

Setting the Standard for Nutrition in Behavioral Healthcare

Integrating Yoga-Based Treatment into a Medical Model for Eating Disorder Treatment

By Beverly Price, RD, MA, E-RYT

In their lifetime, an estimated 0.6 percent of the adult population in the U.S. will suffer from anorexia, 1.0 percent from bulimia, and 2.8 percent from a binge eating disorder (1), the diagnoses of eating disorders have been made in children less than 12 years of age and as old as age 75. Eating disorders are considered spectrum disorders ranging from anorexia nervosa, to bulimia nervosa, to binge eating disorder. Eating disorders are symptoms of depression and anxiety, along with a host of other psychological issues, including mental health conditions resulting from trauma. Depression and anxiety, along with personality disorders, including borderline personality disorder, are consistently found in individuals with eating disorders. Obsessive-Compulsive Disorder (OCD) is often found in individuals with eating disorders along with substance abuse disorders. Further information on the diagnoses and classifications of eating disorders, along with co-occurring disorders, may be found in the *Diagnostic and Statistical Manual of Mental Disorders (DSM) IV-TR* (2).

Cognitive-Behavioral Therapy (CBT)(3) is widely used in eating disorder treatment; although a wide range of eating disorder therapists have adopted the family based Maudsley(4) approach. Progressive outgrowths of CBT include Dialectic Behavioral Therapy (DBT)(5), Mindfulness Based Cognitive Therapy (MBCT)(6) and Acceptance Commitment Therapy (ACT)(7). Yoga-based therapy is a new modality in eating disorder recovery, which is body centered vs. talk therapy.

Review of Literature

Yoga and Eating Disorder Recovery

Research in the area of yoga and eating disorder recovery is quite limited. Douglass (2009) explored the uses of yoga as an experiential adjunct to other forms of therapy in the treatment of eating disorders in residential and outpatient settings. This article indicated that supported by other treatment modalities, yoga can be an effective method for increasing self-awareness, reflection and the ability to self-soothe. Suggestions were also made as to how therapists can support the practice of yoga in residential and outpatient eating disorder treatment settings (3).

Boudette (2006) taught yoga in a class designed specifically for eating disorders and discovered that bulimics and compulsive eaters found a deep sense of peace and freedom, were able to integrate positive coping strategies and connect with their physical bodies. The article concluded that yoga offers a non-verbal, experiential adjunct to talking therapy. The author discussed the importance of goal setting within the yoga practice designed for eating disorder recovery and cautioned about using the yoga practice for physical measurements (i.e. getting your foot behind your head, etc.)(4).

In a 12-week, randomized study of 90 women ages 25 – 63 years of age with binge eating disorder, by McIver et al. (2009), the yoga-intervention group reported small but significant reductions in binge eating activity and body mass index (BMI) compared to the control group (5). On the other hand, Mitchell, et al. (2007) found no significant post-intervention differences in 93 college women studied that were treated with a discussion-based group vs. a yoga intervention group (6).

According to the *Journal of Adolescent Health* (Carei, 2010), yoga treatment significantly reduced food preoccupation immediately after the yoga therapy sessions. The study included a total of fifty girls and four boys aged from eleven to twenty one. Patients were treated over eight weeks time. Twenty-seven patients received standard care, and twenty-six patients participated in yoga in addition to their standard care. The yoga group showed a greater decrease in eating disordered symptoms when compared to the group that only participated in standard treatment. Food preoccupation was measured before and after each session of yoga and decreased significantly after all sessions. The results of this study showed that individualized yoga therapy could be an effective addition to standard eating disorder therapy (7).



Beverly Price

WINTER 2011

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From the Chair

Kathy Russell, MS, RD

WOW! The membership year is half over! Time sure flies when you're having fun. A common saying, but in this case it's a fact. I have been having a great time so far working with a wonderful group of volunteers!

Many of us were at ADA's Food & Nutrition Conference & Expo (FNCE) in November. I hope you took advantage of the several opportunities to participate in a BHN activity. BHN donated a wonderful bag of resources to the ADA Foundation Auction. Thanks to members who contributed books and resources for this! We had the privilege of honoring four of our members for their magnificent contributions to BHN's practice areas at our member award ceremony and reception.

2010 BHN Distinguished Member:

Marion Baer, PhD RD

Excellence in Practice:

Paula Cushing, RD, LDN - Intellectual and Developmental Disabilities

Jessica Setnick, MS, RD, LD, CSSD - Eating Disorders

Ruth Leyse-Wallace, PhD, RD - Mental Illness

We met many current and potential members at the DPG/MIG Showcase. We were thrilled with the attendance at BHN's Spotlight Session "Overcoming Barriers to Eating Disorder Treatment" presented by Dena Cabrera, PsyD and BHN member Debra Johnston, RD from Remuda Ranch. The room capacity was 727 and there were people standing in the back, along the walls, and sitting on the floor!

Our webinar series has started. In November, BHN member Mary Kuester, MA, RD, LD presented on *Addictions and Eating Disorders*. Coming in February we have another BHN member, Eileen Stellefson Myers, MPH, RD, LDN, FADA presenting on *PKU and Motivational Interviewing*. Look for another webinar from member Evelyn Tribble, MS, RD on Motivational Interviewing to follow soon. Other topics will be added. Make sure to take advantage of these webinars. The information is very valuable to our practices. In case you have missed them, all of our previous webinars are available on our website www.bhndpg.org. The webinar cost for members is \$25 and \$40 for non-members.

BHN membership is on the rise! As of this writing we have 1441 members. At the end of last year there were 1371 members. An exciting trend is the increase of student members. We hope that you all find your membership to be a value. If there is anything that you feel we can do better or if there is a need for something that we don't offer, please let me know at katerussrd@yahoo.com. Our members are our most important asset. Please encourage your colleagues to join BHN. The more members we have the more our voices are heard when advocating for the nutrition care of our client populations!

We have a terrific ballot for the upcoming membership year. Make sure to exercise your right to vote. Looking forward to a great new year!

Yours for good health,
Kathy Russell MS RD



BHN Chair, Kathy Russell, RD, LD (front, left) and Paula Cushing, RD, LDN (front right), IDD Resource Professional and 2010 award recipient pose for pictures surrounded by Executive Committee at the BHN Member Reception. Standing (from left to right): Sharon Lemons, MS, RD, LD; Diane Spear, MS, RD, LD; Julie Lovisa, RD, CD; Charlotte Caperton-Kilum, MS, RD, CSSD, LD; Therese Shumaker, MS, RD, LD; and Charlene DuBois, MPA, RD.

BHN DPG is pleased to present the slate of candidates for office for the 2011-2012 year:

Chair-elect:	Therese Shumaker, MS, RD, LD
Treasurer:	Cynthia A. Rutkowski, MA, RD, FADA Cary Kreuzer, MPH, RD
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On-line voting begins
February 1, 2011

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Yoga-Based Treatment...

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Yoga and Body Image

In a study by Jennifer Daubenmier (2002, 2005), Hatha yoga participants reported the greatest degree of body awareness and trust during exercise as well as in daily life. They also reported greater levels of self-acceptance than the baseline condition but equal to the aerobic condition, partially confirming the hypothesis. Hatha yoga participants reported the least amount of internalization of the thinness ideal, the least amount of tendency to compare their physical appearance to those of others, the smallest discrepancies between actual and ideal physical attributes, the least amount of self-objectification, and the most body satisfaction. Hatha yoga participants reported fewer eating problems compared to the aerobic condition. The greater the number of hours a woman practiced yoga in a week was associated with even less self-objectification and greater satisfaction with her body, while the more hours a woman spent performing aerobic activity was linked with greater disordered eating (8)(9).

