

Setting the Standard for Nutrition in Behavioral Healthcare

## Trauma and Addiction

Anne S. Hatcher, EdD, RD(ret), CACIII, NCACII



Anne S. Hatcher, EdD,  
RD(ret), CACIII, NCACII

### Introduction

Working with clients who present with long-term chronic conditions can be frustrating, especially when little or no progress is obvious and relapses are frequent. Some of the most challenging clients are those who are alcoholic and/or drug abusers. Social

sanctions related to drug and alcohol abuse compound the problem. In the opinion of many persons including medical, legal and political scholars, addiction is a disease of choice that results from poor choices made by the client. During the 70 plus years of exploring the causes of addiction and experimenting with various treatment modalities, little attention has been given to the childhood experiences of the clients as a possible cause of substance abuse.

At the end of the Vietnam conflict, veterans began reporting symptoms that were known to have occurred after other wars and were thought to be the result of poor coping skills. It was not until towards the end of the war that neuropsychiatric disorder among persons who had served in the military began to increase. A number of medical and psychology professionals began to assess what was seen and reported a syndrome that was later labeled Post Traumatic Stress Disorder (PTSD). A book about PTSD by Tom Williams, himself a Vietnam veteran, was printed and distributed by the Disabled American Veterans Association. Williams (1987) found that among the veterans having PTSD symptoms with whom he worked, 85% of them had substance abuse issues (1). Women who read the book reported that they had similar symptoms that related to rape, domestic violence and other traumatic events.

Within the last 20 years, research has documented a relationship between trauma and addiction and other major health issues. This article is an overview of what is currently known about trauma and addiction.

### Definitions

Drug/alcohol abuse is an intense desire to obtain increasing amounts of the specific substance to the exclusion of other activities. Drug dependence is the body's physical need (or addiction) to specific agent(s). Over the long term, the dependence results in physical harm, behavior problems, and mental health issues.

Trauma for the purpose of this article is an event that is overwhelming and which the victim thinks might result in physical death, serious injury or changes in the brain and psyche that will disrupt the ability to maintain stability and a sense of self. PTSD is the result of stress that crosses the threshold of the person's ability to cope; the experience(s) is large, unpredictable or sustained and the person experiencing it has little or no ability to stop it or to challenge the perpetrator(s). Individuals who have experienced traumatic events develop coping skills that include what is often considered maladaptive behavior. As a result, the individual is often perceived as having mental health issues for which medication is usually prescribed. Treatment for PTSD is made difficult for the client because of the conflict between wanting to tell his/her story and for the health care professional who finds it difficult to hear the story and to believe that unspeakable acts have been perpetrated by one human being on another.


### Impact of Trauma on Addictive Behaviors and Adult Health

The correlation between trauma and alcoholism was reported by counselors working in addiction recovery programs for many years before research was published to support this knowledge. In one of the first studies on addicted women and trauma, 75% of the women reported sexual abuse, 52% reported physical abuse and 72% reported emotional abuse (2). Data further indicated that addicted women had been abused by more perpetrators, more frequently, and for longer time periods than their non-addicted counterparts. Some counselors also reported that males in addiction treatment programs also had a

*continued on page 3*

WINTER 2012

## INSIDE this issue

- 
- 2 From The Chair
  - 4 Medical Complications of Eating Disorders: Intervention Tips for the RD
  - 6 Increased Glucose Levels in Psychiatric Patients
  - 7 The Busy World of Down Syndrome
  - 8 Impaired Carbohydrate Digestion and Transport and Mucosal Dysbiosis in the Intestines of Children with Autism and Gastrointestinal Disturbances
  - 9 Student Corner . . . On Your Own: Advice for Starting a Nutrition Practice
  - 10 In Search of Evidence
  - 11 "Cook for Life" Photo by VA RD wins JADA Contest and Promotes Hands-on Nutrition Education
  - 12 Behavioral Health Nutrition Dietetic Practice Group Annual Report • 2010-2011
  - 14 BHN Awards
  - 15 In the BHN Pipeline
  - 16 BHN DPG Executive Officers

**BHN Newsletter** is published quarterly (Winter, Spring, Summer, Fall) as a publication of Behavioral Health Nutrition, a dietetic practice group of the Academy of Nutrition and Dietetics. All four issues are published electronically; members receive an email announcement and link for direct access. Newsletters are available on the BHN Website at [www.bhndpg.org](http://www.bhndpg.org).

