BHNewsletter

Behavioral Health Nutrition
a dietetic practice group of the American Dietetic Association

Setting the Standard for Nutrition in Behavioral Healthcare

Sensational Eating at the American Dietetic Association's Food & Nutrition Conference & Expo (FNCE) 2009

Nutritional and Sensory Processing Factors That Affect Mealtime

Patricia Novak, MPH, RD, CLE

Two-year-old Carlos was sitting at a high chair looking apprehensively at a small pile of whipped cream. When his shirtsleeve touched the whipped cream, his apprehension turned to panic leading to vomiting and the end of the feeding session. Allowing the whipped cream on his tray was a big step for Carlos but whipped cream on his shirtsleeve was just too much. Michael, 4 years old, was referred for a nutrition assessment because he was not gaining weight. He ate only dry, crunchy foods and thin liquids. Milk, supplemental formula, all refused. Even a tiny bit of peanut butter on a cracker would lead to a tantrum, resulting in the end of a meal. Alan, 8 years old, was still eating pureed foods. He could not eat in the school cafeteria with peers nor could he join the family at meals, entering the kitchen when his mother was cooking frequently led to gagging. Each of these children carried different medical diagnoses yet each was experiencing sensory barriers to developmentally appropriate feeding. Regardless of the etiology of the feeding challenge, the success of nutrition intervention was dependent upon the dietitian's ability to consider sensory barriers to feeding. Sensory barriers include not only the actual sensory aspects of food (taste, smell, texture, color, etc) but the ambient sensory factors (sounds, smells, etc) in the eating environment as well.

Addressing sensory issues is most effective when utilizing a team approach. Sensory integration and processing concerns are typically assessed and treated by an occupational therapist. Collaboration with the occupational therapist is essential for the dietitian to combine "what" the individual needs to eat with "how" they will best accept the food.

Although the population presenting with sensory based feeding pathology continues to grow as the number of infants surviving pre-maturity increases and the rates of autism spectrum disorders rise, sensory issues are not limited to children. Adults with neurological impairments, eating disorders or mental illness may also find specific sensory aspects of food overwhelming. Meals themselves are rich sensory experiences that can either be enjoyed or endured. Our effectiveness in improving our client's nutritional status is dependent on our understanding of how sensory input is perceived and our ability to integrate the individual's sensory profile into our recommendations.

Plan to attend the BHN Priority Session "Sensational Eating" at FNCE 2009 featuring BHN member Patricia Novak, MPH, RD, CLE along with Winnie Dunn, PhD, OTR, FAOTA. Patricia has worked in pediatric nutrition primarily with children on the Autism Spectrum or with other special health care needs for over 25 years. Dr. Winnie Dunn is professor and chair of the Department of Occupational Therapy Education at the University of Kansas Medical Center. She is the leading authority and author on sensory processing and internationally recognized for her research regarding how people respond to sensory experiences in their everyday lives.

SUMMER ISSUE 09

INSIDE this issue

BHNewsletter is published quarterly (Winter, Spring, Summer, Fall) as a publication of Behavioral Health Nutrition, a dietetic practice group of the American Dietetic Association. The Spring and Fall issues are published electronically; members receive an email announcement and link for direct access. Newsletters are available on the BHN Website at www.bhndpg.org.

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Future Submission Deadlines

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eat right. American Dietetic Association

From the Chair

Andrea D. Shotton, MS, RD

The Behavioral Health Nutrition (BHN) Dietetic Practice Group welcomes you to a new and exciting year. BHN was the lucky recipient of a grant from ADA for the executive committee strategic planning session in May with ADA Past President, Marianne Smith Edge, MS, RD, LD, FADA. Thanks to those of you who completed our recent member survey sent via email in March and April 2009. As a result of your input, BHN is working on a new mission and vision for the practice group.

Many tough decisions were made to ensure BHN becomes the high quality empowering expert organization of RDs and DTRs in the four focus fields, Intellectual and Developmental Disabilities, Eating Disorders, Mental Illness, and Addictions. The plan of work has been approved and we will see an abundance of success following the services and strategies implemented to reach the vision and mission of BHN. We are excited to hear your comments and especially thrilled if you would like to participate in achieving our five year goals. One such goal focuses on members and prospective members viewing BHN as essential to their professional success. A strategy to meet this goal is increasing member involvement. Please email Volunteer Coordinators from our Nominating Committee, Therese Shumaker, MS, RD, LD, at shumaker.therese@mayo.edu and Sharon Lemons, MS, RD, LD at slemons@prodigy.net who will match you with a project that is of interest to you. Another strategy is increasing BHN listserv membership, as the quality of discussions there is incredible, especially considering you receive this advice for free with your membership. If you are not already a member, you can join by sending an email to newly appointed Membership Chair, Julia Lovisa, RD, CD at jlovisa@memorialsb.org with the following information:

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Please title the subject of the email: **BHN LIST SUBSCRIBE**.

Although the flow of emails is not excessive, if you prefer to receive a digest of all emails once per week, you can note it in the email.

BHN is moving forward and especially committed to making your membership dollars work for you. You may view the full listing of Goals and Strategies via the BHN Website once posted (www.bhndpg.org). As always, with a new fiscal year come new Executive Committee members. Please welcome the newly elected and appointed BHN Executive Committee and committee members to aid in the tasks of the strategic plan. BHN is growing, not only in membership numbers, but also on the website, through webinars, student participation, publications, educational podcasts, networking alliances, and much more to come in the next five years. We look forward to an exciting year of progress towards our growth with YOU on board!

