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.
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:

- First Name
- Last Name
- Email Address

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
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

Reprinted with permission from the Medical Nutrition Practice Group Medical Nutrition Matters, Volume 27, Number 4, 2008

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 (3), anemia (4), infertility (5), risk of malignancy and mortality (6, 7), 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 postmenarchial females (8). 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-evaluation (9). 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 predominant 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 concomitant 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 pre-season 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 instituted.

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
Eating Disorders and Celiac Disease
continued from page 3

ages of 20 and 35. In this age group, individu-
als with EDs made up 11.6% of the total (n = 84). A psychologist with specialized train-
ing in both CD and EDs, a registered dieti-
tian, 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 presence of an ED made the treatment of CD more difficult by compro-
mising 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 inaccu-
rate 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 depres-
sion, was referred for confirmation of CD
diagnosis, dietary education and manage-
ment. Upon initial presentation the patient
had a BMI of 23.9. Her foremost concern was
that she had gained 15 pounds after starting
the GFD. Her adherence to the GFD was rea-
sonably strict overall but she was bothered by
elevated calorie and fat content of gluten-free (GF) foods. She articulated that she wished to lose 25 pounds, but compro-
mised 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 fol-
dow after her second nutrition visit.

Patient B
A 35-year-old female with a lengthy psy-
chiatric history of AN, BN, and depression
was seen for enduring weight loss despite
reporting control of her ED. 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 refereing
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,
aneurysmal, Gravel’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 defi-
ciency anemia, resulting in a subsequent
diagnosis of CD. Specifically upsetting to her
was her inability to lose weight while follow-
ing the GFD. She presented with little moti-
vation to follow a strict GFD. Despite repeat-
ed counseling with a diettian versed in CD
and referral to an ED diettian, ongoing
hematemesis and abdominal pain, she con-
tinued to ingest gluten and engage in fre-
quent 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 resolu-
tion of CD-related symptoms including
abdominal bloating, fatigue, and hema-
tochezia. Despite this she complained of a
40-pound weight gain (BMI 27.3) after
beginning the GFD, in part due to binge eat-
ing. Diet recall revealed high intake of sugar
and sodium-rich snack foods. She was
able to see 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 inten-
sive ED program. In conjunction with main-
taining a strict GFD, the patient was motivat-
ed to follow healthier eating patterns.

Clinical Implications

The above cases demonstrate the com-
plex ways in which CD and EDs interact with
important clinical implications for the diag-
nosis 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
loss. Our findings suggest that the clinic
likely interpreted her requests for GF food as
manipulations of the refereing process. At the
most recent nutrition visit, the patient openly acknowledged purposeful
ingestion of gluten-containing snack bars as
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As an added incentive, these whole
grains tend to be much less expensive than
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FINAL:
OBJECTIVE: To measure the association between body mass index (BMI) and psychiatric disorders.

METHODS: Data on 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 disorders, as well as any personality disorder, with odds ratios (ORs) ranging from 1.21 to 2.08. Specfic Diagnostic and Statistical Manual of Mental Disorders-revision IV mood and personality disorders associated with obesity included major depression, dysthymia, and manic episode (OR, 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 included major depression, mood and personality disorders associated with obesity included major depression, dysthymia, and manic episode (OR, 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.

Overweight and obesity are associated with psychiatric disorders: results from the National Epidemiologic Survey on Alcohol and Related Conditions.

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References:


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Dr. Leffler is a senior fellow in gastroen
terology and a founding member of the Celiac Center at Beth Israel Deaconess Medical Center.

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OBJECTIVE: To measure the association between body mass index (BMI) and psychiatric disorders. METHODS: Data on 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 disorders, 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, dysthymia, and manic episode (OR, 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 overweight 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 avoidance 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.


Want to Get Involved? Let us know!

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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 be able to pinpoint what 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 over-weight, as they may engage in other behaviors to remain slim (e.g., purging, taking laxatives, excessively exercising).

**Addictions 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 industry 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 some of these 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.
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. FAA does not provide 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 depriving food produce similar psychological manifestations and neurochemical changes in the brain that are observed with drug and alcohol abuse. (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)

The limbic system, which 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 reformation 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 regimen for this condition.

About the Author: Susan Shapiro, PhD, 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.

References


Congratulations!...to Dale Schmeeier, RD of Iron Mountain, Michigan, winner of BHN publication “Nutrition Therapy. Thank you Dale for sharing your insights in the recent Behavioral Health Nutrition survey, BHN is stronger because you did!”
The Role of the Health Professional: Knowledge about CAM use in Autism

Questions:
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. There is little 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 barriers pertaining to parental report, self-disclosure, and rationale behind CAM therapy for children with ASD (4,5,7). 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...
Subject: Body Mass Index (BMI) Screening

Questions:
1. Do any of you measure body fat % or MAMC (mid-arm muscle circumference)?
2. I started working at an HV clinic and am interested in purchasing calipers and/or a hand-held BIA to measure % body fat and to approximate muscle mass in our (lipoatrophy)/cachectic 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 may 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 triceps 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 (infra 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.
Champion Nutrition

ADA Encourages Members To Be A “Voice For Nutrition”
By Charlotte Caperton-Kilburn, MS, RD, CSSD, LDN

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 through 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 disease and managing illnesses,” she said.

“Millions of Americans are healthy – living – examples of the power of nutrition because they worked with a diettian 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/hs.xs?l/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 help 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=HotMePagePath=&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 vote, 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.
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 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
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
- Multivitamin/mineral supplement and addictions
- Equipment to measure body fat
- Menu development
- Low literacy education materials

- Inositol 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

To subscribe to the BHN LIST Electronic Mailing List (EML): Send an email to assist@bhndpg.org with your First Name, Last Name, and Email Address. Please title the subject of the email: BHN LIST SUBSCRIBE.