

# DEVELOPMENTAL ISSUES

A publication of

*Dietetics in Developmental and Psychiatric Disorders (DDPD)*

*A dietetic practice group of the American Dietetic Association*

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The views expressed in this publication are those of the author and are not necessarily those of the American Dietetic Association.

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

### Future Deadlines

Winter . . . . . November 16, 2003

### Please forward Information To

Melissa Altman-Traub, MS, RD, LDN  
1997 Turkey Trot Rd.  
Jamison, PA 18929  
Nutrisolutions@aol.com

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## Eating Disorders and Pregnancy: What Every Dietetics Professional Should Know

Jessica Setnick, MS, RD/LD

Because disordered eating behaviors often lead to amenorrhea and other hormonal abnormalities, conventional wisdom suggests that eating disorders must be resolved prior to conception. In reality pregnancy is more common than expected among women with eating disorders, and eating disorders are not rare among pregnant women. In addition, the stresses of pregnancy can cause a recurrence of eating and body image problems for women who had previously recovered from their eating disorders.

The shame many women associate with their eating problems may discourage full disclosure to their health professionals, with associated consequences for both mother and child. As eating disorders continue to increase among women of childbearing age, dietetics professionals working in eating disorders and women's health areas should be aware of the basic issues and common misconceptions regarding eating disorders and pregnancy, in order to best recognize, care for, and monitor their eating disordered patients and their children.

### How Significant are Eating Disorders in Pregnancy?

The prevalence of eating disorders in pregnancy is difficult to determine due to the secrecy that often accompany eating problems in our society. Existing studies are usually retrospective and conducted with small sample sizes, and therefore may not accurately reflect the scope of the true problem, however estimates suggest that as many as 1% of pregnant women have active eating disorders.<sup>1</sup> Bingeing and bulimia seem to be more common during pregnancy than anorexia, although pregnancy itself may rekindle anorexia during or after pregnancy in a woman who was previously in recovery.<sup>2</sup>

*continued on page 3*

# From the Chair

*Susan S. Zabriskie RD, MS*

When summer finally arrived in the North Country it fulfilled every promise of blue sky days, sunset cruises on Lake Ontario, camping on islands in the middle of the St. Lawrence River, bike rides past corn fields and cow pastures.

The building where I work, Jefferson Rehabilitation Center (JRC), is a beehive of activity in the winter, but in the summer it's pretty quiet. Our clients, people with the full range of developmental disabilities, are off on fishing trips, camping trips, picnics at the beach, you name it. They take off in vans, fully staffed, fully equipped, big ice chests, all the supplies for the event. Everyone has a great time. But it is rarely if ever the case that the group home residents share those experiences with the rest of the community. We did, however, have that happen this summer.

Handcycling, as I've noted previously, is the sport of biking adapted for those in wheelchairs. We hold instructional clinics for this twice a month. At one clinic, held on an unseasonably (but not unpredictably!) windy day one of my friends from JRC got dropped off early by her staff. She had her own yellow handcycle and was getting ready to ride by the time several other handcyclists drove in. Alice's bike became the source of discussion, the mechanical aspects of sports equipment always of significant interest to the male athlete-why she chose that model, how fast it could go, how it cornered, how many gears, where were the brake levers, etc,etc. We got our table set up and when I looked around, no Alice! She was off on her own, but where? The parking lot near us was of some concern to me, but since I had not heard the screeching of brakes I didn't panic. As I rounded a row of parked cars, there she was, chatting with a cou-

ple kids as they piled out of a minivan for a day at the zoo. Later on, some teenagers wandered by. From a distance I could see them stopping to admire Alice's alternative mode of transportation-another little discussion ensuing before she took off to join the other cyclists. None of this would even be memorable for me under most circumstances-there are a thousand moments like that on a Saturday in the park. But for a group home resident who has been separated from the pack since birth, there is nothing about our social system that provides such contact. In this very mundane series of events Alice not only became a part of the mainstream; she left her disability behind. For once, it just didn't matter. That was really quite extraordinary. We can easily recite the health benefits and disease risk reductions associated with sports and physical activity; the social and emotional rewards also fit into those lists.

Please join us at Food & Nutrition Conference & Expo (FNCE) this October 25th-28th. Reserve a place at our networking breakfast on Monday morning from 7:00 a.m. - 8:00 a.m. Sponsored by Dupont/Solae, our speaker, Dr. Amy Rothenberg will lend insight into successful treatment of PMS symptoms in a lively and entertaining talk entitled, OK, Hand Over the Chocolate and Nobody Gets Hurt!

The DDPD planned educational session: Weight Management and Nutrition Considerations with Use of Psychotropic Drugs has already been identified by the ADA as a topic highlighting one of their position papers. It will take place on Monday afternoon from 2:00 p.m - 3:30 p.m. There are many exciting events planned for this year's FNCE in San Antonio; don't miss it!