Dittmann and Freedman (2009) evaluated attitudes about body image and eating in women practicing postural yoga. Results showed significant improvements in body satisfaction and disordered eating due in part to yoga and its associated spirituality (10).

Scime and Cook-Cottone (2008) studied the impact of a primary prevention program for eating disorders in 75 fifth-grade girls. The curriculum incorporated interactive discussion, yoga, and relaxation into 10 weekly sessions. Pre- and post-test data from five groups conducted over two years compared with 69 control group participants indicated that the intervention group had a significant improvement on scores from the Eating Disorder Inventory-2 measuring body dissatisfaction and bulimia, as well as on the Social scale of the Multidimensional Self-Concept Scale (11). Scime et al. (2006) looked at three groups, in a similar intervention over 13 months that showed a significant improvement on scores measuring body dissatisfaction and drive for thinness, as well as media influence (12).

Yoga Therapy for Eating Disorder Treatment – Best Practices

Yoga therapy is conducted in small or one-on-one groups conducted by a Yoga therapist. Emphasis is on integrating breath and movement with traditional medical or psychological interventions. A Yoga therapist's training incorporates the traditional training

requirements of a registered Yoga teacher through a 200 or 500 hour Yoga Alliance (YA) registered Yoga school. However, their training goes beyond the Registered Yoga Teacher (RYT) certification to incorporate several healing modalities with specific populations in which the yoga therapy school is geared towards. Legitimate Yoga therapy programs are credentialed by the International Association of Yoga Therapists (IAYT). Practitioners entering Yoga therapy programs are generally licensed professionals (physicians, psychologists or other ancillary licensed or registered health professionals) or trained peer coaches, who have been in recovery, for the specific disease that they are treating, for greater than two years.

In contrast, a Yoga "class" is generally held at Yoga studios or gyms in a larger group setting, conducted by a Yoga teacher. Classes emphasize moving from one pose to the next, often in a sequenced method. Many Yoga classes



today are quite westernized, emphasizing the physical body and often accompanied by music typically found in an aerobics class.

Reconnect with Food® Yoga Therapy is a systematic program specifically designed for the population of eating disorders across the spectrum—anorexia, bulimia and binge eating, and tailored to meet individual needs. Reconnect with Food® Yoga Therapy program combines a unique healing modality of Yoga philosophy and a sequenced flow intertwined with traditional psychotherapy. The focus is not exclusively on the Yoga postures. The chakras, along with the eight limbs of Yoga are intertwined as themes in the healing process over a seven week time frame. Yoga Therapy may be conducted in small groups along with one-on-one sessions and can be incorporated into inpatient/residential, day treatment, support groups or individual counseling sessions for eating disorder recovery. The following is a suggested, best

practices integrative Yoga therapy model of treatment that can be incorporated into eating disorder treatment programs:

The therapeutic Yoga asana practice

Yoga Therapy for eating disorder recovery begins with the asana practice with the lighting very dim, or devoid of light, along with any curtains closed. The temperature is moderate, approximately 75 – 80 degrees. Space heaters are available to warm the room on a cool day or for those who need extra heat to loosen up muscles. There is very little music played, if any, except for possibly light, new-age background music. There may be a song played in savasana (resting pose at the end of the Yoga asana practice), which aligns with the theme of the Yoga therapy session.

The first five minutes of the asana session is spent in meditation, with guidance from the Yoga therapist. Foundations of meditation are brought into the session. Clients are invited to close their eyes and encouraged to keep them closed throughout the entire session. The Yoga therapist will begin to bring in the theme for the session in these first five minutes.

Following this introduction, clients are encouraged to move their body in any way. This may include "cat-cow" postures, "cobra", "downward dog" or just wiggling their hips from side to side.

Whatever feels right to the client is encouraged in these few minutes to warm up the body.

A dynamic sequence of postures is then brought into the session, which is designed to bring clients to their edge quickly. The edge is defined, while clients are also encouraged to soften around their edge. The flow, following this sequence, involves long holding and challenging postures, teaching to the strongest student in the room, while offering modifications. Clients are encouraged to take "child's pose" at any time or simply sit on their mat and breathe if that is what serves them on any given day.

Clear and simple directions are given by the Yoga therapist, while modeling is not done. This is why clear and simple directions are imperative. The flow of long holding postures covers one side of the body, followed by the other side of the body over 35 – 40 minutes. The remaining 5 – 10 minutes of the session ends with Yin Yoga postures, followed by savasana (pose of total relaxation). Seated meditation is also offered as an alternative to savasana by the Yoga therapist.

Dialogue and word choices

Continuous dialogue is brought into the session, by the Yoga therapist, honing the theme and relating the theme to what the client might be experiencing in the postures. Analogies and metaphors are used, along with studies and benefits explained during

the flow. The Yoga therapist links the breath with postures in every movement and continually reminds the client to come back to their breath. In addition, the Yoga therapist uses the phrases, "Your arm," "Your leg," or "Your body," vs. "the" or "that" limb/body in order to help the client connect more with his or her body. Moments of silence are also given by the Yoga therapist in order to give the client space. Adjustments are given to make "connections" vs. "corrections" and to assist the client in going deeper if the Yoga therapist senses that the client is holding back. In addition, an "adjustment" may consist of the Yoga therapist sitting next to a client during the session and listening for his or her breath.

At the close of the session, the Yoga therapist will offer words of wisdom that bring the theme home. The Yoga therapist may also choose to read a poem to the group. It is important for the Yoga therapist to assess what they see in the client during the entire flow, to not react to any acting out on a given day by the client and to not take anything personally. Feedback is always important from the client along with peers to continually improve the skills of the Yoga therapist.

Connecting the asana practice with all limbs and facets of Yoga

In the PHP and IOP programs, the practice of Yoga is held at the start of the day. The theme of the Yoga practice parallels the Hindu chakras and Patanjali's eight limbs of Yoga, where each chakra and limb of Yoga is covered in order on a weekly basis. The day's activities (group therapy, lunch experiential, creative arts therapy) are held following the Yoga practice and integrate the particular chakra and eight limbs of Yoga of that respective week into all facets of the day's program.

The chakras

Caroline Myss, PhD, developed the field of Energy Anatomy, a science that correlates specific emotional/psychological/physical/spiritual stress patterns with diseases. Caroline Myss has devoted the majority of her life to learning and teaching others about spirituality, human consciousness, energy medicine, and the mystical art of healing using the seven Hindu chakras to create a map of the human "energy anatomy".

Chakra means "wheel" or "circle", and sometimes referred to as the "wheel of life". The chakras are aligned in an ascending column from the base of the spine to the top of the head. In modern age practices, each chakra is associated with a certain color and is associated with multiple physiological functions such as aspects of consciousness and other distinguishing characteristics. These are seen as lotuses with a different number of petals in every chakra.

The chakras not only vitalize the physical

body but also regulate the interactions of a physical, emotional and mental nature. The chakras are the locus of life energy (prana), which flow among them along pathways called nadis. The main function of the chakras is to keep the spiritual, mental, emotional and physical health of the body in balance by spinning and drawing energy.

The modern world has drawn inspiration from the chakras and draws a parallel between the position and role of the chakras and those of the glands in the endocrine system. The modern world also recognizes that there are additional chakras which exist such as ear chakras.

The different parts of the world use different models of chakras such as Chinese medicine, Tibetan Buddhism, western world, etc. The western world mainly adheres to the shakta theory of seven main chakras as translated versions of the Sat-Cakra-Nirupana, and the Padaka-Pancaka, which are two ancient Indian texts.