Your chair,
Andrea D. Shotton

(From Left) Kathy Russell, MS, RD, Chair Elect; Andrea Shotton, MS, RD, LDN, Chair; Marianne Smith-Edge, MS, RD, LD, FADA; Jessica Setnick, MS, RD, LD, Past Chair

Interaction Between Eating Disorders and Celiac Disease: Implications for Clinical Nutrition Assessment and Care

By: Melinda Dennis, MS, RD, LDN, Jessica B. Edwards George, PhD, NSCP, and Daniel Leffler, MD, MS

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What is Celiac Disease?

Celiac disease (CD) is an inflammatory disease whereby peptides from wheat, rye, and barley (i.e., gluten) trigger and maintain an immune reaction in the small intestine. When an individual with CD ingests gluten, the immune reaction that results causes chronic inflammation of the small intestine. This inflammation can lead to loss of the intestinal villi, tissue injury, malabsorption, and the presentation of clinical manifestations in symptomatic individuals. The clinical manifestations of CD are diverse due to the complex relationship between genetic, environmental, and immunogenic factors, making it difficult to identify and diagnose. Typical symptoms include chronic diarrhea and abdominal discomfort, but many also have atypical symptoms where gastrointestinal symptoms are either absent or not prominent. The only effective treatment for CD is removal of gluten from one's diet and adopting a gluten-free diet (GFD). The removal of gluten from the diet has been shown to lead to improvement in the majority of CD-related health problems, including diarrhea, malabsorption, abdominal bloating and discomfort (1, 2), osteoporosis/osteopenia (3), anemia (4), infertility (5), risk of malignancy and mortality (6-8), psychological distress and decreased quality of life (2).

What are Eating Disorders, Body Image Dissatisfaction, and Eating Disturbances?

Eating disorders (EDs), namely anorexia nervosa (AN) and bulimia nervosa (BN), are life-threatening forms of psychopathology that include extreme emotions, attitudes, and behaviors surrounding weight, shape, and food. EDs typically develop in adolescence and early adulthood and occur mainly in females. AN is defined by a refusal to maintain a normal body weight (15% or more below expected for the individual's age and height), severe restriction of food intake (often with excessive exercising), presence of an intense fear of becoming "fat" (even though underweight), a disturbance in the way in which body weight or shape is experienced, an unwarranted influence of body weight or shape on self-perception, and the absence of menstrual cycles in postmenarcheal females (9). BN, on the other hand, is described as the presence of recurrent episodes of binge eating (eating objectively large amounts of food and losing control over these eating episodes) and recurrent inappropriate compensatory behaviors (e.g., self-induced vomiting, use of laxatives or diuretics, and strict dieting or excessive exercise) together with a persistent preoccupation with body size and shape on self-evaluation9. Movement from a diagnosis of AN to a diagnosis of BN or binge-eating disorder is frequent, occurring in about 50% of AN cases (10). AN and BN affect up to 1% to 3% of young females, respectively, and carry high rates of morbidity and occasional mortality, especially in AN. Eating disorders also occur in males and in adults, but young females continue to be the predominate group afflicted by these disorders.

In addition to clinical EDs, many individuals suffer from sub-clinical body image dissatisfaction and eating disturbances that do not meet the criteria for an ED, but remain concerning. Simply said, many individuals struggle with an incongruity between the perception of their body shape and size and their preferred body shape and size. The larger the discrepancy between that perception and preference, the greater the body dissatisfaction. Eating disturbances occur when the individual engages in problematic eating behaviors due to body image dissatisfaction: these can include extreme dieting, binge eating, vomiting or laxative use, diet pill use, fasting, and excessive exercise.

How might Celiac Disease and Eating Disorders Interact?

Despite a large body of evidence describing the detrimental effects of EDs on the gastrointestinal system, information on the role of the gastrointestinal system in causing or mimicking EDs is scarce. Very little has been published in the literature on the co-existence of CD and EDs and much of what has been published are single case studies. One concern corroborated in the literature is that clinicians may overlook the possibility of an additional medical illness, such as a gastrointestinal disorder, in the presence of disordered eating behavior and its concurrent symptoms. An example of this is the case of a 31-year-old female diagnosed with an atypical ED who was ultimately diagnosed with CD when her atypical symptoms were brought under further investigation (11). Yucel and colleagues clearly state regarding this case that "celiac disease may lead to confusion in the differential diagnosis of anorexia nervosa." (11)

In a second case report, a 29-year-old woman presented to the emergency room with exhaustion, fatigue, abdominal pain, marked pallor, severe malnutrition, and extremely low hemoglobin level of 1.7 g/dL, as well as low serum iron, ferritin, and serum transferring (12). A diagnosis of CD was later confirmed by serum levels of endomysial antibodies, tissue transglutaminase (tTG), and antigliadin antibody. CD can be assumed to be responsible, at least in part, for the severe symptom report. Jost and colleagues (12) suggest that additional somatic conditions should be considered in the anorexic patient who presents with severe anemia and malnutrition.

In another case report, a female volleyball player presented with diarrhea, a 17-pound weight loss within 20 days, critically high platelet counts, and fatigue after preseason training (13). Interestingly, despite the lack of psychological symptoms indicative of an ED, such as body dissatisfaction and preoccupation with weight or shape, the initial differential diagnosis was an ED. A duodenal biopsy, however, confirmed CD and the GFD was initiated.