Some women with eating disorders do not use contraception because they believe themselves to be infertile. Bulimics may increase their risk of unplanned pregnancy through accidentally vomiting their oral contraception and/or impulsive sexual behavior, including unprotected sex.<sup>3</sup> In addition to accidental conception, fertility technology allows even underweight anorexia patients to become pregnant. Pregnancy is often a trigger for eating disorder symptoms in recovered patients and can spark a bingeing disorder in women who have been restricting their eating as a weight control method and feel that pregnancy releases those restrictions. For all of these reasons, it is clear that eating disorders and pregnancy are not mutually exclusive.

### **Why Are Eating Disorders in Pregnancy so Hidden?**

Eating disorders are often missed diagnoses in pregnancy due to the common misconception that women with eating disorders cannot conceive. Although many women with eating disorders do not menstruate normally, menstrual irregularity does not always indicate infertility.<sup>4</sup> In addition to preventing pregnant women with eating disorders from getting care for their eating problems, other dangers of this misconception include inadequate contraception, unplanned pregnancies, and delayed detection of pregnancy and therefore prenatal care. Unfortunately the early symptoms of pregnancy resemble common symptoms of eating disorders, including nausea and vomiting,

syncope, fatigue and weakness, amenorrhea, and a bloated feeling, contributing to delayed recognition by the pregnant woman herself.

Other misconceptions about eating disorders and pregnancy persist - pregnancy motivates eating disorder patients to stop their behaviors; women with eating disorders have little or no sex drive; it will be obvious if a pregnant woman has an eating disorder because she won't gain enough weight. The most dangerous misconception about pregnant women with eating disorders is that as long as weight gain is adequate, eating disorders do not affect pregnancy or outcomes.

### **What Are the Consequences of Eating Disorders During Pregnancy?**

Several studies have shown increased health risks when a pregnant woman has or has had an eating disorder.<sup>2,3,5,6</sup> A past history of anorexia may increase the risk of miscarriage even if the patient is recovered before conceiving.<sup>2</sup> It is not known if this is the result of permanent effects on reproduction or of eating disordered behaviors (caloric restriction, overexercising) that continue at subclinical levels.

Pregnant women with eating disorders may not gain adequate weight during gestation, which can affect fetal growth and birth weight. Babies may be small for gestational age, with an increased

risk of prematurity, hypothermia, hypoglycemia, infection, and lower Apgar scores.<sup>2,5</sup> Stress alone has been shown to increase the risk of prematurity,<sup>7</sup> so the stress of an eating disorder as well as the fact that eating disorders are stress-related may increase the risk of premature delivery. Women with eating disorders also have up to twice the risk of hyperemesis gravidarum. One estimate suggests that up to half of all women with hyperemesis also have bulimia.

Other less common physical complications of maternal eating disorders are gestational diabetes (more common with bulimia), preeclampsia, hypertension, difficult labor, increased need for Caesarean delivery and other delivery complications.<sup>2,3,6</sup> Studies are divided on whether eating disorders increase risk of congenital abnormalities, but it is not far-fetched to presume that children born to mothers with eating disorders will be more likely to suffer the typical consequences of malnutrition during fetal development, including neural tube defects and cleft lip and palate.

In addition to the physical concerns presented by eating disorders during pregnancy and delivery, the emotional consequences of becoming pregnant may seriously affect the health of a woman with an eating disorder. Some women experience an exacerbation of eating disorder symptoms, including body image disturbance and abnormal stress from normal

pregnancy weight gain, if they are unable to distinguish appropriate weight changes from “fatness.”<sup>3,8,9</sup> Weight-related and “out of control” feelings may lead to increased anxiety and inappropriate food restriction, as well as depression.

On the other hand, some women with eating disorders experience relief from their symptoms during pregnancy.<sup>1,3,10</sup> Pregnancy provides some women with permission to relinquish the female thin ideal and therefore to eat without restricting, with health superseding appearance in importance. Other women attribute this freedom from their eating disorders as putting concern for the baby over concern for themselves. Some experts have suggested that perhaps pregnancy-induced hormonal changes are responsible for these improvements.

### **Are There Any Aftereffects of Eating Disorders During Pregnancy?**

Of all the research findings on the topic of eating disorders and pregnancy, the most supported conclusion was this: regardless of their improvement during pregnancy, eating disorder symptoms frequently relapse to their highest level almost immediately after delivery.<sup>3,8,9</sup> Weight loss to lower than pre-pregnancy weight may occur.<sup>8</sup> This worsening of symptoms likely results from a combination of factors: loss of the motivation toward health that pregnancy provided, a desire to speed post-partum weight loss, the stress

of caring for a baby that leads to old coping strategies, the inability to wear pre-pregnancy clothes perceived as fatness, post-partum depression and/or hormonal changes.