**CPE Credit:** *BHN Newsletter offers at least one CPE article with each publication. CPE articles, test questions and certificates are available at [www.bhndpg.org](http://www.bhndpg.org). BHN Newsletter also falls under the Professional Portfolio Guide's CPE Section-200 Professional Reading for peer reviewed, science-based articles equivalent to one-half (0.5) CPE if read within 5 years of publication.*

**Address Changes and Missing Issues:** Contact the Academy of Nutrition and Dietetics with your new address information. If you missed an issue, contact [newsletter@bhndpg.org](mailto:newsletter@bhndpg.org) or the newsletter editor.

**Advertisement Policy:** BHN accepts advertisements for the quarterly newsletter. Ads are subject to approval of the editorial board. For guidelines and fee schedule contact the editor at [newsletter@bhndpg.org](mailto:newsletter@bhndpg.org).

Advertisements should not be construed as endorsement of the advertiser or product by the Academy of Nutrition and Dietetics or by BHN.

**Submissions:** Articles about successful programs, research, interventions and treatments, meeting announcements and educational program information are welcome and should be forwarded to the editor by the next deadline.

#### **Future Submission Deadlines**

Spring 2012 ..... February 1, 2012  
 Summer 2012 ..... May 1, 2012  
 Fall 2012 ..... Aug 1, 2012  
 Winter 2013 ..... Nov 1, 2012

#### **Editor:**

Diane M Spear, MS, RD, LD  
[newsletter@bhndpg.org](mailto:newsletter@bhndpg.org)

#### **Assistant Editors:**

Mary Kuester, MA, RD, LD  
 Marley Peale, Student

#### **Newsletter Review Board:**

Charlotte Caperton-Kilburn, MS, RD, CSSD, LDN  
 Charlene Dubois, MPA, RD  
 Mya Jones, DPG/MIG/Affiliate Relations

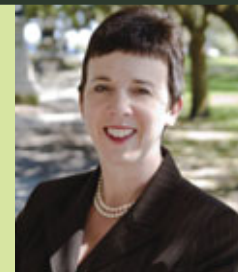
Individuals not eligible for Academy of Nutrition and Dietetics membership may apply to become a "Friend of BHN" for the subscriber cost of \$50.00. A check or money order should be made payable to ADA/DPG #12 and sent in care of the BHN Treasurer (see officer contacts in this newsletter).

Copyright 2012 BHN. All rights reserved.

The BHN Newsletter may be reproduced only by written consent from the editor. Direct all requests to [newsletter@bhndpg.org](mailto:newsletter@bhndpg.org).

## From the Chair

**Charlotte Caperton-Kilburn, MS, RD, CSSD, LDN**



Experiencing the changing season in the Southeast, more from my visits to Knoxville and the Smoky Mountains than here in Charleston, SC (we do have a few trees that lose their leaves) and planning of my daughters 5th grade basketball team, I am reminded that my time as Chair is coming to an end. With all the changes that have been taking place with BHN and all of the hard work, it is surprising for me to realize just where we are on the calendar year. It has been so good to see the plans past BHN Chairs have put into motion come to fruition.

FNCE 2011 was a huge success, thanks to all the work put forward by the BHN Board of Directors. It was great to see all of you at FNCE and to put faces with names.

"Getting it Started" has proven to be just what has happened in BHN this year. I hope that you have taken the time to earn your free 3 CPE's from the last newsletter. The quiz to earn CPE's for our August Webinar should be up by the time you receive this newsletter. Please visit and post on our Facebook page and EML and follow BHN on Twitter.

In February 2012, BHN will offer a free webinar to members who are interested in Twitter. Lindsay Ek, MS, RD, BHN Social Media Chair will be the speaker for this event. Look for a survey soon related to this webinar.

We are always looking for webinars in which our members will benefit, so please pass along any timely topics and speakers that you feel the membership would like to hear about.

Having experienced the holiday festivity, it is with celebration that I say to you that many more things are in the works for BHN for the remainder of this year through 2013. If you would like to be part of the volunteer experience in BHN, please contact me at [nflperformance@yahoo.com](mailto:nflperformance@yahoo.com).

Don't forget to vote during February and March...