The body's chakras parallel two chains of nerve bundles located on each side of the spinal cord. By activating these chakras, the emotional pain imprisoned in the body as physical pain around the spinal cord can be released. Yoga involves spinal movements that activate the body's chakras and can easily release a person's physical pain, which then in turn can help rid the body of emotional pain. The chakras are also very useful to help the recovering individual get to the root of eating disordered behavior. Often, when emotional pain is unresolved, this emotional imbalance manifests itself through physical pain based on the emotional energy or block and is associated with a specific chakra. An interesting parallel may be created with the chakras to incorporate discussion on a physical, emotional and spiritual level as it relates to eating disorder behavior (13).

Eight limbs of Yoga

Patanjali, a physician who lived in India between 200 B.C. and 200 A.D., compiled 195 sutras or concise aphorisms that are essentially an ethical blueprint for living a moral life and incorporating the science of Yoga into one's life. The heart of Patanjali's teachings is the eightfold path of yoga. It is also called the eight limbs of Patanjali, because they intertwine like the branches of a tree in the forest. The eight fold path is helpful for individuals to gain insight as to how they treat themselves and others, while working towards personal disciplines and attitudes, withdrawal of the senses, inward focus and letting go of old attachments—including attachment to illnesses—that keep one "stuck" (14). The Yamas and Niyamas (first two limbs) particularly intertwine nicely with eating disorder recovery as many individuals with eating disorders often have other related addictions. In work-

ing with the eight fold path of Yoga, individuals may gain insight into relationships between themselves and others, along with the parallel relationship food.

Conclusion

Most eating disorder treatment facilities and professionals interviewed have not looked at Yoga beyond a class or basic "stretching" in their respective facility. None report integrating Yoga and its philosophy to facilitate healing as most programs are very compartmentalized. Although a model for best practices in integrating Yoga-based therapy into comprehensive eating disorder treatment has been outlined in this article, further research is needed in the effectiveness of Yoga-based therapy on the treatment of eating disorders and is currently underway in our treatment program.

In addition, further studies are warranted in order to understand how the exact mechanism of Yoga affects intricate brain centers and how Yoga can be beneficial in eating disorder recovery along with the many co-occurring disorders involved. Yoga can be a very beneficial adjunct to treatment as illustrated in this article, in order to facilitate healing on a deeper level. Yoga therapists can be a significant adjunct to the eating disorder treatment team as can a licensed psychotherapist and dietitian who are also trained as Yoga therapists. The integration of Yoga into the medical treatment model of eating disorders can make Yoga more powerful in the healing process.

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Information on Complementary and Alternative Medicine

For access to information on Complementary and Alternative Medicine (CAM), including mind-body practices of yoga, The National Institutes of Health, U.S. Department of Health and Human Services presents an overview of the types of CAM, summary information on safety and regulation, the mission of the National Center for Complementary and Alternative Medicine (NCCAM), and additional resources. This information is available on the "Health Information" page of the NCCAM Web site (<http://nccam.nih.gov/health/>). Materials include:

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Source: What Is Complementary and Alternative Medicine? National Institutes of Health, U.S. Department of Health and Human Services. Updated April 2010; <http://nccam.nih.gov/health/whatiscam/D347.pdf>; accessed January 03, 2011

Phenylketonuria (PKU) and Motivational Interviewing Webinar

Date: February 4, 2011 at 11:00 AM (CST)

Presenter: Eileen Stellefson Myers, MPH, RD, LDN, FADA - Private Practice, Eileen Myers Nutrition and Wellness Consulting

Webinar Description: Providing education and resources to patients and families with PKU may not be enough for them to follow their strict diet. Motivational Interviewing is a style of communicating and interacting that increases the likelihood of compliance while decreasing the RDs frustration. In this webinar, you will learn how to incorporate motivational interviewing into your assessment and counseling of patients and families with PKU.

BHN Priority Session a Huge Success!

By Therese Shumaker, MS, RD, LD

BHN's priority session at Boston, **"Breaking Down Walls: Overcoming Barriers and Obstacles in Eating Disorder Treatment"** was a huge success! The room was packed and the speakers were excellent. Dena Cabrera, PsyD, and Debra Johnston, RD from Remuda Ranch spoke of the ways to overcome the barriers and obstacles patients and care providers face in treating eating disorders (ED).

Four obstacles were identified that they commonly encounter in treating their patients with eating disorders.

Obstacle One: Complexity - Eating disorders are the most frustrating and recalcitrant forms of psychopathology. Patients with ED are notorious for denial and resistance. Eating disorders evoke strong reactions from professionals and treatment for the disorder is often voluntary.

The ED recovery environment is viewed as hostile by the pro ana and pro bulimia web sites and the media often promotes the idea that thinness is what makes you a better person. In part, this mentality often sets an eating disorder in motion if the person has a predisposing factor to the disorder (genetics). A combination of nature and nurture factors cause eating disorders.

Obstacle Two: Resistance and Motivation - Patients who are resistant to treatment should represent a signal for the counselor to shift the approach or strategy in treatment. It is a signal of dissonance in the relationship, and a mismatch of the counseling strategy to the patient's readiness level. Resistance is an "interpersonal phenomenon and how the counselor responds will influence whether it increases or diminishes". One needs to provide treatment matched to the readiness level of the patient.

The stages of change can be compared in relationship to traffic lights. The *pre-contemplation* stage is like the RED light. The patient is not currently considering change and unable to move forward.

The *contemplation stage* is similar to the YELLOW light. The patient undertakes a serious evaluation of considerations for or against change, choosing whether or not to enter the change arena.

The *action stage* is like the GREEN light. The patient moves forward to implement specific behavioral change.

Change cannot happen without acceptance, and acceptance cannot happen without change.

The majority of anorexia patients receiving inpatient treatment at the Remuda Ranch are in the pre-contemplation stage. So how then does one help the patient to shift to contemplation? The pre-contemplator is most influenced by the negative factors of the eating disorder to push them into contemplation. The focus is on losses: physical, emotional, relational, and spiritual. It is associated with increasing the understanding of ED functions, decreased distress, and shifts in self-concept.

Eating disorders can be viewed as the mountain that needs to be climbed and conquered in order to gain a new perspective of what life might be like at the top. Recovery is gradual, not a straight path to the top, and there will be slips and slides along the way.

A discussion ensued of how dialectical behavior therapy (DBT) can be used as a way to move patients from one stage to the next – hopefully getting the patient to acceptance and change. "Change cannot happen without acceptance, and acceptance cannot happen without change."

Helping the patient learn skills in mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness is an important part of the work that is accomplished with patients at Remuda Ranch.

Obstacle Three: Differing Philosophy - working with a team that includes the therapist, family, patient, dietitian, and psychiatrist, treatment goals are not always the same and others may have different nutrition philosophies. The philosophy at Remuda is that all foods fit in a healthy meal plan when it incorporates: Balance, Variety and Moderation.

Obstacle Four: Treatment Cost, Drop-out Rate and Relapse – according to treatment response rates, one third of patients take two to three years to recover from ED, another one third of patients take seven to eight years toward recovery, and the remaining one third of patients receiving treatment die.

Given all of these impending obstacles, after all is said and done, the presenters agree that one of the most important treatment concepts is to let the ED patient know and affirm that there is hope! Hope for a life of recovery. As specialists in ED, we need to change our thinking and instead of saying "What are you recovering from?" it should be "What are you recovering to?" We need to validate our patients more often, and get connected with them.

Our speakers received an overwhelming response to the invitation for questions from the audience, allowing for excellent interaction and discussion. A huge "Thank you!" to such talented speakers and to the many members who attended this session! BHN members are the best!!

The BHN Priority Session for 2011 will focus on nutrition practice in mental illness. Stay tuned for more information on this outstanding session aimed at *setting the standard for nutrition in behavioral healthcare*.

Save the Date!

