we will be recruiting new members too.

**Tuesday, October 2nd** is all about **BHN's Priority Session**. It begins at **noon**. You have found by now a brief article by Dean Elbe B.Sc. (Pharm), BCPP titled "Psychotropic Drug/Food Interaction." We asked Dean to submit this piece so that you will have a taste of

what will occur during his presentation with Zaneta Pronsky, MS, RD. Zaneta and Dean co-author a publication that many of us reference routinely when we need to look up food and medication interactions for our clients. Join us for this session to learn **"Psychotropic Drugs/Food Interactions: What RDs Need to Know."**

Officers, Harriet Cloud, MS, RD (Nominating Committee Chair), Sharon Wojnaroski, MA, RD, (past-Chair) and I, will be attending the ADA House of Delegates (HOD) session on Friday, September 27th, as your representatives. We are very interested in observing the HOD process and then working with Professional Issues Delegates to identify BHN issues that need to be heard by the ADA House of Delegates. Mega Issues before the HOD on that day will include **Health Disparities**. This is indeed an issue pertinent to the practice of BHN Dietetics Professionals. Which of your clients/patients have inadequate access to your services and what are their barriers to access? Email me at [pkerr6818@charter.net](mailto:pkerr6818@charter.net). I need to know. We will report back to you on events of that day.

Welcome to Behavioral Health Nutrition! Let's make it a great year - together.

Paula Kerr MS, RD, CD

## What's Eating Your Patients?

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even drop out, preventing the support that they desperately need.

They may seek support anonymously on-line, where they may find sympathy, but also dangerous ideas on how to "cheat" their post-surgery diets and continue emotional eating. It's intimidating to admit that you're struggling with food when you just had the surgery that was supposed to be the solution. Patients may feel like they have done something wrong, when they are not "succeeding" like their peers. And although the profes-

sional team may be as understanding as possible, our patients often see us as authority figures, and don't want to "disappoint" us with news they are struggling. If the amount of food eaten for emotional reasons is not adequate to promote noticeable weight gain, patients may suffer in silence without seeking assistance.

### **Emotional Eating: What can happen if we miss it?**

Some of our patients are obese for reasons other than emotional eating. These patients may have

complications post-surgery, but of a different kind than emotional eaters. The reported complications of post-surgery emotional eating can range from weight regain, with associated comorbidities, to shame, depression and attempted suicide. On the way, patients may turn to substance abuse, smoking, promiscuous behavior, compulsive shopping or other vices because they aid brain chemistry in the way their eating used to do (13).

Patients with severe trauma history or adverse sexual events may

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even require hospitalization for psychiatric needs when the protective barrier of weight starts to thaw. Becoming more open to relationships, even though desirable on the surface, can be scary to the person who has been abused, ignored, or disgraced by society (4).

### What Can We Do to Improve Outcomes?

Our review of literature suggested that emotional eating is not necessarily a contraindication for surgery, but that emotional eaters may need more support post-surgery than other patients. The problem remains that many emotional eaters do not self-identify, and to date, there is no standard assessment that can be used in advance to predict post-surgical success. The responsibility to identify emotional eating, therefore, lies with any and all members of the treatment team who interact with patients.

Because the hallmark of emotional eating is the underlying, primary issues, the main goal of treatment is to provide healthy alternative outlets for handling these emotions. Patients do not need to resolve or eliminate all past and future negative emotions, but they must learn to avoid non-hunger eating as a response.

Some clues are available to guide professionals in detecting emotional eating in their patient population. Ideally, each team member addresses the possibility of emotional eating in his or her own way. The patient then has multiple opportunities to confide in the per-

son they relate to the best. If questions and concerns are repeated by more than one professional, patients may better appreciate the relevance of the answer and the corresponding recommendations. Destigmatizing emotional eating in group or individual sessions can also promote patient disclosure. Emotional eating IS NOT rare in our bariatric patient population. It is common enough to deserve at least a mention in all pre-operative assessments and education. Even with all of our efforts, because our patients are often unaware of their emotional eating, it may not be revealed until after surgery.