*Charlotte Caperton-Kilburn, MS, RD, CSSD, LDN  
 BHN Chair 2011-2012*

## Finding Balance:

### Obesity and Children with Special Needs

Children with special needs are far more likely to be overweight or obese than their counterparts according to "Finding Balance: Obesity and Children with Special Needs," the second in a series of groundbreaking reports produced by AbilityPath.org, an online resource and social community for parents and professionals serving the needs of adults and children with disabilities. This landmark report, the first to focus exclusively on how the obesity epidemic affects children with disabilities and special needs, presents not only the extent and causes of the problem, but also offers practical solutions for families and others caring for these children. This newly published guide, developed in coalition with Special Olympics and Best Buddies International San Francisco, Calif, is available at <http://www.abilitypath.org/health-daily-care/health/growth-and-nutrition/articles/obesity/pdfs/obesity-report.pdf>

## Don't Miss Member Messages!

The primary form of communication sent to the BHN membership is via email through Mail Chimp or Survey Monkey. If you choose to opt out of email from these services, then you risk missing most of the member messages from BHN. If you missed receiving the 2011 BHN Member Survey, please contact Milton Stokes at [miltonstokes@gmail.com](mailto:miltonstokes@gmail.com).

## Trauma and Addiction

Continued from page 1

history of trauma and were using drugs and alcohol to cope. Despite these reports, research data correlating addiction and other health issues with trauma was lacking until recently.

Vincent Felitti, a physician with Kaiser Permanente Medical Care in San Diego, observed patients who responded well to a weight loss program and then gained the weight back. When these patients weighed less, they became anxious and fearful. In response to these incidents, staff working with Dr. Felitti began exploring the life histories of patients. The interviews revealed a pattern of childhood sexual abuse, trauma, family suicides, brutality, and other evidence of dysfunctional family relationships. In a study of 286 obese patients, Dr. Felitti found that half had been sexually abused as children, which was 50% greater than the normal rate reported by women and 300% higher than the rate reported by men (2). These patients were overeating because food was a reliable "friend" that served the same purpose that alcohol serves for the alcoholic. A report of this finding in 1990 to a meeting of the National Association for the Study of Obesity was criticized because it was contrary to the accepted thinking about the causes of obesity. One person from the CDC found the data interesting but wanted a larger study (3).

Kaiser Permanente physicians developed a questionnaire on Adverse Childhood Experiences (ACE) and asked 26,000 consecutive patients receiving a non-illness-related comprehensive medical examination to complete it. Seventy-one per cent of the patients who were asked agreed to complete the questionnaire. The patients were mainstream, middle-class patients with an average age of 57. The group was evenly divided between men and women, 77% were Caucasian and 74% had attended college. The results of the study documented the prevalence of maltreatment and adversity and the impact on health 40 to 50 years later. The study results indicated that adverse experiences in childhood were more common than expected. Sixty-six percent of a large, representative sample of middle-class, predominantly white, educated patients with good health insurance had suffered maltreatment and/or family dysfunction as children. Persons who had a score of 4 or above on a 10-point scale were more likely to have mental and emotional problems in adult life including depression, anxiety, panic reactions, poor anger control, sleep dis-

turbances, dissociation, and hallucinations. Further study found a correlation with heart and lung diseases, autoimmune diseases, liver diseases, diabetes, sexually transmitted diseases, alcohol and drug abuse, heavy tobacco use, and chronic pain (3).

Physicians in other disciplines and from other agencies were hesitant to administer the ACE questionnaire because of time constraints. They were also concerned that they would "open a can of worms" that would be more traumatizing for the patients and require additional treatment. However, the Kaiser physicians found that there was no need to spend a lot of time hearing patient stories. The opportunity to say what happened and acknowledgment by a physician that life had not been easy was therapeutic for patients. When compared to other Kaiser patients, the ACE study patients had a 35% drop in doctor's visits and an 11% drop in emergency room visits within the following year (3).

Felitti (2002) reported that a male with an ACE Score of 6 is 46 times more likely of becoming an IV drug user when compared to a man with an ACE score of 0 (4). Szalavitz (2011) reported additional statistics from the ACE study as follows: smoking is more likely among a person with an ACE score of six, alcoholism is greater in persons with a score of four or more and 60% of persons with a score of four or more have a greater chance of obesity (5). In 2011, Szalavitz also reported that by age 16, a high percentage of children have been exposed to at least one potentially traumatic event including a natural disaster, a car accident, child abuse or the loss of a close family member (6). Children with a history of traumatic experiences were more likely to have attention problems even when they did not meet the criteria for a diagnosis of PTSD. Persons experiencing trauma symptoms have higher than normal levels of adrenaline and noradrenaline according to research reported in her article.