International Association of Eating Disorders Professionals
March 3 – 6, 2011, Phoenix, AZ
www.iaedp.com

Binge Eating Disorder Association National Conference
March 31 – April 2, 2011 in Scottsdale, AZ
<http://www.bedaonline.com/>

National Council Mental Health and Addictions Conference
May 2 – 4, 2011 in San Diego CA
www.thenationalcouncil.org/cs/conference

Nutrition & Health Conference
Nutrition and Health: State of the
Science and Clinical Applications
May 9 - 11, 2011 in San Francisco, California
<http://www.nutritionandhealthconf.org/agenda.html>

National Alliance on Mental Illness Convention
July 6 - 9, 2011 in Chicago, IL
www.nami.org

Cooking with Addicts (and Others)

By Renée Hoffinger, MHSE, RD, North Florida/South Georgia Veterans Health System

As Registered Dietitians we know that good nutrition is essential to recovery from substance abuse. Eating well replenishes nutrients enabling the recovering alcoholic or addict to function at their optimum mentally and physically, thus able to avail themselves of the cognitive aspects of the rehabilitation program, fully engage themselves emotionally in the process, and bolster their shot at relapse prevention by keeping their mood and emotions on an even keel. In an effort to motivate and empower our residents to make positive food choices, we have been conducting hands-on, interdisciplinary (Occupational Therapist and Registered Dietitian) nutrition education as an integral part of the Substance Abuse Residential Rehabilitation Treatment Program (SARRTP), at the Veteran Administration Medical Center in Gainesville, FL, since 1997. Until recently, residents of this 20-bed, 90-day program prepared most of their meals as a community. This allowed us to reinforce didactic classes on the role of diet in recovery with actual menu planning, functional, as well as educational, shopping trips, and weekly hands-on cooking classes. Although our residents are now temporarily housed on a hospital ward, the cooking (albeit scaled down) and shopping classes continue.

Indeed, hands-on nutrition education can benefit any patient population. As the adherence literature reveals, most patients fail to follow dietary and other lifestyle advice. Via hands-on nutrition education, adults (most of us learn best by doing) can master basic food skills, thus boosting their self-efficacy (perceived capability), and hence likelihood of succeeding in the behavior change process. Edible lessons are literally internalized; resistance to trying new foods relaxed and patients are empowered with practical tools to actively participate in their own health care – the hallmark of patient-centered care. Plus rubbing elbows in the kitchen transforms the RD-patient dynamic in ways that foster a therapeutic alliance.

For those in recovery, nutrition can serve as an aspect of life in which they can practice self-control and self-determination, and as a means for nourishing oneself, both literally and emotionally. From the perspective of my Occupational Therapist partner in this endeavor, substance abuse also leads to “role deficiency” – the loss or lack of development of the many roles that usually anchor our lives in the realms of relationships, work, leisure and schooling. Such problems in role performance frequently serve as the catalyst for people to enter recovery programs. The hands-on approach reinforces those roles providing successful experiences which assist in the development of motor, process and communication skills and a sense of compe-

tence, thus imparting the sense of mastery, purpose, and structure necessary to meaningful living and successful recovery.

My first “taste” of hands on nutrition education was during my Coordinated Undergraduate Program (CUP) internship, during a stint with a DTR on the psychiatry ward. She shepherded an assortment of patients through a food preparation exercise. What inspired me is that even though some believed themselves to be Joan of Arc, Napoleon and the like, when they started grating that cabbage for coleslaw, normalization reigned. Remarkable!

In our SA work we have found that food issues often provide “grist for the mill”: opportunities to deal with interpersonal and other issues such as control, deprivation and gender, in a therapeutic environment. Cooking and taking meals together also allows residents to develop leadership skills and those with food backgrounds to “shine” by contributing their expertise, lends a sense of family and normalization, and can be a venue for all staff team members to model appropriate “dinner” conversation and interact in less formal ways with residents. The cooking classes have also been a terrific volunteer experience for dietetic students, advantageous to both them and us.

Here are some general, practical guidelines for setting up and conducting hands-on cooking classes with your patients/clients (which may or may not apply to your situation).

- Wrangle the support of your “higher ups” with the logic (and hard data) that adherence is cost-beneficial in both human and dollar terms and that active participation, increases the overall quality of care and improves customer satisfaction.
- Identify your target population. Participants can be out-patients with similar diagnoses, folks interested in eating well on a tight budget, or just staying healthy. Whoever they are, including family members multiplies the effect.
- Ideally, you want a well-lit kitchen where you can store your equipment securely, with enough elbow room and work surfaces, at an easy to find location with parking.
- In terms of equipment it is best to approximate your standard participants’ basic kitchen so they feel at home and recognize that they don’t need to get fancy to eat healthy. That being said, I do make suggestions for healthy cookware and try to inspire people to use a second generation pressure cooker. Once you get the hang of a pressure cooker, I’m convinced that it increases your repertoire of delicious foods (beans!!) and cuts down on time spent in a hot kitchen.
- A key element in running a cooking class is having a patient-centered approach. Keeping the atmosphere supportive, non-judgmental, gentle and fun will inspire creativity, confidence and ownership. Include participants in the planning by asking them to submit recipes for “redux”, survey their likes, dislikes, medical needs and interests.
- Limiting class size to 5-10 (depending on space and staffing) and the number of dishes prepared helps to maintain the sanity of all involved. Having more than one staff person plus student volunteers allows you to work in smaller groups on several recipes simultaneously. Preparing the space in advance by setting up “stations” with each written recipe and its corresponding ingredients, utensils, etc. streamlines the process. Beginning by gathering the entire group, explaining what they are going to prepare and the nutritional concepts/benefits to be presented, sets the intention, putting the lesson into a larger framework. You may want to have a pre-class on kitchen sanitation and safety (we use a video and quiz). Obviously, everyone must wash their hands before getting down to work.
- Our overall learning goal is to demystify the process of putting food on the table (as Chef Gustave in *Ratatouille* proclaims, “Anyone can cook!”). Along the way we impart general kitchen skills (e.g. measuring ingredients, use of knives), techniques and shortcuts, use of equipment, sanitation and safety, following and modifying recipes, preparing food from scratch for control of nutrient content, preparing lower fat and sodium, higher fiber, less processed, less expensive, better tasting food, overcoming fear of trying new foods, and reducing our carbon food print. The specifics will be predicated by participants’ interests and dietary goals.
- It is best to introduce new “weird” foods (tofu, quinoa, and the like) by weaving the familiar with the less familiar. For example, being in the South we prepare collards (seasoned with lemon juice or sesame oil instead of fatback), BBQ tempeh (with a homemade low sodium sauce), a glorified version of macaroni and cheese (sneaking in some tofu), and an oriental stir fry with gluten (affectionately dubbed “Chinese Chitlins”). Presenting healthy foods in the context of phytochemicals and other health issues specific to your audience



Renée Hoffinger

(e.g. isoflavones and prostate cancer) also helps to pique interest and increase acceptability.

- Other hands-on nutrition education activities can include field trips to farmers' markets, "health food" stores, supermarkets, restaurants, and farms, menu planning... you are only limited by your imagination.
- Glean some outcome data with simple pre-and post tests of objective knowledge, food habits, attitudes, and/or self-efficacy. Do the participants still think "tofu" is a four-letter word? Take your results back to your administrators so you can get support to expand your program.

So whether your patients are diabetic, hypertensive, overweight, HIV+, in cardiac or drug rehab, or simply interested in optimizing their health, incorporating hands on nutrition education into your RD toolbox can enhance customer success, broaden your skills, job satisfaction and fun quotient.