Relapse after delivery is more common in women who had more severe symptoms pre-pregnancy and whose eating disorder symptoms lasted into the second trimester or later. Other predictors of relapse include a past history of anorexia, even if the patient was recovered at the time of conception or in a more bulimic-like stage of anorexia; an unplanned pregnancy; a history of alcohol abuse; and gestational diabetes.<sup>3</sup>

Significantly, women with eating disorders have been reported to be at up to five times higher risk than the general population for post-partum depression.<sup>6,3</sup> In addition to the fact that eating disorders are often comorbid with depression in general, childbirth is a major life-event that taps into gender and social roles, attachment and separation—issues for many eating disorder patients.<sup>3</sup>

Children of mothers with eating disorders are more likely to be underweight, undernourished, and slow to grow, as many as 17% diagnosed as failing to thrive in the the first year of life. These children are at risk due to the trend of mothers with eating disorders to restrict their children’s food intake, to make negative comments about food and eating during mealtime, to routinely underestimate their children’s hunger and food needs, and to

expose their children to their own disordered eating and/or purging behaviors. There is also the possibility of overfeeding in order to compensate when the mother knows that her judgment about food is unreliable.

The risk of eating disorders in children of mothers with eating disorders is unknown, and there is no long-term research on intellectual or physical growth or neurological development. But food refusal, childhood feeding problems and mimicking of eating disorder behaviors are all common. Sadly, some documentation suggests that maternal caloric restriction during pregnancy predisposes a child to be overweight.

### **How Can We Help?**

As dietetics professionals, how we can help depends on our practice area. In psychiatric settings, often we have the luxury of knowledge of patient’s eating disorder diagnosis. In a general practice, obstetrics/gynecology or women’s health setting, eating disorders are more likely to be hidden. Dietetics professionals working in these areas should assess every pregnant patient for risk factors by obtaining information about highest and lowest weight as an adult, history of weight loss/weight control behaviors, menstrual history, and if the patient has had an eating disorder in the past.<sup>11</sup>

It is important not to assume that if a pregnant patient has an eating disorder, her primary caregivers will know. As with eating disorders in general, many of

those suffering are unaware that their behaviors constitute a harmful disorder, and those who do admit their disorder to themselves may nevertheless feel too ashamed to reveal it to their health professionals.<sup>5,11</sup> Many women know their eating is affecting their health but may have no intention of discussing it unless asked directly. Because it is our job to ask questions about food and eating, and because sensitive questioning may be enough to encourage disclosure from a patient, dietetics professionals may be the first to identify that a pregnant patient is struggling with her eating.

The accepted fact that no lab values are reliable indicators of eating disorders holds true for pregnant women, so dietetics professionals working with a pregnant population should be aware of the possible warning signs of eating disorders in pregnancy. A history of an eating disorder is probably the strongest risk factor, but may not be obvious. More visible indicators include failure to gain adequate weight, especially in the second trimester; a small baby for gestational age; gestational diabetes; and hyperemesis, especially if any of these coexist with preoccupation and anxiety related to weight gain.<sup>3,11</sup> Although it may seem “normal” for a woman in our society to be concerned about her pregnancy weight gain, because of the effects that stress can have on pregnancy outcomes, if the anxiety persists, she should be referred to counseling even if she doesn’t have an eating disorder.<sup>7</sup>

In addition to assessing already pregnant patients, dietetics professionals should assess for eating disorders and related behaviors in patients with unexplained reproductive and/or fertility problems. Although as discussed above eating disorders do not guarantee infertility, because of the hormonal changes that accompany eating disorders, infertility may result even if the patient is normal weight.<sup>11</sup> It would be irresponsible to induce pregnancy in such a patient without addressing the eating disorder itself, and resolution of the eating disorder may render fertility technology unnecessary. Patients with known eating disorders should be encouraged to delay pregnancy until their eating disorder is treated and under control.

In those cases where an eating disorder is not identified until during pregnancy, treatment should be initiated immediately. Pregnancy provides an opportunity to intervene as the patient is already in frequent contact with medical care, motivation may be high due to concern for the baby, and the eating disorder cycle can be broken before it is passed on to the child.<sup>2,12</sup> Treatment should include nutrition counseling, increased support and monitoring by medical and nursing staff, and mental health care, all addressing both general eating disorder recovery and stress management, while providing for the specific needs of pregnancy.<sup>5,6,9,12</sup>

Depending on the level of interaction with the patient, the role of the dietetics professional

may overlap with other members of the treatment team. The dietetics professional can help by preparing the patient for her expected weight gain, ensuring that all health providers are giving the same weight recommendations and providing an estimated timeline to help the patient feel safer. Weighing in a gown is recommended to prevent confusion about weight changes, and the patient should be asked if she wants to know her weight or not.<sup>5</sup> As long as she is meeting weight recommendations, she may not need to know her weight at all.

All providers should address the patient’s fears of weight gain and emphasize the importance of proper nutrition to the baby without scare tactics.<sup>5</sup> Explaining the size and nutrient needs of baby, focusing on fetal weight gain rather than maternal weight gain, recommendations for exercise and eating, and helping the patient meet her nutrient needs with foods she is willing to eat are all helpful. If a patient is struggling with purging, a support person at meals and after meals may help, and ultimately hospitalization may be necessary to provide a safe environment for mother and child.