Covington described the difference between women and men in terms of risk for physical and sexual abuse (2); both are relatively equally at risk for abuse from family members and people known to them. As they grow up, males are more likely to be harmed by enemies or strangers and women are more likely to be harmed by lovers or partners. Being harmed by a person or persons who are known and on which a child must rely for survival alters the experience and the response to the abuse. The experience can skew relational experiences and hinder psychological development. Use of mind-

altering chemicals is a means of suppressing memories and a way to soothe feelings associated with relationships.

There is an assumption that the most destructive problem among persons with adverse childhood experiences is incest and in fact incest is often noted as the number one cause of PTSD. However, it is co-equal with other causes. The experience that seemed to have the greatest impact was emotional abuse, especially chronic recurrent humiliation. Szalavitz observed that a common treatment modality for addiction clients (and for some obese clients) has been confrontation and shaming of the individual, which was thought to lead the client to make different choices. This treatment approach may lead to additional trauma.

Fisher (2000), in her paper for the International Society for the Study of Dissociation, made the assumption that any addictive behavior begins as a survival strategy that numbs the body and mind, walls off intrusive memories, self-soothes, increases hyperarousal, combats depression, or facilitates dissociation (7). The use of chemicals controls symptoms and provides a sense of control for an individual who has experienced a lack of control in her/his surroundings. Psychoactive chemicals require continual increases in dose to maintain the desired effect and eventually are needed to prevent physical and emotional withdrawal. Thus the substance use acquires a life of its own that overtime disrupts the client's functioning until it might become a threat to the individual's life. For this reason, addiction issues must be addressed concurrently with issues related to trauma and mental health.

Compensatory strategies developed by persons experiencing trauma are aimed at self-regulation and maintaining safety. Strategies often incorporate lessons learned in the midst of trauma and include some of the following:

- Self-injury and eating disorders relate to the client's experience that the body can be used for and is nothing more than a vehicle for shifting or discharging tension
- High risk behaviors of all kinds stimulate an adrenaline and/or endorphin production that serves to alleviate feeling states of fear and powerlessness and substitute feelings of excitement, alertness, or well-being.
- Dissociation, which allows the individual to be physically present while not being consciously aware of what is occurring at the present moment

*continued on page 4*

## Trauma and Addiction

continued from page 3

- Use of psychoactive chemicals to alter consciousness and change the psychophysiological experience (7).

Since the publication of Felitti's findings, some clinicians have questioned the strong correlation between adverse childhood experiences and health. Irving and Ferraro (2011) noted that the impacts of child abuse do not manifest uniformly (8). They considered the role of personal control in mediating the effects of traumatic experiences. The research cited supports the fact that individuals who were abused, due in part to lower personal control in the reported situation, have poorer self-care practices and are less able to develop self-care priorities. They noted that longitudinal studies would provide more complete data.

As more knowledge related to the effects of trauma on long term health and especially on drug and alcohol use/abuse accrues, the addiction profession has moved towards providing trauma informed care. At the time of this writing, the training for counselors is in its early stages so there is no documentation base of research that supports the advantages of integrating recognition of trauma experiences into addiction treatment. Recognition of the impact of traumatic experiences on adult health issues including diabetes and obesity, as well as addictive behaviors, is important among dietitians working with these clients.

**About the Author:** Anne Hatcher, EdD, RD (ret), CACIII, NCACII, is Professor

Emeritus at Metropolitan State College of Denver. She co-directs the Center for Addiction Studies and instructs courses designed to meet requirements for certification of addiction counselors in Colorado. Dr. Hatcher previously served as the Addictions Resource Professional for BHN and received the 2009 BHN Award for Excellence in Practice: Addictions.