About the Author: Renée Hoffinger, MHSE, RD is BHN's resource professional for the addictions practice area and recipient of the BHN 2008 Excellence in Practice Award. She is employed at North Florida/South Georgia Veteran Health System.
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Book Review: Let's Cook! Healthy Meals for Independent Living

Reviewer: Paula Cushing, RD, LDN

"Let's Cook! Healthy Meals for Independent Living" is a cookbook designed by and for adults with special needs to learn how to cook simple and healthy meals, gain confidence in the kitchen, and build self worth. This cookbook, which contains over 50 healthy recipes, began as a collaborative project between Anne Kissack, MPH, RD, and Elizabeth Riesz, PhD, a professor and mother of a young woman who has Down Syndrome. The objectives of this book are to assist teens and adults with developmental disabilities to learn basic concepts of creating nutritious dishes, plan healthy meals, respect food and kitchen safety, and to eat well. Editor Linda Hachfield, MPH, RD, beautifully enhanced the original text to pictorially show cooking steps, meal planning tips, and how each recipe can "fit" on the plate.

The easy-to-make recipes are in large print and written at a third grade or lower reading level. Each recipe is written in an easy-to-follow fashion, including "what I need", "what I use", and "what I do" and contains step by step food preparation photos as well as a large color photo highlighting the finished product. Recipes are organized by MyPyramid food groups and include meal planning guidelines, healthy meal tips, and nutrient information. Additional tools and guidelines include healthy serving sizes, the My Plate approach, shopping list, healthy restaurant choices and healthy snacks.

"Let's Cook!" according to the authors is a result of many voices with recipes that really work. The recipes were triple taste tested and prepared by a number of individuals at various ability levels. This cookbook is highly recommended for use in supported living residences with individuals with intellectual and developmental disabilities and their staff whose goals are to improve health and wellness through improved cooking skills and healthy meal planning. The book is very user friendly and proven to help increase the enthusiasm of individuals and their staff regarding cooking healthy meals and help increase their comfort level in the kitchen. An added plus - it helps to promote and reinforce life skills for independent living.

For more information, visit www.appletree-press.com or call 507/345-4848.

NEW!

You Spoke, We Listened...

Submitting Nominations for National Honors and Awards Just Got Easier!

ADA is shining the spotlight on outstanding food and nutrition practitioners and supporters of the profession through its National Honors and Awards program. Don't miss this chance to honor those who have advanced the profession, exhibited leadership and shown devotion to serving others in both dietetics and allied fields.

You may now submit your nominations entirely online! The submission deadline is midnight Central Standard Time on March 1, 2011. Award recipients will be announced in May 2011 and recognized at the ADA 2011 Food & Nutrition Conference & Expo in San Diego, CA.

eat right. American Dietetic Association



Visit our website to learn more and to submit your honors and awards nominations online: www.eatright.org/nationalawards.

National Survey Confirms that Youth are Disproportionately Affected by Mental Disorders

The National Institute of Mental Health (NIMH) is part of the National Institutes of Health (NIH), a component of the U.S. Department of Health and Human Services.

Science Update • September 27, 2010

<http://www.nimh.nih.gov/science-news/2010/national-survey-confirms-that-youth-are-disproportionately-affected-by-mental-disorders.shtml>

About 20 percent of U.S. youth during their lifetime are affected by some type of mental disorder to an extent that they have difficulty functioning, according to a new NIMH survey published in the October 2010 issue of the *Journal of the American Academy of Child and Adolescent Psychiatry*. The data support the observation from surveys of adults that mental disorders most commonly start in early life.

Background

Many regional surveys conducted in the United States have indicated that about one in four to five children experience a mental disorder sometime in their life. But until now, no nationally representative surveys had been conducted to determine if these prevalence rates of a wide range of mental health problems hold true across the nation.

Kathleen Merikangas, Ph.D., of NIMH and colleagues analyzed data from the National Comorbidity Study-Adolescent Supplement (NCS-A), a nationally representative, face-to-face survey of more than 10,000 teens ages 13 to 18. They used standard diagnostic criteria set by the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV) to determine lifetime prevalence of mental disorders among the teens. To follow up on the teens' responses, they also collected data via mailed questionnaires completed by one parent or guardian of each teen surveyed.

Results of the Study

Overall, nearly half of the sample reported having met diagnostic criteria for at least one disorder over a lifetime, and about 20 percent reported that they suffered from a mental disorder with symptoms severe enough to impair their daily lives. In addition,

- 11 percent reported being severely impaired by a mood disorder (e.g., depression or bipolar disorder),
- 10 percent reported being severely impaired by a behavior disorder such as attention deficit hyperactivity disorder or conduct disorder,
- 8 percent reported being severely impaired by at least one type of anxiety disorder.

In addition, about 40 percent of those who reported having a disorder also met criteria for having at least one additional disorder. Those with a mood disorder were more likely than others to report having a coexisting disorder. Underscoring the notion that mental disorders manifest early in life, the researchers also found that symptoms of anxiety disorders tended to emerge by age 6, behavior disorders by age 11, mood disorders by age 13, and substance use disorders by age 15.

The researchers also noted strong links between parental characteristics and their teen's disorders. For example, children of parents with less education (e.g., no college degree) were at an increased risk for having any kind of mental disorder. And compared to teens with married or cohabiting parents, those with divorced parents also were at higher risk for a disorder, especially anxiety, behavior and substance use disorders.

Significance

The NCS-A results provide a broader and longer-term outlook compared with last year's National Health and Nutrition Examination Survey (NHANES), which asked respondents

about diagnosed disorders and service use within a 12-month window only, and was limited to six disorders.

According to the NCS-A researchers, the percentage of youth suffering from mental disorders is even higher than the most frequent major physical conditions in adolescence, including asthma or diabetes. The results reiterate the importance of developing prevention strategies and promoting early intervention for at-risk children and adolescents.

What's Next

More research is needed to better understand the risk factors for developing a mental disorder in youth, as well as how to predict which disorders may continue into adulthood. In addition, the researchers acknowledge the need for more prospective research to tease apart the complex interplay among socioeconomic, biological and genetic factors that may contribute to the development of mental disorders in youth.

Reference

Merikangas KR, He J, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, Swendsen J. Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Study-Adolescent Supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry*. 2010 Oct. 49(10):980-989.

The above information can be found on the NIMH website. The public may reproduce without permission information from the National Institute of Mental Health website, except for documents that state another copyright policy applies.

Practical Tools You Can Use



- ◆ Coaching services to hone person & family-centered skills.
- ◆ Tools to use in your work.
- ◆ Continuing Education.
- ◆ Health literacy services.

DownSyndromeNutrition.com

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1400 members quarterly!**

STUDENT CORNER

Eat Good Food - A French Paradox

By Stephanie Joppa, Student Assistant Newsletter Editor

As American waistlines have ballooned, there has been a corresponding boom in self-help books and diet products for people to tone their tummies. Despite this, news reports tell us that we are still as overweight and artery-clogged as ever. With one of the world's largest market of diet aids, how can this be?