After delivery, encourage continued treatment to prevent or handle post-partum relapse and consider referral to a pediatric dietitian who can watch for mother-infant feeding problems.<sup>8</sup> Motivation toward recovery may still be high at this time to prevent passing on the disorder to the child, but follow-up care for mother and child is strongly indi-

cated. Communicate with the infant's pediatrician or nurse practitioner - whoever will be following mother and child - to let them know of the eating disorder history and treatment so far, and that the infant should be monitored closely to ensure adequate intake and growth.

More research is needed in this important area, and we have a long way to go until we fully understand the causes and long-term impact of eating disorders before, during and after pregnancy. Eating disorders care requires a team effort, and dietetics professionals can play a critical role in minimizing the devastation of these illnesses. Because early detection and treatment are essential to reduce the risk of complications from eating disorders in pregnancy, our ability to identify, educate and support our patients can make

a meaningful difference in the health of both mother and baby.

*Jessica Setnick, MS, RD/LD, is the founder of Eating Disorders Boot Camp™ training workshops for professionals seeking practical skills for treating their patients with eating disorders. To bring Eating Disorders Boot Camp™ to your location, or to reach Jessica, email [info@understandingnutrition.com](mailto:info@understandingnutrition.com).*

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## Patient-oriented websites

<http://www.anred.com>  
[www.eating-disorder.org/pregnancy.html](http://www.eating-disorder.org/pregnancy.html)  
[www.storknet.com/ip/reproductive\\_years/high\\_risk/eating\\_disorders](http://www.storknet.com/ip/reproductive_years/high_risk/eating_disorders)

*DDPD EML and Web site*

## Are you part of the DDPD EML?

DDPD started an EML (electronic mailing list, or listserv) this summer for members only. Don't miss out on this opportunity to network, ask questions, and keep in touch with your peers. To join: send an email message to [imailsrv@ddpd.org](mailto:imailsrv@ddpd.org) with the following in the body of the message (remove the < > brackets): subscribe ddpdlist <Your Full Name>

If you're a member of the electronic mailing list and want to send a message, address your message to [ddpdlist@ddpd.org](mailto:ddpdlist@ddpd.org)

## Are you a member of the DDPD Web site public database?

The public database on the DDPD Web site [ddpd.org](http://ddpd.org) allows potential clients to search for someone in their geographical area, or with a special area of expertise. This is another free member service! To become part of the public database, email Lynn Grieger, DDPD Web Chair, at [lgrieger@adelphia.net](mailto:lgrieger@adelphia.net) Send Lynn your full name, credentials, work address/phone/email/fax, and area of expertise. It's that simple!

DDPD Web site member log-in reminder: To log into the DDPD member-only areas of our Web site, type "ddpd" in the first prompt box and "ddpd\_visitor" in the second box. Leave out the quotation marks, and make sure the letters are all lower case. If you have questions, contact DDPD Web Chair Lynn Grieger at [lgrieger@adelphia.net](mailto:lgrieger@adelphia.net)

# What is HIPAA?

Mary Ellen Posthauer RD, CD, LD

HIPAA is the Health Insurance Portability and Accountability Act. The Privacy Rule (“Rule”) is a section of this law designed to protect the privacy of certain health information. This information is referred to as Protected Health Information (“PHI”): information that relates to the health of an individual and identifies, or can be used to identify, the individual.

The Privacy Rule applies only to “Covered Entities,” which include certain health-care providers, clearinghouses and health insurance plans. However, the Rule requires a Covered Entity to obtain written assurances, in the form of a contract, from its Business Associates that they will safeguard PHI. The effect of this contract is to extend privacy protections contained in the Rule to protected health information that we give to you.

## ***What makes you a Business Associate?***

Business Associate (“BA”) has a specific meaning under the Privacy Rule. You are a Business Associate because you provide a service that requires the exchange of Protected Health Information. You may be a Business Associate and a Covered Entity at the same time. For instance, a physician is a

Covered Entity, but may also be a Business Associate in his or her role as Medical Director; the physician may participate in quality assurance and review activities on the facility’s behalf.

The Rule provides an exception to the requirement of a Business Associate Agreement if the Business Associate is a health-care provider to whom the facility provides PHI solely for treatment purposes. One dimension of the working relationship may qualify under the “treatment” exclusion while another does not. In this case, a Business Associate Agreement is required. For example, if a pharmacy providing medications to residents at a skilled nursing facility (treatment) also provided consultation services to the facility, a Business Associate Agreement would be required.

In both examples, only the PHI received pursuant to the Medical Director or Pharmacy consultant roles would be covered by the Business Associate requirements. Any PHI this physician received pursuant to his/her treatment relationship or that the pharmacy received pursuant to its medication supplier role is not subject to the BA requirement.

## **Practice note**

An RD practicing in home care or an environment where client’s charts or records are stored in a brief case or file may be in violation of HIPAA. For example: an RD employed by a home care agency may have protected information in the car since she travels from site to site. The RD left a file in her car which identifies the terminal diagnosis of a client. The dietitian was driving her teenager who glanced at the file and found out her friend had a terminal diagnosis.

# UNDERCUT THAT OVERWHELMED FEELING

Rita Emmett

Do you feel overwhelmed with so much to do that you can't do it all? Like most dietetics professionals, are you so swamped that you don't know where to begin?