Given the GI symptoms, potential weight fluctuations, and intense focus on eating and food typical in patients with CD, an association between CD and EDs seems likely. At The Celiac Center at Beth Israel Deaconess Medical Center (BIDMC), Boston, MA, (January 2006) a research study was launched to evaluate the incidence of EDs in the CD population at BIDMC and the potential for interaction between CD and EDs (14). The Celiac Center clinicians decided that a study of this kind was important due to common clinical observations of the complex interaction between CD and EDs, the notion that the interaction between CD and EDs is largely misunderstood, and that the topic has received very little attention in the literature. As a result, 10 cases of co-existing CD and ED were identified within a database of 603 individuals with CD at BIDMC (1.6%) and analyzed. All were females between the

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Eating Disorders and Celiac Disease

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ages of 20 and 35. In this age group, individuals with EDs made up 11.6% of the total (n = 84). A psychologist with specialized training in both CD and EDs, a registered dietitian, and two gastroenterologists reviewed all co-morbid cases.

Results of Case Series and Specific Case Descriptions

From the 10 total case studies identified, the following associations were identified. In three patients, the two disorders existed separately with little interaction. In two patients, the presence of an ED made the treatment of CD more difficult by compromising adherence to the GFD. An exacerbation of an ED occurred for two patients who were diagnosed with CD. In one patient, diagnosis and treatment of CD was delayed because the symptoms of CD mimicked those of an ED. One patient received inaccurate education of CD from an ED clinician, which compromised the patient's health and trust. And in one patient, the diagnosis of CD helped her to facilitate recovery from her ED.

Specifics of four contrasting cases of co-morbid CD and ED identified as a result of the above study are presented below to highlight significant details and to reflect on the multiple associations between CD and EDs.

Patient A

A 27-year-old female diagnosed with CD at age 25, with a history of BN and depression, was referred for confirmation of CD diagnosis, dietary education and management. Upon initial presentation the patient had a BMI of 25.9. Her foremost concern was that she had gained 15 pounds after starting the GFD. Her adherence to the GFD was reasonably strict overall but she was bothered by the elevated calorie and fat content of gluten-free (GF) foods. She articulated that she wished to lose 25 pounds, but compromised and pursued a (healthier, or more appropriate) weight loss goal of 5 to 10 pounds, as recommended (weight 140 pounds, BMI 23.3). She was agreeable to a healthy calorie-restricted diet with adequate vitamins and minerals. She was lost to follow-up after her second nutrition visit.

Patient B

A 35-year-old female with a lengthy psychiatric history of AN, BN, and depression was seen for enduring weight loss despite reporting control of her EDs. Her BMI had declined from 21 to 16 over the course of one year. In addition, she stated that she experienced frequent mild epigastric pain and diarrhea. She was then diagnosed with CD and began adhering to the GFD. Her BMI increased to 18 after gluten withdrawal. The patient battled with her ED, but initially was adherent with the GFD. She noted struggling to maintain the GFD while in an inpatient ED clinic, stating that the clinic staff were not "helping" her to find GF substitutions for the allowed snacks and did not allow her to bring GF foods into the program. It was thought that the clinic likely interpreted her requests for GF food as manipulations of the refeeding process. At the most recent nutrition visit, the patient openly acknowledged purposeful ingestion of gluten-containing snack bars as a weight loss strategy, as well as exercising beyond the recommended level ordered by her physician.

Patient C

A 35-year-old woman presented with a history of AN, BN (BMI 20.6), depression, osteoporosis, Grave's disease, and "runner's colitis." She reported that her EDs had been in remission until she experienced a knee injury that left her temporarily unable to run. This injury precipitated an ED relapse. She then developed diarrhea and iron deficiency anemia, resulting in a subsequent diagnosis of CD. Specifically upsetting to her was her inability to lose weight while following the GFD. She presented with little motivation to follow a strict GFD. Despite repeated counseling with a dietitian versed in CD and referral to an ED dietitian, ongoing hematochezia and abdominal pain, she continued to ingest gluten and engage in frequent distance running.

Patient D

A 31-year-old female diagnosed with CD at age 30 with a history of depression and schizoid personality disorder was seen for GFD education. On a GFD, she noted resolution of CD-related symptoms including abdominal bloating, fatigue, and hematochezia. Despite this she complained of a 40-pound weight gain (BMI 27.3) after beginning the GFD, in part due to binge eating. Diet recall revealed high intake of sugar and sodium-rich snack foods. She was agreeable to seeing a dietitian specializing in EDs to assist her with her "eating issues, diet obsession and binge habits." At 3-month follow-up, she returned with a healthy 17-pound weight loss (BMI 24.7). At six months, the patient fully acknowledged her ED and reported completing an intensive ED program. In conjunction with maintaining a strict GFD, the patient was motivated to follow healthier eating patterns.

Clinical Implications

The above cases demonstrate the complex ways in which CD and EDs interact with important clinical implications for the diagnosis and treatment of both illnesses. Our findings suggest that clinicians treating patients with EDs or CD should be aware of both conditions to provide optimum care.

Clinically, at The Celiac Center, we have seen that a patient newly diagnosed with CD who also presents with symptoms of an ED and/or acknowledges an ED is typically concerned with the possibility of weight gain as a result of following the GFD. It is appropriate to acknowledge the possibility of weight gain on the GFD; this is a common occurrence when a previously untreated malabsorptive disease is brought under control, which allows the patient to absorb nutrients more efficiently. In addition, many processed GF foods are higher in calories and fat than their gluten-containing counterparts. For this reason, those with EDs may feel as though they are being "forced" to follow a high calorie/high fat diet. Many of these same foods are also predominantly made with rice, corn, tapioca, and potato-based flour and/or starch. While these starches are "safe" foods on the GFD, they are also high in refined carbohydrates and low in fiber. In addition to educating on a balanced healthy diet, a reasonable clinical recommendation is to encourage patients to consume between 6 and 11 servings (depending on caloric needs) of whole grain or enriched GF grain foods on a daily basis (15). Some of these nutritious GF grains include quinoa, millet, teff, amaranth, buckwheat, and sorghum. These grains are slowly entering the mainstream markets and are becoming more widely available to individuals seeking to understand and follow this challenging diet16.