How can the French, conversely, eat notoriously rich food (e.g. wine, cheese, and oils), yet live longer and be healthier than us? Part of the answer lies in their health system, which is ranked #1 in the world by the World Health Organization (the U.S. for comparison's sake, ranks 37th) (1). However, it is arguable that their diet also plays a strongly fundamental role in their health. It appears the French live by a few generally healthy food rules:

- 1.) Eat good food. If one eats real food (i.e. minimally processed foods, which can be pronounced without a chemistry degree), one will be more likely to be satisfied and less likely to eat more food later. For example, traditional French meals always include a dessert. Typically, desserts are not overly processed versions, nor are they low-fat or low-sugar. In essence, choose quality over quantity.
- 2.) This leads us to the next point: portions, portions, portions. This is usually a good rule to follow in general. If you are going to indulge, eat a small amount of a version that is going to cure your craving. For example, eat a small piece of rich dark chocolate rather than having a king-sized candy bar.
- 3.) Consume large amounts of fruits and vegetables. From personal observation, there appears to be a huge difference between France and the U.S. on the quantity and quality of vegetables consumed. It's my experience that produce in France has incredible flavor. Not only this, but it is less expensive than the produce in the U.S. and cheaper than the junk food in France. For example, a locally-grown Gala apple may cost 0.37 Euros (about 50 cents), whereas a medium bag of chips might cost between 2 and 3 Euro (2.8-4.2 USD).
- 4.) Eat slowly. Eating is a social experience in France, and traditional meals take a lot longer than they do in the U.S. This allows your brain the time it needs to register that you are full.
- 5.) If you are of legal age, drinking red wine in moderation may have a beneficial impact on artery health. Research is reportedly being done to find out what the apparent benefits of drinking wine or alcohol in

some populations may be due to, including the role of antioxidants, an increase in HDL ("good") cholesterol or anti-clotting properties.

These differences can be incorporated into any diet (even on a college budget!). Here are a few simple rules to lead a lifestyle more in line with the French diet:

- Start frequenting farmer's markets if they are offered in your city. Not only will you be supporting local farmers, but there is a higher likelihood that the produce will be fresher and of higher quality.
- Start gardening yourself! If it is winter, many herbs can be grown in a small pot on your windowsill indoors. If you live in an apartment, many cities now have community gardens, where you can go to garden. The bonus is that it will be easier on your wallet!
- Throw away the diet gimmicks and concentrate on eating real food. Don't deprive yourself (which can lead to bingeing), but try and focus the bulk of your diet on foods rich in vitamins and minerals.
- Reduce your plate and glass size. This will make eating smaller portions easier.
- Slow down while eating. Take time to put down your fork and knife and converse with those around you. Savor your food and make eating an enjoyable experience.
- Start cooking for yourself more often. When you cook for yourself, you know exactly what goes into the preparation.

Bon appétit! (Enjoy your meal!)

About the Author: Stephanie Joppa is a pre-med student at the University of North Dakota with a double major in French and minors in nutrition and psychology. She studied abroad at the Université de Caen Basse-Normandie, France during fall semester, 2010.

References:

- (1) The World Health Report 2000 – Health systems: Improving performance. Published by the World Health Organization, Geneva, Switzerland ISBN 92 4 156198 X. Full report on www.who.int/whr



Stephanie Joppa

PUBLIC POLICY UPDATE

While much is unknown about the 112th Congress, one thing that is certain is that the "Face of Congress" as currently known will change as a result of the recent Mid Term elections. The 111th Congress has adjourned after passing numerous bills that help advance ADA's mission and goals.

- Child Nutrition Reauthorization funds the jobs of many ADA members, including those working in school nutrition, WIC and SNAP-Ed. ADA will continue to monitor changes in these work environments as regulations implementing new laws are written.
- The "Doc Fix" bill halted a scheduled 25 percent cut in Medicare payment rates and guarantees physicians stable Medicare reimbursement through 2011.
- The FDA Food Safety Modernization Act will overhaul the nation's food systems and provide more safeguards to prevent illness and deaths from food-borne illness.
- The Special Diabetes Program was renewed, ensuring that much-needed research will continue through September 2013 along with funding for the Special Diabetes Program for Indians and the Special Diabetes Programs for Type 1 Diabetes.

Thanks to all ADA members for their efforts in making ADA's voice heard, especially during the closing days of the current Congress.

The 112th Congress begins January 5. Once Congressional committee appointments are made and as other breaking news happens, they will be communicated to ADA members via the Eat Right Weekly and the Take Action link on the Public Policy section on the ADA Member Center page.

Do you know the US Senators that represent your state? The member of the House of Representatives from your district? If you don't know or are unsure, access the Grassroots Manager on the Public Policy section on the ADA Member Center page to find out. In order for ADA to be successful in getting effective legislation passed, it's up to each of us as grassroots activists to get to know our Congressional Representatives and to communicate to them the importance of food & nutrition.

Submitted by
Cinde Rutkowski, MA, RD, FADA
BHN Public Policy Liaison

Behavioral Health Nutrition (BHN) Dietetic Practice Group (DPG) 2009-2010 Annual Report

Fiscal year 2009-2010 was prosperous for BHN. In addition to carrying out the traditional work of our practice group, it was a year of investment in our mission, vision and new strategic goals.

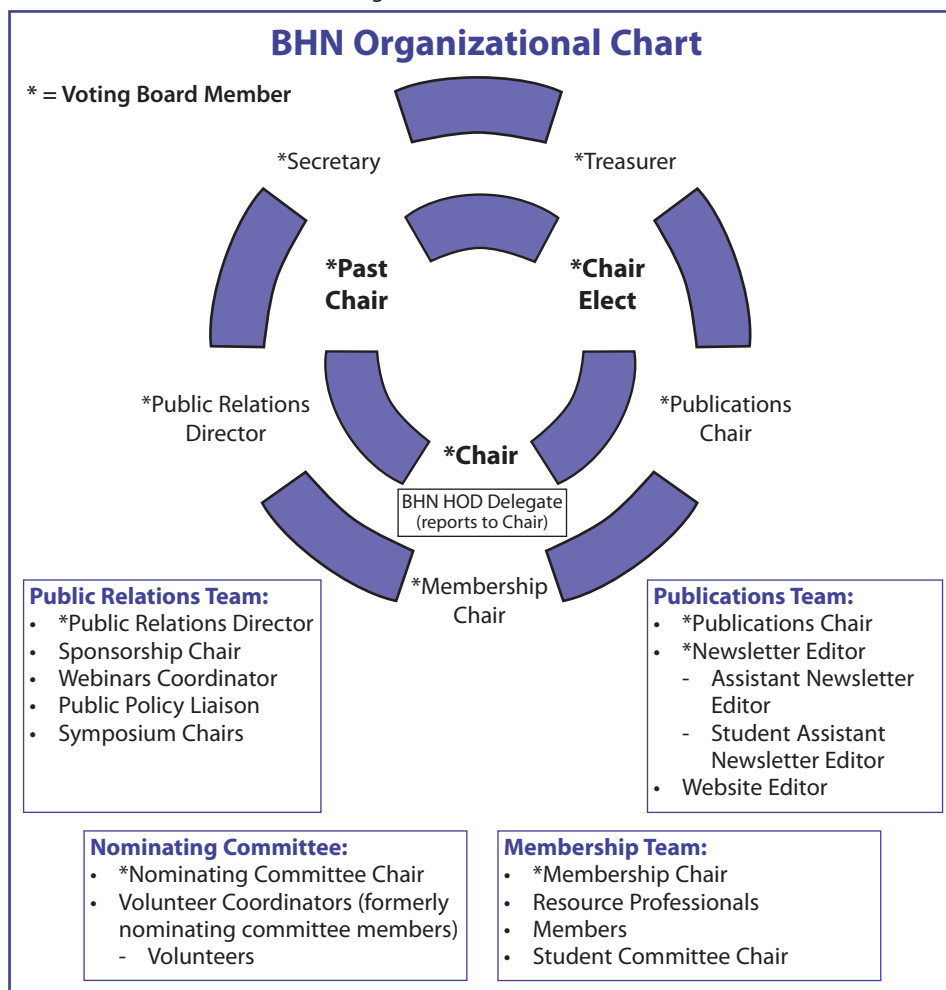
New BHN Vision: Impact the nutrition of the behavioral health populations we serve.