There's help and hope — even if you consider yourself to be a hopeless procrastinator. Here are five steps to take the **STING** out of being overwhelmed. Together, they form a powerful strategy that will help you accomplish your priority no matter how many other priorities are nipping at you.

Where to start? “A journey of ten thousand miles begins with but a single step.”

Your first step is the “S” of STING:

**S** *Select one task you've been putting off.*  
You're right, you can't do everything, so select just one project. Now, the first thought many really good procrastinators have is: “I've selected my task. Now I have to wait till I have a whole day free to work on it.” But you know you'll NEVER have a whole day free. You probably find it almost impossible to carve out a whole afternoon or evening free; but you can try to find one free hour.

So the “T” of STING is:

**T** *Time yourself. Give the task one full hour.*

Set a kitchen timer for one hour. Don't just mentally time yourself; the ticking of a timer adds a wonderful sense of urgency to the project.

And during that hour, there are two simple rules.

**I** *Ignore everything else. Focus on doing just this one task.*

Of course, you can't always control others interrupting you, but at least watch out for those “self imposed” interruptions. Many procrastinators will start to tackle “just one task” but then they decide to first look through today's mail, then perhaps make one quick phone call, next it's time to organize all the paper clutter on their desk, and then one ... just one ... computer game. In the blink of an eye, there are 15 things started, none completed, and the procrastinator says, “Well, I was multi-tasking”. But it's not productive if nothing is complete. Ignore EVERYTHING else (when possible).

Here's the second rule to the STING strategy.


**N** *No breaks allowed while the timer is ticking.*

To be honest, back in my procrastinating days, this is where I excelled. I could take a one-hour job and make it last 14 months because I was SO terrific at taking breaks.



This one rule will help you accomplish an incredible amount of work, especially all that paperwork that is so dear to every caregivers heart.

So what do you do when the timer dings and your time is up? Your last step in this journey is the “G” of STING:

 ***Give yourself a reward when the job is done.***

This is an amazingly important part of the strategy, but it also can be the hardest. Health care professionals often know what makes their patients happy or what their co-workers need, but many never give any thought to what would make *them* happy.

As you start your journey to become a “Recovering Procrastinator,” take a few minutes to list at least seven rewards for you that would move you to get going on this project. Don’t cop out and say, “The satisfaction of completing the job is enough reward for me” because if it truly was, then why in heaven’s name were you putting it off in the first place?

What kind of reward? Try putting off your favorite beverage or the chance to check your email until the hour is up. Or a reward for doing something at work can be time-off at home. Think of all those things you love to do but never have time to do - read a novel, spend time with your spouse, children or friend, walk out in nature, go to a movie or a museum, take a nap. Then when your hour of work-with-no-breaks is complete, you can enjoy your reward **GUILT FREE.**

There you have it - five steps that together form a surefire strategy that will take the **STING** out of feeling overwhelmed:

Select one task you’ve been putting off

Time yourself. Give the task one full hour.

Ignore everything else. Focus on doing just this one task.

No breaks allowed while the timer is ticking

Give yourself a reward when the job is done.

If you’d like a free visual reminder of this strategy, go to my Web site ([RitaEmmett.com](http://RitaEmmett.com)) and on the first page you’ll find the sentence: “Looking for the bumble bee?” Click on it and you can print out the five steps along with an illustration of a very cool little bumblebee that has a smashed stinger.

Every step you take in blasting away procrastination leads you to a greater sense of freedom. Now go ahead and set that timer, and you’ll find yourself feeling energized instead of exhausted, organized instead of swamped, and productive instead of overwhelmed as you start taking these first small steps in your journey of ten thousand miles.

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*Rita Emmett is a professional speaker and author of THE PROCRASTINATOR’S HANDBOOK and THE PROCRASTINATING CHILD: A HANDBOOK FOR ADULTS TO HELP CHILDREN STOP PUTTING THINGS OFF.*

*She also writes a free monthly e-zine, “The Anticrastination Tip Sheet”. To subscribe, go to [www.RitaEmmett.com](http://www.RitaEmmett.com) and you’ll see a place to sign up toward the bottom of the first page.*

## DDPD Financial Report for FY 2002 - 2003

Financial concerns continue to be in everyone's mind recently. Our income this year was less than anticipated, but our expenses were considerably less also. Interest income continued this year in the negative (not a surprise to anyone who listens to the news).

As of 5/31/03:

Actual Revenues totaled: \$21,488.

Budgeted: \$22,650.

Actual Expenses totaled: \$29,330.

Budgeted: \$37,859.

Total assets were: \$53,123

Revenue consists of membership dues and newsletter subscriptions.

Expenses funded the quarterly newsletter, development of publications, honorariums to support speakers at state and regional meetings, the audiovisual lending library, resource professionals in four areas (developmental disabilities, psychiatric disorders, alcohol and substance abuse, and eating disorders), the membership survey, the administration of the practice group, and the DDPD Web site.