As an added incentive, these whole grains tend to be much less expensive than commercially prepared GF products, which are almost three times as expensive as their gluten-containing counterparts (16). It is our practice in the Nutrition Department at The Celiac Center to teach our patients with CD about the nutrient-dense alternative grains– their fiber content, nutrient value, benefits for bowel motility, ability to satiate the appetite, and cost benefit.

Finally, it is helpful information for patients to know that studies have shown the standardized mortality ratio to normalize with good adherence to the GFD (17). In addition, a study by Mustalahti, et al demonstrated that quality of life significantly improved for patients with CD after one year of adherence to the GFD (18). For those patients with CD who are responding positively to nutrition counseling, this information can be motivating.

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Attention Students:
We value your input and want to hear from you!
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Overweight and obesity are associated with psychiatric disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions.

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OBJECTIVE:

This study evaluated associations between body mass index (BMI) and psychiatric disorders. METHODS: Data from 41,654 respondents in the National Epidemiologic Survey on Alcohol and Related Conditions were analyzed. RESULTS: After controlling for demographics, the continuous variable of BMI was significantly associated with most mood, anxiety, and personality disorders. When persons were classified into BMI categories of underweight, normal weight, overweight, obese, and extremely obese, both obese categories had significantly increased odds of any mood, anxiety, and alcohol use disorder, as well as any personality disorder, with odds ratios (ORs) ranging from 1.21 to 2.08. Specific Diagnostic and Statistical Manual of Mental Disorders-revision IV mood and personality disorders associated with obesity included major depression, dysthmia, and manic episode (ORs, 1.45-2.70) and antisocial, avoidant, schizoid, paranoid, and obsessive-compulsive personality disorders (ORs, 1.31-2.55). Compared with normal weight individuals, being moderately overweight was significantly associated with anxiety and some substance use disorders, but not mood or personality disorders. Specific anxiety disorders that occurred at significantly higher rates among all categories of persons exceeding normal weight were generalized anxiety, panic without agoraphobia, and specific phobia (ORs, 1.23-2.60). Being underweight was significantly related to only a few disorders; it was positively related to specific phobia (OR, 1.31) and manic episode (OR, 1.83), and negatively associated with social phobia (OR, 0.60), panic disorder with agoraphobia (OR, 0.40), and avoidant personality disorder (OR, 0.59).

CONCLUSION:

These data provide a systematic and comprehensive assessment of the association between body weight and psychiatric conditions. Interventions addressing weight loss may benefit from integrating treatment for psychiatric disorders.

http://www.ncbi.nlm.nih.gov/pubmed/18378873

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Contact: Cary Kreutzer, MPH, RD
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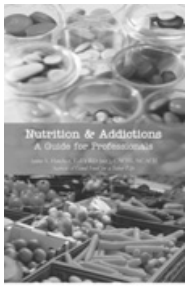

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Addiction and Overeating

By Susan Shapiro, PhD, MS, RD, FADA

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When most people hear the word "addiction," they usually think about alcohol and drugs. Sometimes they may also think about cigarettes, gambling, or sex. However, probably few people consider overeating, or compulsive overeating, to be an addiction.

Addictions Defined

From a medical perspective, addiction is defined as a compulsive and maladaptive dependence on a substance (e.g., alcohol, cocaine, opiates, tobacco) or a behavior (e.g., gambling). The dependence typically produces adverse psychological, physical, economic, social, or legal ramifications. (1) From a psychological perspective, addictions are classified as Addictive/Substance Use Disorders. (2)

The spectrum of addictive behaviors ranges from acute to chronic, and there is a wide variation in the way individuals experience addiction, including whether it is even part of their consciousness. For some individuals, the pain of addiction is intense and intolerable. Others may feel a variety of moods (e.g., depressed, anxious, restless), yet may not able to pinpoint why they feel the way they do. By using drugs or alcohol, the distress becomes more bearable, which can lead to dependence on these substances and push the individual to choose a specific substance to modulate the particular distressful mood. (2.

Compulsive overeating (COE) and compulsive misuse of food (CMF) may be characterized by uncontrollable eating (often when not hungry); feeling out of control with food; and having a feeling of anxiety, guilt, disgust, and/or shame about this behavior. COE and CMF are often accompanied by a constant preoccupation with food and body weight. Individuals with COE or CMF are usually depressed and/or experience swings in their moods.

The definition of compulsive overeating used in this article is a construct drawn from a variety of sources. (3) The medical and psychological descriptions of addiction fit many of the behavioral and psychological pathologies of COE/CMF, yet they do not include the overuse or misuse of food when addressing/identifying addiction. These descriptions are similar to what is often encountered in clinical practice as well as to those described in professional publications. (4-6) Interestingly, not all compulsive overeaters or misusers of food are overweight, as they may engage in other behaviors to remain slim (e.g., purging, taking laxatives, excessively exercising).

COE/CMF and the Weight Loss Industry

Approaches to weight loss are often overly simplistic. A plethora of commercially available weight loss programs typically suggest eating less, selecting better choices of food, and exercising more, and they promise rapid weight loss of 10 or more pounds in just a few days or weeks. Some state that eating one type of food, consuming food at a certain time, or eliminating certain foods can produce significant amounts of weight loss. A Google search in November 2008 for "diet programs" provided 5,270,000 results, suggesting that the scope of the weight loss issue is mammoth. Furthermore, bariatric surgery has been used increasingly as treatment for obesity, even though it does not directly address the behaviors that lead individuals to overeat. In general, bariatric surgery in the United States increased from 12,480 to 113,500 between 1998 and 2005, with women accounting for 83% of procedures among patients aged 18 to 45 years. (7)

While these various programs—from dieting to surgery—promise weight loss, few of them promise long-term weight loss. Furthermore, most fail to include strategies for maintenance once a final weight loss goal has been achieved. They also do not address the underlying issues associated with COE/CMF.