New BHN Mission: Empower Behavioral Health Nutrition (BHN) members to be the food and nutrition experts in the areas of:

- Intellectual and Developmental Disabilities
- Eating Disorders
- Mental Illness
- Addictions

New BHN Tag Line: *BHN: Setting the Standard for Nutrition in Behavioral Health Care*

To begin reaching the Goals of the 2009-2010 BHN Strategic Plan a BHN Organizational Chart was created.



Strategic Plan

Goal 1: The public recognizes, trusts, and chooses our members as the experts in behavioral health nutrition.

Strategies (Objectives)

1. Establish Registered Dietitians as preferred providers of Behavioral Health Nutrition services mandated/paid for by government entities by 2014.

Tactical highlights met in 2009-2010:

- The Public Policy Liaison and the Public Relations Director began the search for a

Joint Commission Speaker to provide a webinar for BHN.

- The Public Policy Liaison and the Public Relations Director made contact with The Joint Commission to identify opportunities for BHN members.
- The Public Policy Liaison and the Past Chair collaborated with ADA and additional BHN Members to provide insight in Eating Disorders and the need for the Registered Dietitian in Legislation with the United States.

2. Establish eight strategic alliances after identifying opportunities for Behavioral Health Nutrition Registered Dietitians to collaborate with other Behavioral Health organizations and broaden system of publication by 2014.

Tactical highlights met in 2009-2010:

- Appointed a Public Relations Director to the Executive BHN Committee and created a job description for the Public Relations Director position.
- Contacted desired organizations to introduce Behavioral Health Nutrition and publications (Applied Nutrition, American Society of Addictions Medicine, International Confederation of Dietetics Associations [ICDA])
- Investigated the opportunities to share the BHN Newsletter and BHN members as speakers at national/local Behavioral Health meetings (brochures handed out at Oklahoma Dietetic Association Spring Convention; Anne Hatcher, RD spoke at an Addictions Conference; and Charlotte Caperton-Kilburn, MS, RD, CSSD, LDN at the American Overseas Dietetic Association; two speaker stipends were given – Marilyn Ricci, MS, RD to speak at the National Alliance on Mental Illness Convention and Joan Medlan, MS, RD to speak at the Idaho Dietetic Association Conference)
- The Publications Chair investigated additional methods to promote publication sales to the public via Amazon.com, Borders, and Barnes & Noble.
- The Chair and Public Relations Director developed a sponsorship prospectus template.
- The Student Liaison and Volunteer Team Member created the official BHN Facebook WebPage.

3. Introduce Behavioral Health Nutrition to one health care professional organization per year (i.e. nurses/practitioners, MDs, Pas, OTs, etc.)

Tactical highlights met in 2009-2010:

- Chair submitted proposal to ADA for podcast development.

4. Optimize sponsorship opportunities to gain income of \$6000 per year and each year thereafter.

Tactical highlights met in 2009-2010:

- Created sponsorship job description in order to appoint Sponsorship Chair.
- Developed sponsorship prospectus template to facilitate sponsorship.
- Encourage increased Executive Committee and BHN DPG membership participation in seeking sponsorship via conference calls, Food & Nutrition Conference & Expo

- (FNCE) DPG Membership Showcase, and electronic listserv.
- Increased sponsorship income gained for fiscal year.

5. Introduce/Expose 10 Didactic Programs for dietetic students to Behavioral Health Nutrition per year.

Tactical highlights met in 2009-2010:

- Student Assistant Newsletter Editor position was appointed with an approved job description.
- Student Assistant Newsletter Editor submitted an article from the fall 2009 BHN Newsletter edition and it was published in the Student Scoop March edition.
- BHN Resource Professionals participated in the March Student Community of Interest via EML.
- Produced four BHN Webinar series for each of the four practice areas to market to ADA Members, non-members and students.
- Conducted August orientation for the Student Committee for Behavioral Health Nutrition via conference call.

Goal 2: Members and prospective members view Behavioral Health Nutrition as essential to their professional success.

Strategies (Objectives)

1. Listserv membership will increase to 50% in five years.

Tactical highlights met in 2009-2010:

- Listsers was advertised in the BHN Newsletter on "Why? BHN Listserv."
- Provided directions for logging on to the listserv via the BHN Newsletter on "Why? BHN Listserv?" as well as via the Web site.
- Publicized the daily digest format availability in newsletter on "Why? BHN Listserv."
- Listed topics discussed on the listserv in two issues of the BHN Newsletter via "From the Listserv" and "Practice Tips from the Listserv."
- Increased listserv members to 448 (~50% from last year of ~300 members on the listserv)

2. Increase member participation through volunteerism (20% of total members are actively engaged in Behavioral Health Nutrition volunteer opportunities)

Tactical highlights met in 2009-2010:

- Identified BHN Members to blog on the ADA Eatright.org website along with approved BHN Blogger Job Description (Therese Shumaker, MS, RD, LD; Gale Maleskey, MS, RD, LDN; Evelyn Tribole, MS, RD; Jacqueline Larson, MS)
- Established the Nominating Committee as the Volunteer Coordinator Team with updated job descriptions.
- Posted and identified opportunities for volunteering through the BHN Newsletter, listserv and e-blasts.

- Anne Hatcher volunteered to be a BHN spokesperson to aid ADA with the Substance Abuse Section in the Nutrition Care Manual (NCM).
 - BHN member, Les Rosenzweig, MS, RD volunteered to aid ADA in the NCM for adult development disabilities section.
 - ED Standards of Practice/Standards of Professional Performance(SOP/SOPPs) committee volunteers: Mary Tholking, Med, RD, LD; Suzanne Girard Eberle, MS, RD; Roberta Pearle Lamb, MPH, RD, LDN; Amanda Comstock Mellowspring, MS, RD, LD; Eileen Stellefson Myers, MPH, RD, LDN, FADA ; Christina Scribner Reiter, MS, RD, CSSD; Reba Faye Sloan, MPH, LRD; Karen Balnicki Wetherall, MS, RD, LDN;
 - BHN members who offered their assistance in reviewing the ED SOP/SOPPs: B. "Lynn" Kasper, MS RD, LD, ; Garalynne Binford, MS, RD; Paula Van Aken, MS, RD; Charlotte Caperton-Kilburn, MS, RD, CSSD, RD; Beverly Price, RD, MA; Pam Kelle, LD, LDN, CDE; Dodi Wicks, RD; Leslie Schilling, MA, RD, CSSD, LDN.
 - IDD SOP/SOPPs committee volunteers: Patricia Novak, MPH, RD; Joan Medlen, MS, RD; Lee Wallace, MS, RD, LDN, FADA; Diane Spear, MS, RD, LD; Sharon Lemons, MS, RD, LD; Catherine Conway, MS, RD, CDN, CDE; Lester Rosenzweig, MS, RD; Wendy Wittenbrook, MA, RD, CSP, LD.
 - IDD Resource Tool volunteers: Suzanne Geerts, MS, RD; Kathy Humphries, MS, RD; Melody Rankin, RD, LD; Andrea Shotton, MS, RD, LD; Diane Spear, MS, RD, LD; Sarah Thompson, MS, RD, CDN; and Lee Wallace, MS, RD, LDN, FADA.
 - FNCE 2009 Volunteers: Ruth Leye Wallace, RD, LD, Anne Hatcher, EdD, RD(ret), CACIII, NCACII
 - BHN EatRight messages review panel volunteers: Cynthia Van Riper, MS, RD, CSP, LMNT; Kim Fox, RD, LD, CDC (two were needed but many others offered their assistance, thank you members for the abundance, it is greatly appreciated.)
 - SCAN Symposium BHN Liaisons: Jessica Setnick, MS, RD, LD, CSSD and Roberta Pearle Lamb, MPH, RD, LDN
 - Research Toolkit Liaison: Susan J Arnold, MS, RD, LD
 - HOD BHN Representative: Leslie Schilling, MA, RD, CSSD, LDN.
 - All appointed BHN committee positions and elected positions for ballot (21 positions filled.)
 - BHN's donation to ADAF Silent Auction at FNCE 2009 was put together by four volunteers
 - Increased volunteerism to ~64 BHN Members (~4.6% of total members)
3. Behavioral Health Nutrition DPG is viewed as creating the future of behavioral health nutrition practice as evidenced by 80% retention rate annually.