For FY 03-04, which started June 1, 2003, we have budgeted to support the Plan of Work for DDPD. Although we had no publications income this year, we are working on future plans.

I would be happy to answer any other specific questions about the financial operation of DDPD. Please contact me either by phone at 423-838-3663 or by e-mail at leesgoodfood@comcast.net.

Lee Shelly Wallace, MS,  
RD, LDN, FADA,  
DDPD Secretary/Treasurer

## 2003 Food & Nutrition Conference & Expo (FNCE) Activites

### Saturday, October 25

8:00 a.m. - 2:00 p.m. Executive Committee Meeting,  
Marriott Riverwalk Hotel, San Antonio

### Monday, October 27

7:00 a.m. - 8:00 a.m. DDPD Breakfast meeting.

OK, Hand Over the Chocolate and Nobody Gets Hurt!

10:45 a.m.-12:30 DPG Showcase, Henry B. Gonzalez  
Convention Center, Exhibit Hall B in San Antonio

2:00-3:30 pm DDPD Session. Weight Management and Nutrition  
Considerations with Use of Psychotropic Drugs

### OK, Hand Over the Chocolate and Nobody Gets Hurt!

Mark your calendar and plan to attend this entertaining and informative talk at Food & Nutrition Conference & Expo (FNCE) 2003! DDPD presents Dr. Amy Rothenberg, who will address the topics of PMS and menopause at a breakfast sponsored by Dupont Protein Technologies. Please reserve spaces in advance by sending a message to Susan Zabriskie at wezy4@yahoo.com or call 315-788-2730 ext. 1237. This is a breakfast you will not want to miss!

### Weight Management and Nutrition Considerations with Use of Psychotropic Drugs

It can be a challenge to provide effective nutrition therapy to those who are prescribed psychotropic medications. Come to the DDPD planned education session to enhance your scientific background and professional skills with guiding patients who are dealing with mental or emotional disorders. This session has been selected by the Association Positions Committee to highlight the ADA position paper "Integrating MNT and Pharmacotherapy".

Speakers:

**Dr. James Jefferson**, Clinical Professor of Psychiatry

**Marilyn Ricci, MS, RD**, nutrition educator with a parent's  
perspective as well

**Zaneta Pronsky, MS, RD**, author of Food Medication Interactions

## New Books from ADA

*Pediatric Manual of Clinical Dietetics, 2e*

Nancy Nevin-Folino, MEd, RD

**NEW!**

This invaluable resource for nutrition care of pediatric patients has been completely revised. New chapters/appendixes include "Support for the Breastfeeding Mother", "Cultural Competence", "Nutrition Management of Seizure Disorders", "Nutrition Management of Cardiac Conditions", formula recipe charts with preparation and mixing instructions, and "Cultural Considerations in Medical Nutrition Therapy". An excellent reference for the pediatric community and a must for practitioners and pediatric departments.

Manual w/3-Ring Binder 828 Pages 2003

ISBN: 0-88091-405-X

Order # 405X

**ADA Members \$105.00**

Nonmembers \$132.00

**COMING SEPT. '03!**

*ADA Pocket Guide to Nutrition Assessment*

Pamela Charney, MS, RD and

Ainsley Malone, MS, RD

This new pocket guide provides convenient, reliable information on the tools and techniques of nutrition assessment. From nutrition screening to physical assessment, laboratory assessment, anthropometrics and determining protein and energy requirements, this guide emphasizes interpretation and application of the findings to individual patient situations. Both practical and comprehensive, the ADA Pocket Guide to Nutrition Assessment is the ideal resource for the practitioner in any health-care setting.

Softbound 248 Pages

ISBN: 0-88091-161-1

Order # 4061

**ADA Members \$25.00**

Nonmembers \$32.00

**COMING OCT. '03!**

*Infant Feedings: Guidelines for Preparation of Formula and Breastmilk in Health Care Facilities*

Pediatric Nutrition Practice Group

This newly revised and expanded version of the Guidelines for Preparation of Infant Formula now includes specific guidelines for the preparation, storage and bedside handling of infant formula, as well as expressed breastmilk in health care facilities. All hospitals with NICUs or pediatric units, nurses, dietitians, pharmacists or any staff responsible for infant feedings will find this an indispensable resource.

Softbound 100 Pages

ISBN: 0-88091-309-6

Order # 3096

**ADA Members \$35.00**

Nonmembers \$46.00

**COMING OCT. '03!**

*Real Solutions Weight Loss Workbook*

Toni Piechota, MS, RD

This new workbook incorporates cognitive behavioral therapy for weight loss, along with principles of nutrition and exercise. Topics covered include: emotions and eating; the importance of food journals; setting realistic weight loss goals; nutrition and weight loss; and how to maintain weight loss after losing it. The workbook design allows readers to jot down their thoughts to motivate the weight loss process. It is the perfect tool for lessons in classroom settings, as well as one-to-one sessions with a registered dietitian.

Softbound 56 Pages

ISBN: 0-88091-323-1

Order # 3231

**ADA Members \$15.00**

Nonmembers \$20.00

## 2003 DDPD Membership Survey Results

Thanks to each of you who completed the membership survey. Your responses will help guide the officers and committee chairs of the practice group in planning for the coming year.