### References:

1. Williams T. Post-traumatic stress disorders: a handbook for clinicians. Disabled American Veterans National Headquarters. Published 1987.
2. Covington SS. Women and addiction: a trauma-informed approach. *Jour. Psychoactive drugs*. SARC supplement 5. November 2008; 377-385. [www.stephaniecovington.com/pdfs/Covington%20SARC.pdf](http://www.stephaniecovington.com/pdfs/Covington%20SARC.pdf). Accessed October 30, 2011.
3. Wylie MS. As the twig is bent. *Psychotherapy networker*. September/October 2010. [www.psychotherapynetworker.com](http://www.psychotherapynetworker.com). Accessed October 31, 2011.
4. Felitti VJ. The relationship of adverse childhood experiences to adult health: turning gold into lead. *Translation of Belastungen in der Kindheit und Gesundheit im Erwachsenenalter: die Verwandlung von Gold in Blei*. *Z psychosom Med Psychother* 2002; 48(4): 359-369. [www.acdstudy.org/files/GoldintoLead.pdf](http://www.acdstudy.org/files/GoldintoLead.pdf). Accessed October 31, 2011.
5. Szalavits M. How childhood trauma creates life-long adult addicts. Sept. 25, 2011. [www.thefix.com/content/trauma-and-addiction9180](http://www.thefix.com/content/trauma-and-addiction9180). Accessed October 30, 2011.
6. Szalavitz M. Diagnosis: ADHD – or is it trauma?. *MSN health & fitness*. Feb. 27, 2011. <http://health.msn.com/health-topics/adhd/diagnosis-adhd-or-is-it-trauma>. Accessed November 1, 2011.
7. Fisher J. Addictions and trauma recovery. Paper presented at the International Society for the Study of Dissociation. Nov. 13, 2000. [www.janinafisher.com/pdfs/addictions.pdf](http://www.janinafisher.com/pdfs/addictions.pdf). Accessed October 30, 2011.
8. Irving SM, Ferraro K. Reports of abusive experiences during childhood and adult health ratings person control as a pathway?. <http://midus.wisc.edu/findings/pdfs/350.pdf>. Accessed October 31, 2011.

## CPE Credit

Continuing Professional Education (CPE) credit (1 hour) is available from BHN for the article, "Trauma and Addiction". Access the article, CPE quiz and certificate of completion at [www.bhndpg.org](http://www.bhndpg.org).

## BHN Slate of Candidates for Office for the 2012-2013 Year:

### Chair-elect:

Mary Kuester, MA, RD, LD  
Sharon Lemons, RD, LD

### Secretary:

Ellen Griffiths, RD, LDN, MPH

### Nominating Committee:

Lester Rosenzweig, MS, RD CDN  
Wendy Wittenbrook, MA, RD, LD

### DPG Delegate:

Harriet Cloud, MS, RD  
Sharon Wojnarski, MS, RD

Online voting begins February 1, 2012. Candidate information and ballot will be made available to members through Survey Monkey.

## Medical Complications of Eating Disorders: Intervention Tips for the RD

By Karen Wetherall, MS, RD, LDN

### Review of ADA/FNCE Session

On Tuesday September 27, 2011 in the session at ADA's FNCE on Medical Complications of Eating Disorders (EDs), Therese Shumaker, MS, RD, LD, provided participants with helpful tips for Registered Dietitians (RDs) working with anorexia nervosa (AN) and bulimia nervosa (BN). She also explored issues associated with diabulimia, where individuals with type 1 diabetes deliberately give less insulin to lose weight.

### Update on ED

#### Diagnostic Criteria

Diagnostic criteria were reviewed with discussion of possible changes in the DSM V scheduled for release in 2013.

Regarding AN criteria considered changes include removing criteria of amenorrhea and percent body weight. Suggested changes for BN criteria include decreasing frequency of purging from three times per week to once per week. The Eating Disorders Not Otherwise Specified (EDNOS) title may be changed to Feeding and Eating Disorders Not Otherwise Classified. It appears likely that Binge Eating Disorder (BED) may be recognized as a separate ED.

### Causes of EDs:

#### Genes Play Significant Role

The data associated with the genetic underpinnings of EDs was highlighted. Regarding the onset of EDs, it is thought

that "genetics loads the gun and the environment pulls the trigger". The severity of an ED (i.e. extreme weight loss or excessive purging) often indicates a need for longer treatment. The shorter the length of time the individual has had an ED and the more supportive the family unit the quicker one is likely to recover from AN. Hence diagnosing and early treatment of AN are key to treatment.