Post-surgery clues to emotional eating include:

- Slow weight loss or failure to lose weight
- Gradual weight regain >10-15 pounds from lowest post-surgical weight
- Rapid weight regain
- Resentment or lack of motivation to follow dietary recommendations
- Maladaptive eating behaviors (increased and/or excessive intake of sweets, soups, calorie-containing liquids, soft foods, etc.)
- Reported vomiting, either spontaneous or self-induced
- Depression (look for crying, decreased self-care such as grooming, isolation, etc.)
- Reported increase in alcohol consumption
- Angry dissatisfaction with

surgery results or treatment provider(s) in the absence of medical or mechanical complications

Once you realize that a patient is struggling with either emotional eating or emotional barriers to dietary compliance, recommend psychological or behavioral counseling. In a supportive and non-accusatory manner, explain to patients that their surgery has changed the way they are able to cope with stress, and assistance with stress management is needed. If a patient is resistant to comply, suggest that counseling can be solution-focused or in a non-clinical setting and need not dwell on past bad experiences.

If your clinic does not offer a support group, and/or if a patient's financial resources are limited, Overeaters Anonymous or Alcoholics Anonymous may be available in your community (see Table 2 for resource information). Individual counseling may be preferred for patients who need more intense intervention, and can be recommended in addition to group therapy or support. The goal of any of these therapeutic modalities is to separate food and emotions, rather than eliminate one or both.

In the case where you choose to directly provide your patient with guidance, and you are willing to spend the necessary time to counsel your patient, food records can be a useful tool in determining where emotions are interfering with eating. A typical food diary of

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## What's Eating Your Patients?

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simply what is eaten is not as helpful as a more detailed journal of situational factors that come into play. For example, keeping track of where, when, and with whom someone eats can identify links between eating and outside factors, and listing emotional state before and after eating can identify which emotions and triggers are most likely causing the problem.

Incorporating a rating of hunger before and after eating can help identify non-hunger eating which may be emotional. However, many patients post-surgery have impaired perceptions of hunger and satiety, and should not necessarily be advised to follow these signs. The goal instead should be to identify if and when eating is clearly not nutrition-related, for example when a patient is eating out of anger, frustration, or simply boredom.

Once emotional eating triggers are acknowledged, the next step is to separate the response from food. In other words, patients need something else to do when the urge for comfort food arrives. Meditation or resting is preferred to television, as television advertisements frequently suggest eating, and reading should be limited to books, rather than magazines, for the same reason. Emotional eating patients may not be accustomed to sitting still without an activity. Distracting activities like exercise, knitting, crossword puzzles, or anything that keeps attention off food, can be very helpful if

used consistently.

One project should be selected in advance, as the stressful state that induces emotional eating may also prevent clear thinking about alternatives. A support person may also be involved, as someone whom your patient can call when the destructive eating strikes. Some patients may find that a healthy expression of feelings is suitable and relieving, such as writing in a journal, artistic pursuits, listening to music, scrapbooks or photo albums, or writing a poem. Again, the key is to preplan an activity, and place the supplies in the kitchen or cupboard, wherever the patient goes for their food. The goal is not to resolve all feelings, simply to avoid food, which cannot help. If a patient finds that your ideas are still impossible to put into practice, psychotherapy is once again indicated to identify emotional resistance to change.

In some cases, psychiatry is warranted in addition to psychotherapy. Some patients may be more willing to take medicine in lieu of counseling, which is a start. Other patients may be reluctant to take psychoactive medication, and would rather pursue counseling alone.

Encourage your patient to take advantage of all possible treatment modalities; if you think psychiatry is warranted, refer to an appropriate professional. Because both depression and anxiety, individually or in conjunction, can exacerbate emotional eating and cause

weight gain, anti-depressant and anti-anxiety medications (sometimes the same medicine, working on both problems) can help dietary compliance and promote continued weight loss. The emotional lift of weight loss can then keep the food-mood spiral moving in the right direction, and ultimately medication may no longer be necessary.

However since emotional eating can stem from depression, anxiety, social insecurity, trauma, neglect, or abuse, medical management may be necessary long after body weight has normalized. In other words, our society may indicate that depression is an effect of obesity, depression may actually be a cause as well, and may require treatment regardless of weight. Patients who show signs of depression, anxiety, insomnia, or post-traumatic stress before or after bariatric surgery should be treated for these conditions. Although these and other psychiatric conditions may be worsened by obesity, poor nutrition, and/or social consequences of being obese, that doesn't mean they will completely resolve simply by weight loss alone. No medications have been approved by the FDA specifically for the treatment of emotional eating, so treatment must be individualized to each patient's particular symptoms.