Not all respondents answered all questions. The results of the responses are as follows:

### Current area of practice/expertise

	Primary	Secondary
DD/MR	40%	16%
Children	25%	16%
Adult	33%	5%
Psychiatric Disorders	17%	13%
Eating Disorders	16%	23%
Substance Abuse	2%	13%
Other		15%

### Years of practice

<1 year	13%
1-3 years	16%
4-7 years	15%
8-11 years	9%
12-15 years	15%
16-20 years	16%
> 20 years	15%

### Work setting

DD/MR	11%
Psychiatric Hospital	11%
Group Home	11%
CSHCN	8%
Substance Abuse Treatment Ctr	8%
Mental Health Agency	6%
Other	13%

*(hospital with psychiatric unit/ward, private practice, community/home)*

### Number of years a member of DDPD practice group

<1	24%
1-2	12%
3-6	27%
7-10	12%
11-15	9%
16-20	6%
>20	9%

### Opinion of member benefits

	Very Useful	Somewhat Useful	Not Useful	No Opinion	Not Aware of Benefit
Newsletter	55%	28%			
AV Library	18%	28%		28%	7%
Speaker Stipend	13%	7%	7%	28%	20%
Resource Pros	20%	33%		15%	7%
DDPD Ses'n at FNCE	20%	10%		38%	
DDPD Website	20%	25%		23%	10%

### Opinion of DDPD Newsletter

	Very Useful	Somewhat Useful	Not Useful	No Opinion	Not Aware of Benefit
DDPD Business	20%	33%	10%	10%	
Informational Articles	58%	15%			
Legislative Highlights	20%	40%		8%	
Fact Sheet	43%	20%			10%
Q&A by Resource Professional	28%				

### What do you like about the DDPD web site

Member Section	15%
Newsletter Articles	23%
Links to other Web sites	23%
DDPD Executive Committee Listing	10%
DDPD Events	18%
Discussion Forums	13%
AV Lending Library Listing	20%
Speaker Stipend Request Form	10%
Other	20%

(have not visited the Web site)

# Welcome to Holland

By **Emily Perl Kingsley** (From the “Dear Abby” column)

*Contributed by Susan S. Zabriskie RD, MS*

*Contributor’s note: A friend of mine whose son has Down Syndrome made an observation when he was three. As she watched him approach the public playground she saw he was watching everyone, not running to the swings or racing to get started on some climbing maze, he just watched for several minutes. She realized at that moment that he knew that he was different.*

She didn’t know how he knew or what she was going to do about it at that moment, but it opened the door into a place that most people don’t enter. As professionals who may work with people who have developmental or psychiatric disabilities we come and go through that door many times, without much thought...

“I am often asked to describe the experience of raising a child with a disability-to try to help people who have not shared that unique experience to understand it, to imagine how it would feel. It is like this....when you are going to have a baby, it is like planning a fabulous vacation trip-to Italy. You buy a bunch of guidebooks and make your wonderful plans. The Coliseum. The Michelangelo David. The gondolas of Venice. You may learn some handy phrases in Italian. It is all very exciting.

After months of eager anticipation, the day finally arrives. You pack your bags and off you go. Several hours later, the plane lands. The stewardess comes in and says, ‘Welcome to Holland.’ ‘Holland?’, you say. ‘What do you mean Holland? I signed up for Italy I

am supposed to be in Italy. All of my life I have dreamed of going to Italy.’

But there has been a change in the flight plan. They have landed in Holland and there you must stay.

The important thing is that they have not taken you to a horrible, disgusting, filthy place, full of pestilence, famine and disease. It is just a different place.

So you must go out and buy new guide books. And you must learn a whole new language. And you will meet a whole new group of people you would have never met. It is just a different place. It is slower paced than Italy, less flashy than Italy. But after you have been there for a while and you catch your breath, you look around, and you begin to notice that Holland has windmills. Holland has tulips. Holland even has Rembrandts.

But everyone you know is busy coming and going from Italy, and they are all bragging about what a wonderful time they had there. And for the rest of your life, you will say, ‘Yes, that is where I was supposed to go. That is what I had planned.’

And the pain of that will never, ever, ever go away, because the loss of that dream is a very significant loss.

But if you spend your life mourning the fact that you did not get to Italy, you may never be free to enjoy the very special, the very lovely things about Holland.”