These simplistic approaches have yet to provide a way to help people who have the deadly and highly recidivist disease/addiction of COE/CMF. Most individuals who are compulsive overeaters or misusers of food usually return to using food to soothe their addiction. Dieters typically return to their pre-diet weight and often wind up heavier than before starting their diet. (8) This recidivistic behavior is not that dissimilar from that exhibited by individuals who return to their drug or alcohol addiction after attempting to stop.

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Difficulties in Addressing COE/CMF

According to National Health and Nutrition Examination Survey (NHANES) data, the percentage of individuals considered overweight rose from 47% in 1980 to 66% in 2004. (10) The percentage of individuals considered obese increased from 15% to 32% over this same time period. Furthermore, the prevalence of overweight and obesity has steadily increased over the years among genders, all ages, all racial/ethnic groups, and all educational levels. (10) Recent statistics show that nearly 17% of youth aged 6 to 19 years in the United States are considered overweight as defined by having a body mass index (BMI) above the 95th percentile for their sex and age. (11) Research is needed to determine the percentage of these individuals who exhibit COE/CMF traits and to address the underlying problems associated with COE/CMF.

Most treatment programs for "traditional" addictions involve elimination of the substance or replacement therapy, in addition to psychotherapy and/or psychopharmacology (9). At least one organization, Food Addicts Anonymous™ (FAA), addresses COE/CMF as an addiction and as a biochemical disease; however, it demands that certain foods be eliminated from the diet. FAA also uses a traditional 12-step format popularized by organizations such as Alcoholic Anonymous.

FAA suggests that by avoiding or staying abstinent from addictive substances such as sugar, flour, wheat in all forms, fats, and any other high-carbohydrate, refined foods, individuals can recover and eliminate their problems. There are no scientific data to support this generalized restriction, yet scientific data do suggest that food restriction can result in individuals becoming more compulsive about overeating and obsessive about food. (12-15) Furthermore, data suggest that intermittent bingeing and deprivation of food produce similar psychological manifestations and neurochemical changes in the brain that are observed with drug and alcohol use. (16-19) Replacement therapy for some drugs and alcohol in the treatment of these addictions provides evidence for how this treatment can return a "hijacked" brain to its pre-addictive state. (9) However, food is necessary for survival, and it is also interwoven into the social and cultural fabric of human life. It is therefore impossible to eliminate food, but with the right treatment it may be possible to make different choices.

Finding and consuming food are among the basic behaviors necessary for human survival. The limbic system, which appears to be responsible for the control of these survival behaviors, seems to be vulnerable to disorders in brain chemistry and in brain electrical activity. (9,20) Damage to this area of the brain may result in an inability to form new memories (9) and can produce emotions that are "out of control". (12) Drugs and alcohol (9) and food (17) can indirectly or directly "dupe" or "hijack" the limbic system. Because the addiction happens in the "lower," "preconscious" portion of the brain, we cannot rationally consider its effects, and therefore recovery and relapse avoidance can be difficult. (9)

Summary

This article highlights only a fraction of the areas in need of research to comprehensively address the development and treatment of COE/CMF. It is clear from the statistics on obesity and eating disorders that food is being used in a non-normal survival mode, which can be likened to what we observe with abuse of drugs and alcohol. Current treatment methods for obesity obviously are often falling short. Food is an integral part of life and culture; therefore, the treatment approach needs to be unique for this substance and not just a simple reformulation of what is used for other addictions. As evidence becomes available, we may view COE/CMF as a state of addiction rather than compulsion. Such a change in perspective may alter the treatment regimens for this condition.

About the Author: *Susan Shapiro, PhD, MS, RD, FADA, is a registered dietitian, fellow of the ADA, and licensed psychologist. She has been involved in the research and treatment of eating disorders since 1980 and has a private practice in Los Angeles, CA, where she also treats those with nutritional needs and emotional needs. She is the chair of the Los Angeles Psychological Association Addictive Behavior Special Interest Group.*

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Congratulations!

...to Dale Schmeisser, RD of Iron Mountain, Michigan, winner of BHN publication *Psychiatric Nutrition Therapy.* Thank you Dale for sharing your insights in the recent Behavioral Health Nutrition survey. BHN is stronger because you did!

PRACTICE TIPS FROM THE LISTSERV. . . .

The following dialog and recent reviews present challenges we face promoting a healthy lifestyle with the Nutrition Care Process and creative ideas and concerns of BHN members.

Subject: Pervasive Developmental Disorder (PDD)

Questions:

I am being referred for nutritional evaluation a 15 year old patient who has a diagnosis of PDD, indicated as similar to autism.

1. *What should I be looking for specifically in terms of evaluation and nutritional status regarding autism?*

2. *What are the most current nutritional recommendations for medical nutrition therapy for pervasive developmental disorder/autism?*

Response: I have worked with a lot of children with PDD/Autism. Basically, PDD is a diagnosis of exclusion. A child has some of the signs of Autism spectrum disorder (ASD) but not all the diagnostic criteria, thus the child is diagnosed as having PDD. These kids may be a little "quirky" but are higher functioning than a child with ASD. You would evaluate the child as you would any other pediatric patient. ADA has a great book on working with children with special needs that is a great resource.

Children with PDD, as children with autism, may have some diet-related issues. Some are selective eaters and, if the child is being referred to you, he/she might be a selective eater. They tend to eat some foods and exclude all others. They have tantrums if presented with non-preferred foods.