In some cases, patients may refuse further care from you in response to denial that problems exist. They may prefer to blame you or their surgery "failure" than

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explore the emotions that hurt them so deeply. Some patients may not attend follow-up visits because of their shame and their perception (whether deserved or not) that they will be blamed or criticized for their substandard weight loss or their failure to comply with recommendations. You can repeat your suggestions for additional care, but an adult patient may choose not to follow your recommendation.

In these cases, the most pertinent goals are to try to provide as much emotional support as possible and to prevent or minimize further weight regain. Maintain contact in whatever form possible, including, for example, phone calls or email. Leave the proverbial door open for a return to treatment if and when the patient is ready. Encouragement and empathy in a tone of compassion and acceptance can prevent a discontented patient from turning away permanently. Expressing an understanding that changing is hard, even with the assistance of bariatric surgery, can help patients comprehend that this is not "their fault," but that choosing to change is their responsibility. The behaviors that led to obesity developed over years, and reversing them is no easy task. Although weight loss after the initial post-surgery period may be slower or later than expected, it is still possible with dietary and behavioral compliance, even several years down the road.

Emotional eating is hard on everyone surrounding the person

who struggles. In a bariatrics practice, you may become close to your surgery patients, and feel the weight of their struggle. When a patient with trauma or other unseen issues has trouble with their surgery or weight loss, it's tempting to want to fix things for them and help them feel better, lose weight, and succeed. But unless you are willing to monitor patients around the clock, ultimately you will be relying on the individual's motivation. Some of your patients may not be willing to take the steps that only they can.

In these situations, you may benefit from moral support. As a treatment provider, you are a role model for your patients, like it or not. Your patients take notice of your efforts to take care of yourself, emotionally and physically, not just the way you take care of them. In this vein, you may choose to seek support from colleagues in your facility, your town, or your field who have experienced similar challenges. A support group in your clinic to discuss difficult cases, or even simply taking an opportunity to vent, can provide relief from the stress that caregivers inevitably encounter.

Research remains inconclusive about the best course of action for addressing emotional eating in bariatrics patients. For everyone with emotional eating, there is a different set of circumstances that created their pain, and a different path to well-being and health. Helping each patient find their

own way to heal by identifying and providing resources that are appropriate for their individual needs is the best way to help both you and your patients sleep soundly at night.

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## DSM-IV Research Criteria for Binge-Eating Disorder

**Table 1**

A	Recurrent episodes of binge eating, characterized by both of the following:
	(1) Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
	(2) A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
B	The binge-eating episodes are associated with three (or more) of the following:
	(1) eating much more rapidly than normal
	(2) eating until feeling uncomfortably full
	(3) eating large amounts of food when not feeling physically hungry
	(4) eating alone because of being embarrassed by how much one is eating
	(5) feeling disgusted with oneself, depressed, or very guilty after overeating
C	Marked distress regarding binge eating is present.
D	The binge eating occurs, on average, at least 2 days a week for 6 months.
E	The binge is not associated with the regular use of inappropriate compensatory behaviors (e.g. purging, fasting, excessive exercise) and does not occur exclusively during the course of Anorexia Nervosa or Bulimia Nervosa.

Source: American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, Copyright 2000. (reprinted with permission from the American Psychiatric Association)

**Table 2**

Locate a Support Group for Emotional Eating	
Overeaters Anonymous:	<a href="http://www.oa.org">www.oa.org</a>
Eating Disorders Anonymous:	<a href="http://www.eatingdisordersanonymous.org">www.eatingdisordersanonymous.org</a>
Alcoholics Anonymous:	<a href="http://www.alcoholics-anonymous.org">www.alcoholics-anonymous.org</a>
Eating Disorder Referral Network:	<a href="http://www.edreferral.com">www.edreferral.com</a>

## Request for Nominations

Greetings to all members of BHN! Opportunities for leadership in BHN abound and as chairman of the nominating committee, I'm looking for those of you who might be interested in running for one of our offices: chair-elect, secretary, and nominating committee (three

names). The current leadership of BHN is planning many activities for members at FNCE this fall and continuing education events throughout the year. If you are interested in being in the leadership pool please e-mail me at [hclouds@bellsouth.net](mailto:hclouds@bellsouth.net). This will

help our committee as we begin the nomination process.

Thanks,  
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