Tactical highlights met in 2009-2010:

- Produced webinars in each of the four Behavioral Health Nutrition practice areas (*Binge Eating Disorder and Night Eating Syndrome, Nutritional Interventions in Autism, Addictions and Nutrition, and Nutrition and the Brain.*)

4. Increase membership by 10% per year for five years.

Tactical highlights met in 2009-2010:

- Marketed BHN at FNCE DPG Showcase.
 - Highlighted upcoming BHN events on DPG Officer listserv to reach other DPG/MIG listservs and on the ICDA.
 - Marketed BHN to other ADA groups by offering products that are of mutual interest (Addiction and Nutrition Webinar in collaboration with the Weight Management DPG.)
 - Increased membership to 1371 (~17% increase from last year at 1172).
5. At least 10% of membership will participate in BHN educational opportunities to increase expertise in Behavioral Health Nutrition

Tactical highlights met in 2009-2010:

- Became a CPEU provider for one CPEU per credit hour of each live webinar.
- Produced four live webinars with a recording of each via the website.
- Included advertisement on the listserv and newsletter educational opportunities in the four practice areas.
- Paid BHN Webinar and BHN MP3 Audio attendees increased member participation in educational opportunities
 - a. Binge Eating Disorder and Night Eating Syndrome ~45 attendees
 - b. Nutritional Interventions in Autism: the Role of the FD ~53 attendees
 - c. Addictions and Weight Management - unknown attendee count
 - d. Nutrition and the Brain ~44 attendees
 - e. What Dietitians Need to Know about Psychiatric Disorders ~10 attendees

6. Increase student participation by 10% annually for the next five years.

Tactical highlights met in 2009-2010:

- Added the "Student Corner" to the newsletter.
- Advised to provide article written by BHN members to the ADA student Newsletter "Student Scoop" – Student Assistant Newsletter Editor submitted an article from the fall 2009 BHN Newsletter edition and it was published in the Student Scoop March edition.
- Provided information to the student networking reception at FNCE with BHN Student Liaison Committee Chair, Chair, and Membership Chair in attendance.
- BHN Resource Professionals participated in the Student Community of Interest discussion.
- Student Membership increased to 177 (~41.6% from last year).

Additional Highlights of the Year include:

Publications

- Thanks to the Newsletter Editor Diane Spear, MS, RD, LD and all of our member contributors, published four newsletters, each featuring original research by RDs. Two were in print via mail and two were sent electronically.
- Continued sales of *Psychiatric Nutrition Therapy: a Resource Guide for Dietetic Professionals Practicing Behavioral Health Care* (CD ROM) - 68 sold 2009-2010
- Continued sales of *The Adult with Intellectual and Developmental Disabilities: A Resource Tool for Nutrition Professionals* (CD ROM) 92 sold 2009-2010
- Continued sales on the book *Nutrition and Addiction* = 104 sold 2009-2010
- Began updating publication *Children with Special Health Care Needs, Pocket Guide for RDs* in collaboration with the PNPG DPG

Member Services

- Continued member networking via Listserv.
- Continued updating and adding member benefits to the BHNDPG.org Web site.
- BHN Student Committee Chair, Sarah Hoffman, and Sharon Lemons, MS, RD, LD implemented a Facebook Page for BHN Members usage ~110 fans at the end of May 2010.
- Presented member awards to Sharon Wojnaroski, MA, RD; Ann Overmyer, RD, CD; Anne Hatcher, EdD, RD(ret), CACIII, NCACII and Roberta Pearl Lamb, MPH, RD, LDN at the FNCE Reception and Awards Ceremony
- Continue to donate funds to attain membership in ADA Foundation 21st Century Club dedicated to nutrition research and scholarship
- Hosted member social at FNCE 2009.

Administration

- Changed DPG mission, vision, tag line and strategic goals by earning an ADA grant to cover the costs involved in the creation process.
- Conducted monthly Executive Committee telephone conferences.
- Trained Executive Committee on strategic planning.
- Updated Web site services to include credit card payment option for webinars, MP3 audio and other publications.
- Updated Guiding Principles and several Executive Committee job descriptions.
- Initiated the development of the IDD SOP/SOPP.

Meetings

- Spotlight Session: *Nutritional and Sensory Processing Factors that Affect Mealtime* at FNCE 2009
- Open Forum Session at FNCE 2009: Procedure Development and Implementation of Behavioral Health Nutrition Practice Standards:
- BHN members donated ADAF Silent Auction items for FNCE 2009.
- Participation in ADA Leadership Institute: Diane Spear, MS, RD, LD and Paula Cushing, RD, LDN (2009)
- Charlotte Caperton-Kilburn, MS, RD, CSSD, LDN represented BHN via ADA Public Policy Workshop
- Collaborate with SCAN DPG for the SCAN

Symposium, *Myths, Mysteries & Realities of Eating and Metabolism – Research to Practice* (March 2010)

Financial Report for June 1, 2009 – May 31, 2010:

	Actual	Budgeted
Expenses Totaled:	\$42,562.00	\$42,579.00
Revenues Totaled:	\$48,079.00	\$40,750.00
Net Profit/ (Loss):	\$ 5,517.00	

Thank you to all who contributed to forwarding the work of this DPG. Special recognition is extended to BHN Executive Committee for leading and implementing the 2009-2010 Strategic Plan.



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Are You Seeking a Great Opportunity?

BHN is offering the opportunity to get involved in the future of Behavioral Health Nutrition.

If you want to advance skills in the following areas, now is the time!

Volunteers needed immediately to fill non-elected positions:

**Sponsorship Chair
Assistant Newsletter Editor**

If you would like to volunteer please contact Sharon Lemons, RD, LD, Nominating Committee Chair at sharon_rd@att.net

Join us, won't you?

Sign up and gain FREE access to hundreds of members and their expertise through the member-only BHN Electronic Mailing List (EML)!

We have a wonderful exchange of information, ideas, and resources.

Find practice support and prompt responses to challenging questions.

To subscribe to the BHN EML:

- Send an email to BHN Membership Chair, Milton Stokes, MPH, RD, CDN at assistU@bhndpg.org
- Include First Name, Last Name, Email Address
- Please title the subject of the email as BHN LIST SUBSCRIBE

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

BHN PUBLICATIONS

The Adult with Intellectual and Developmental Disabilities

This resource tool is designed to provide an overview of nutrition in individuals with intellectual and developmental disabilities. The resource guide is contained on one CD-ROM as a 209 page PDF file.

BHN Member Price: \$28.00



Psychiatric Nutrition Therapy

This resource guide is intended for anyone working in the 4 practice areas within Behavioral Health Nutrition: mental illness, eating disorders, addictions, and those with intellectual and developmental disabilities who also require psychiatric care. The resource guide is contained on one CD-ROM as a 170-page PDF file.

BHN Member Price: \$28.00



Nutrition & Addictions

This is a 244-page manual of information about addiction and drugs of abuse, including legal, illegal and pharmaceutical drugs, alcohol, nicotine, caffeine, and more. Patient educational handouts on nutrition and recovery topics are also included.

BHN Member Price: \$24.95



To order, visit

<http://www.bhndpg.org/publications/index.asp>