Other issues may be related to digestive problems. There is little to no hard evidence that kids with PDD/ASD have more digestive problems, but there are certainly many accounts of increased GI problems. Many of these children are placed on restrictive diets to try to alleviate or even prevent digestive problems. There is a lot of information and misinformation on the internet. There are recommendations for gluten-free, casein-free (GFCF) diets because there is a hypothesis that the bi-products of these create morphine-like substances that cause ASD behaviors. The hypothesis has not been proven.

If the child is a selective eater or is on a restrictive diet, your role would be to make sure that it is balanced and that the child is meeting his/her nutritional needs (not just macronutrients but also micronutrients). I find that doing a complete nutrition analysis of at least 3 days of food records is invaluable with this population because oftentimes they are lacking micronutrients.

Many of these kids are also on multiple vitamin/mineral/herbal supplements. I usually evaluate those as well and ask the parent to bring all the containers of supplements. There is a lot of information and misinformation on the internet about the "benefits" of large doses of certain nutrients. I make sure that the child is not exceeding the upper limit of any nutrients, and if they are, talk to the parents about potential side effects and dangers.

Lastly, if the parent wants to try a special diet (like GFCF), I usually help them do it slowly and carefully. Start with documenting baseline: what behaviors do they think could get
better with eliminating these foods? It could be anything child-specific, but sometimes tantrums are the biggest hurdle. I have them keep a log of behaviors, even if it's subjective, it's better than no data. Then start eliminating foods slowly, eliminating casein is sometimes easier, but do find good calcium sources to substitute. Once that is done, start to gradually find substitutes for gluten-containing foods and eliminate those over time. It could take 3-6 months in a child that is not a selective eater to eliminate these. The whole time it is really important to keep a log of behaviors. If the child is on this diet for about 3 months with no obvious changes, I would tell the parent that in the child's case, this doesn't seem to be a diet that is needed, then go back to normal eating.

My main advice is to listen to the parent. I don't walk in their shoes and I want to help them and their child. Even if I think a diet is "crazy", if they really want to do it and it can be done safely (the child is being nourished), then I am there to help them.

The bottom line is, no child with PDD/ASD is the same. It might be useful to you to call the family ahead of time and find out what they are hoping to gain from meeting with you. That way you can be prepared. It may be a very simple question/consultation.

STUDENT CORNER

The Role of the Health Professional: Knowledge about CAM use in Autism

By Alissa Lippman, MS

Within the past decade, the use of Complimentary and Alternative Medicine (CAM) has increased from 33.8% in 1995 to 45-47% in 2003 (1). The World Health Organization states that an estimated 75% of all healthcare practices today are known as alternative, with approximately $3.8 billion U.S. dollars spent out of pocket on these therapies (2). According to the National Center for Complimentary and Alternative Medicine, CAM therapy can be defined as "a group of diverse medical and health-care systems, practices, and products not presently considered to be a part of conventional medicine (3)." Many families of children with chronic illnesses, including Autism Spectrum Disorders (ASD), turn to CAM therapies without the knowledge of their primary healthcare provider when they are not seeing medical or behavioral results. Several studies have identified and reviewed the barriers pertaining to parental report, self-disclosure, and rationale behind CAM therapy for children with ASD (4,5,7,9).

Parents of children with ASD are more inclined to use biologically-based CAM therapies, which consist of vitamin supplements, dietary modifications, and other therapies not traditionally recognized (4,5). Additional CAM use within this population includes acupuncture, hypnosis, prayer, and herbal supplements in addition to vitamin supplements (7). Health professionals should be aware that parents of young children with ASD are more likely to be experimenting with various diet therapies than parents of adolescents with ASD. During the transition to adolescence, when puberty and behavioral temperament change, parents seek the use of medical drug treatments (1).

Within the pediatric population, 1.8% – 83.5% of caregivers use some form of CAM therapy with hope for a cure (6). Within the United States, 53% of caregivers reported the use of CAM therapy; however, only 36% disclosed this information to their primary care provider (7). Research shows families of children with ASD are using multiple CAM

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Subject: Body Mass Index (BMI) Screening

Questions: *What are other behavioral health professionals doing with BMI and nutrition screening? Do you use a BMI indicator of 30, 35, or 40 (kg/m2)?*

How does this affect your workload?

Responses:

1. I work with 4 other RDs in a large residential facility for clients ranging from profoundly retarded, multiply handicapped to traumatic brain and spinal cord injured, to autism and behavior. We assess the nutritional status of every client at 3 months, 6 months or annually, depending on their level of risk. Every client has their weight and height assessed quarterly even if an assessment is not required. Risk may be BMI <10th percentile or >85th percentile for children or adults, BMI <18.5 or > 25 or 30 depending on the RD's judgment. There are many other risk factors including medications such as atypical antipsychotic, lithium, antiepileptic, etc. Picky eaters are considered at risk. Clients w/ abnormal labs including glucose intolerance, dyslipidemia, hyponatremia, anemia as well as clients with gastrointestinal disorders such as dysmotility, reflux, constipation, or celiac disease are at risk. Clients with certain syndromes (Prader Willi, Rhetts and others) are considered at nutritional risk. Nursing services provide the incremental height and weight measurements; whereas alternative height estimation (knee height or arm span) is completed by the RD. Weights are obtained monthly; heights are measured quarterly up to age 20 and annually for ages 20 or greater.

2. I work with adolescent males. A BMI of 18 or less and greater than 30 is part of the nutrition assessment criteria. These parameters were recommended five years ago at a Psychiatry ARNP conference and implemented by our facility medical/clinical director.