## 2003-2004 DDPD Executive Committee

### Chair (03-04)

Susan S. Zabriskie, RD, MS  
441 Paddock Street  
Watertown, NY 13601  
H: 315/782-2838  
W: 315/788-2730 ext 1237  
Fax: 315/782-6612  
wezy4@yahoo.com

### Chair Elect (03-04)

Mary Emerson, MS, RD/LD  
Spring Harbor Hospital  
175 Running Hill Road  
South Portland, ME 04106  
telephone & voice mail: 207-761-2378  
fax: 207-761-2387  
beeper: 207-759-8991  
e-mail: emersonm@springharbor.org

### Past Chair (03-04)

Mary Ellen Posthauer, RD, CD, LD  
916 York Road  
Evansville, IN 47715  
H: 812/476-4781  
Fax: 812/479-0838  
MEPRDCD@aol.com

### Secretary-Treasurer (02-04)

Lee S. Wallace, MS, RD, LDN, FADA  
4512 Kings Lake Ct.  
Chattanooga, TN 37416-2810  
Mobile: 423/838-3663  
W: 423/493-2903  
Fax: 423/493-2952  
Leesgoodfood@comcast.com

### Nominating Committee Chair (03-04)

Ruth A. Foiles, MPA, RD  
3615 Tecumseh River Road  
Lansing, MI 48906  
H: 517/321-2655  
Summer home: 231-894-8223  
Fax: 517/321-2655  
FoilesR@pilot.msu.edu

### Professional Issues Delegate

Annalynn Skipper, MS, RD, FADA, CNSD  
Rush-Presbyterian-St. Luke's Medical  
Center  
425 TOB  
1653 W. Congress Parkway  
Chicago, IL 60612  
312/942-5296  
askipper@rush.edu

### Legislative Chair (02-04)

Daria Polanchik RD  
85 Village ML  
Haverstraw, NY 10927-1069  
845/947-4049  
845/359-7400 ext 4183  
dariap@compaq.net

### Membership Committee Chair (02-04)

Rosalind Wilkins, MS, RD  
Chief-Bureau of Nutrition Policy and  
Education  
Division of Nutritional Health and  
Services  
Missouri Department of Health  
PO Box 570  
Jefferson City, MO 65102  
H: 573-636-5028  
W: 574-751-6183  
Fax: 573/522-3244  
wilkir@dhss.mo.gov

### Webmaster (02-04)

Lynn Grieger, RD, CD, CDE  
493 Crow Hill Road  
Arlington, VT 05250  
W/H: 802/375-9069  
Fax: 801/457-5900  
lgrieger@adelphia.net

### Newsletter Editor (02-04)

Melissa Altman-Traub, MS, RD, LDN  
1997 Turkey Trot Rd.  
Jamison, PA 18929  
H: 215-491-5408  
nutrisolutions@aol.com

### Audiovisual Librarian (02-04)

Joyce Lowe, MS, RD  
507 Chestnut St.  
Clinton, SC 29325-3017  
864/938-3278  
Fax: 864/938-3392  
jolowe@ddsn.state.sc.us

### Manager, Dietetic Practice Team

Kim Hanigan, RD  
American Dietetic Association  
120 South Riverside Plaza, Suite 2000  
Chicago, IL 60606-6995  
W: 800/877-1600 ext 4725  
Fax: 312/899-4812  
Khanigan@eatright.org

## Resource Professionals

*Do you have a professional  
question you need help with?  
Contact the appropriate  
Resource Professional today!*

### Eating Disorders Resource Professional (00-03)

Open position

### Substance Abuse Resource Professional (00-03)

Anne Hatcher, EdD, RD, CACIII,  
NCACII  
2479 S. Bannock Street  
Denver, CO 80223  
W: 303-556-2967  
H: 303-722-2764  
Email: hatchera@mscd.edu

### Developmental Disorders Resource Professional (02-05)

Ann Overmeyer, RD, CD  
2329 Cedar Bend Drive  
Anderson, IN 46011  
H: 765/622-1766  
Fax: 765/622-1766  
anaover@aol.com

### Psychiatric Disorders Resource Professional (03-05)

Linda Venning, MS, RD  
Hawthorn Center  
18471 Haggerty Rd.  
Northville, MI 48167  
W: 248-735-6711  
Email: Venningl@michigan.gov

\* indicates preferred place of contact

Dietetics in Developmental and Psychiatric Disorders  
c/o Melissa Altman-Traub, MS, RD, LDN  
1997 Turkey Trot Rd.  
Jamison, PA 18929

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## Mental Health Information – Internet Addresses

Sharon Wojnaroski, MA, RD

Resource Professional - Psychiatric Disorders.

Internet Mental Health \*  
[www.mentalhealth.com](http://www.mentalhealth.com)

National Institute of Mental Health  
[www.nimh.nih.gov](http://www.nimh.nih.gov)

National Mental Health Information Center  
[www.mentalhealth.org/cmhs/](http://www.mentalhealth.org/cmhs/)

National Mental Health Consumers' Self-Help Clearinghouse  
[www.mhselfhelp.org](http://www.mhselfhelp.org)

American Psychiatric Association  
[www.psych.org](http://www.psych.org)

American Academy of Child and Adolescent Psychiatry  
[www.aacap.org/](http://www.aacap.org/)

National Mental Health Association  
[www.nmha.org](http://www.nmha.org)

National Alliance for the Mentally Ill  
[www.nami.org](http://www.nami.org)

Mental Health Net  
[www.mentalhelp.net](http://www.mentalhelp.net)

*\* This site has numerous links to journals, search engines, and other resources. Recently updated, and excellent*