3. I initiate nutrition interventions for adults with BMI's of 30 or more (refer to the evidence based clinical guidelines National Institute of Health and American Dietetic Association Nutrition Care Manual). A healthier lower fat menu incorporated with patient preferences is implemented. Favorable progress toward weight goals, improved lipid profiles, HgA1c, blood glucose levels, etc. are reported.

For the pediatric population, nutrition interventions begin with BMI's at 85%/age. The workload for both adults and children has greatly increased.

Subject: Measuring Body Fat %, and Mid-Arm Muscle Circumference (MAMC)

Questions: *Do any of you measure body fat % or MAMC (mid-arm muscle circumference)? I just started working at an HIV clinic and am interested in purchasing calipers and/or a hand-held BIA to measure % body fat and to approximate muscle mass in our lipodystrophy/cachextic patients (adults and teens). Does anyone have good data on the accuracy of using these devices? Are there any specific brands you would recommend?*

Responses:

1. I suggest looking into the research from Dr. Lohman at the University of Arizona, he is a pioneer in body composition. We use Lange Skinfold Calipers and do a three site test for body composition on our eating disorder patients at Remuda Ranch. Dr. Lohman's research indicates that skinfold is more accurate than BIA. The most accurate at this time is DEXA Scan which is extremely expensive. I would be careful with BIA because it can be altered by hydration status which could be a problem for your HIV patients similar to our ED patients. Our calculations also include mid-arm circumference with tricep skinfold to calculate the mid-arm muscle circumference.

2. I use BIA equipment (the Quantum II by RJL) and am pretty happy with it. It is lightweight and portable, can be used anywhere (preferable to have a cot or exam table but for mobility purposes we've made do with using fold-up pads parents buy for nursery school naptime), and it takes about two minutes of time with the patient. RJL's software provides a nice printout to share with the patient, and stores the info so you can record, store, and compare serial measurements. There is a lot of literature validating the use of BIA in myriad settings (weight loss, renal, HIV, etc); I initially used it for HIV+ patients. The best application is not the absolute numbers, but rather comparison over time i.e. patient gains or loses weight - was it fat or muscle? The results also include measurements of fluid (intra vs. extracellular) as well as "phase angle", both very useful for critically ill patients. BIA vs. calipers? Admittedly, less skill and practice is needed for accurate use of calipers, but either way you need to know how to interpret the results. Accurate height measurement is essential; don't just ask the patient "how tall are you?" I have a portable (plastic) stadiometer and measure each patient with their shoes off - very often several inches shorter than stated height. Stadiometer information can be found at http://www.scalesgalore.com/seca214.htm.

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therapies, without adequate scientific evidence. Numerous families have reported using six to seven different therapies at a given point in time (1).

Culture, ethnicity, and state of the present condition have been associated with the choice of CAM therapies by caregivers. The role of the health provider in accessing this information is invaluable. Often caregivers will be more inclined to disclose additional information when the health professional invests time with the family. This increases the need for cultural competence, education, and training. Many caregivers do not volunteer information pertaining to CAM therapies unless asked by a health provider; even then, it is not always adequately reported. Most caregivers do not report complete medical histories, either because they are unaware CAM is a supplemental treatment, or due to a negative previous experience with a health professional lacking cultural competence and education about CAM (9).

As health professionals, it is important to invest time with families, hear why they are choosing specific therapies, and shift to a family-centered approach. Family-centered care strengthens the family unit, recognizing the priorities and needs of the family first. Remaining neutral can enhance the effectiveness of health services by the provider. Research suggests effective counseling for patients using various therapies can be met with increased knowledge, attitude, and cultural competence (2, 8). The ultimate goal for health professionals working with children with ASD is to empower the family, provide resources, understand the needs of the family, and listen carefully without judgment.

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Contact newsletter@bhndpg.org

Champion Nutrition

ADA Encourages Members To Be A "Voice For Nutrition"

By Charlotte Caperton-Kilburn, MS, RD, CSSD, LDN
BHN Public Policy Coordinator

This past winter, the American Dietetic Association reached out in a non-traditional format to hold its annual Public Policy Workshop on line. Setting aside a well-liked, three-day, in-person event in Washington in favor of eight Webinars focused on policy issues and advocacy training, seemed foolhardy, but ADA achieved breakthroughs in member awareness and interest in nutrition policies and programs. PPW attendance increased 10-fold and satisfaction with the program exceeded 90 percent.

Since then, teams of dietitians in every state have contacted their lawmakers, communicating in person and though emails, letters and phone calls in support of a new agenda that calls for policies to improve the lives of Americans through food and nutrition strategies. ADA members have said there is no goal more important in the current debate over health reform than to have a lasting, positive impact on all Americans' health.

"Nutrition is at the foundation of health -- necessary to be healthy, and effective in preventing delaying, offsetting and managing disease," has been the underlying message.

Now that health reform is at a critical stage, ADA is re-engaging the membership and encouraging a surge in grassroots efforts. As ADA President Jessie Pavlinac recently wrote "The next 100 days will reflect an intense national debate over the future of health in the United States.

"We do not know how that debate will come out. We do know that we must be the voice that says nutrition is the foundation of health. We need to ensure that registered dietitians are in medical homes community teams and that we are paid providers in a new policy. That policy supports ways of keeping people healthy and recognizes that nutrition is the cornerstone of prevention," she said.

"Millions of Americans are healthy – living – examples of the power of nutrition because they worked with a dietitian to delay or offset or manage a chronic disease. When 75 percent of our health care costs come from chronic disease, our policies need to make nutrition a part of the solution," Pavlinac told members.

In the past couple of weeks, we have seen the introduction of various health reform bills. ADA has summarized key provisions of some of those measures in a Webinar that members may access athttp://www.eatright.org/cps/rde/xchg/ada/hs.xsl/10988_21934_ENU_HTML.htm. This Webinar has essential information for members who want to catch up on this summer's debate of health reform.

ADA also has sent out an ACTION ALERT asking every member to contact his or her legislators to co-sponsor two bills. One is the DeGette pre-diabetes bill. The other is the Bingaman Stop obesity bill. Both expand coverage for MNT. In a matter of moments after going to ADA's Grassroots Manager Software, ADA members can either print out a letter or send an email in support of these two measures.

Separately, there is also a letter of support for amendments to the Child Nutrition Act, to improve the nutrition environments for America's school children.

It is easy to become engaged on issues that matter to all of us as dietitians. Grassroots Manager is accessed at http://ada.aristotle.com/Main.asp?WhichField=Home&PagePath=&Random=0.7055475

ADA is asking all members to be active at this time. "Act as if your nation's future, your family's access to health and your career are on the line, because – in fact – they are," said Pavlinac.

Dietetic Practice Groups like BHN are supporting this effort, and going a step further, asking our members to make sure that our colleagues engage in this once in a lifetime opportunity to reshape policy so that our work and expertise is recognized. As the debate shifts into legislative mark up, amendments and floor votes, we all may need to act again in support of better food, nutrition and health policies.

It's easy. It's important. Grassroots advocacy can make the difference and lead this debate to nutrition solutions that increase the public's access to nutrition services and advance the future of the dietetics profession.

New In Review Hits the Web

The *Journal of the American Dietetic Association's* ***New in Review*** section is moving online! ***New in Review***, a monthly *Journal of the American Dietetic Association* feature bringing dietetics-related abstracts and citations from scientific and professional publications to ADA members, along with reviews of books and Web sites of interest to food and nutrition professionals, will make the jump to the Web in July 2009. July will also mark the last appearance of ***New in Review*** in the print Journal, as it will now appear exclusively at www.eatright.org/newinreview. All ADA members will receive a monthly e-mail with highlights from that month's installment and a link to the ***New in Review*** page at eatright.org, which will feature convenient links to other journals and Web sites and an archive of previous installments of ***New in Review*** for the past year. And ***New in Review*** will continue to be prepared by the Journal's Qualitative Research editor, Judith Beto, PhD, RD, FADA, with the *Sites in Review* section written by Eileen Vincent, MS, RD, so you'll get the same quality and variety of content you're used to getting in the Journal, but now it will all be just a click away.

BHN Schedule of Events American Dietetic Association Food & Nutrition Conference & Expo (FNCE)

Denver Convention Center
Denver, CO

Sunday, October 18, 2009
8:00am – 9:30am
BHN Priority Session # 149; Korbel Ballroom 4
Sensational Eating: Nutritional & Sensory Processing Factors that Affect Mealtime
Speakers: Winnie Dunn, PhD, OTR, FAOTA – (expert OTR professor (KS) Patricia Novak MPH, RD, CLE – BHN (expert RD (CA)

Sunday, October 18, 2009
5:30pm – 7:30pm
Member Reception and Awards; Room 105

Monday, October 19, 2009
10:30am – 1:00pm
DPG & MIG Showcase; Booth #16 (across from Expo Hall)

Tuesday, October 20, 2009
8:00am – 9:30am
Procedure Development & Implementation of Behavioral Health Nutrition Practice Standards: Open Discussion
Room 605-607

We'd like to build something for you!

As the faces and homes of your clients grow more diverse, the American Dietetic Association (ADA) would like to assemble cultural resources for you. With your input, we'll gather the tools and topics that you need to engage in culturally relevant client relationships.

Please let us know what topics on cultural competence you'd like to see addressed. For example, do you want to know what challenges and successes in diverse populations that your colleagues have encountered? Do you want to determine how "culturally aware" you are? Do you want patient materials or visuals? Do you need help in planning for the future "face" of America?

Whatever your suggestions, we'd like to hear them. Send your ideas to ADA via email to: The Journal Team Mailbox (Journal@eatright.org). Many thanks. We look forward to bringing you a useful Cultural Resource Center in the near future.

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

Watch for BHN Webinars!

First topic will be Binge Eating and Night Eating Syndrome with BHN Resource Professional, Roberta Pearle Lamb, MPH, RD.
Don't miss BHN e-blast announcements beginning this summer!
If you are interested in providing a CPE-eligible webinar for BHN, contact Julie Lovisa, RD, CD.
jlovisa@memorialsb.org

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Behavioral Health Nutrition
a dietetic practice group of the
eat right. American Dietetic Association

The American Dietetic Association is the world's largest organization of food and nutrition professionals. ADA is committed to improving the nation's health and advancing the profession of dietetics through research, education, and advocacy.

WHY? BHN Listserv

Do you find yourself as a health professional doing more with less? Not enough hours in a day? Do your responsibilities cross over from clinical to administrative daily?

Do you find yourself alone? Would you benefit from dialog with other dietitians in similar situations?

Allow the BHN listserv to help meet your professional practice needs. This effective tool for daily dialog with other dietitians may provide insight with the challenges you face alone or you may suggest ideas that have worked well for you. Simply reviewing the listserv may help resolve an unanswered question or generate a creative idea.

Recent dialog topics included:

- Assessing BMI in behavioral health patients
- Elderly man with Down Syndrome and Celiac Disease
- Eating disordered checklist
- Gluten and corn free diet
- Multivatamin/mineral supplement and addictions
- Equipment to measure body fat
- Menu development
- Low literacy education materials
- Inostitol for anorexia
- Weight management on psychiatric meds
- Pervasive development disorder
- Latex allergy
- JCAHO guidelines
- Caloric needs in the adult with spastic CP
- BHN-related job announcements, upcoming conferences and seminars, and CEU opportunities

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