### Intervention Strategies for the RD Working with AN

One intervention tip for AN was to "choose foods that do not promote satiety". Suggested foods were calorie-dense and included: nuts, cheese and

*continued on page 5*

## Medical Complications...

continued from page 4

juice. It was stressed to avoid supporting calorie counting, and instead to encourage food planning in other ways, which could include exchanges or food tallies. Reminding a client with AN that the RD is there to help the patient get to the lowest healthiest weight possible can go a long way in helping the patient to begin to trust the advice being given and hasten their path to recovery. Specific advice was given to eat three meals and three snacks per day, and avoid waiting more than 3-4 hours to eat in an effort to normalize eating and prevent bloating. It's important that the RD explain the benefit of the food plan and meal spacing. Having a written, individualized food plan allows the patient to let go of some of the responsibility around food, and instead follow the prescriptive plan. In subsequent counseling sessions it's important for the RD to revisit the food plan and not be afraid to experiment. RDs were encouraged to ask the patient to commit to at least one specific behavior goal at each session.

## Weight Gain Goals for the Patient with AN

Expected weight gain was reviewed with a goal of 90-100% of ideal body weight (IBW) achieved. Increasing calories by 300-400 every 3-4 days is suggested until an adequate rate of weight gain is restored. On an out-patient basis a weight gain goal of 1-1.5 pounds/week is targeted with a more rapid rate of weight gain, 2-3 pounds/week, in an in-patient setting.

## Gastrointestinal Issues

In discussing gastrointestinal (GI) complaints Ms. Shumaker stated that the "gut is the playground of emotions". Bloating is a common issue for patients with AN, and a potential barrier to eating. The medication Reglan can be useful in alleviating symptoms of bloating and early satiety, and can therefore help patients to consume more food. Another frequent GI problem is constipation often due to insufficient caloric intake. Treatment strategies include low doses of fiber supplements as food intake improves. Note that it may take at least 3 weeks to get the bowels moving more regularly. Stimulant laxatives are not recommended due to the potential for dependence. Laxative abuse results in only 10% of calories being absorbed with the risk of dehydration.

Ms. Shumaker used a sponge analogy for gut function. She explained how a dry sponge has difficulty absorbing

water, but a damp sponge that has been somewhat rehydrated will absorb. Hence as the gut begins to heal it becomes more functional.

## Measuring Respiratory Quotient: A Useful Tool if Available

Not all RDs will have indirect calorimetry available to them to measure resting energy expenditure (REE). Typically metabolic needs are calculated to determine basal energy expenditure (BEE). However at the Mayo Clinic assessment of REE provides interesting data regarding where a patient is metabolically and what type of fuel/nutrient is primarily being used. This method measures heat production, and can provide an estimate of substrate utilization based on the ratio of carbon dioxide produced to oxygen consumed which is referred to as respiratory quotient (RQ). The RQ range is from 0.7-1.0. Starvation is indicated with a value under 0.7 and greater than 1.0 indicates excessive calorie consumption and fat storage. An RQ of 0.8 indicates protein being burned and 1.0 indicates carbohydrate being burned. An RQ of .85 is more desirable with mixed substrate utilized. REE increases with refeeding hence the food plan would need to be monitored and adjusted as needs increase.

## Intervention Strategies for the RD Working with BN

The RDs role when working with the patient with BN is to normalize eating. Opposite to the intervention strategy for AN is the suggestion to encourage patients with BN to consume foods that enhance satiety such as high fiber foods. Additionally warm foods tend to be more satisfying. Food records are a key treatment strategy for BN, and should include recording thoughts, situations and ED behaviors. Journaling these items can identify patterns of irregular eating and triggers for restricting, bingeing and purging. This process also increases self-awareness. Once challenge areas are identified specific goals should be set to normalize eating and pattern of eating.

One tip that Ms. Shumaker suggested was to encourage a patient who binges to choose only one food item to binge on; to use this food as the only binge food for the week. This strategy can significantly reduce the frequency of bingeing.

Additional strategies include: small, frequent meals to provide a comfortable volume, and if eating at least every four hours the patient is less likely to binge

due to over-hunger. Including both protein and carbohydrate at meals provides a balance for satisfaction and blood sugar regulation. Patients are restricting and/or purging usually due to a drive to lose weight. It's important to educate the patient that meal spacing aids in sustaining metabolism. Stress management strategies are helpful, and ensuring meals are set in a calm eating environment is beneficial. The structure of a food plan is useful to guide the client toward normal eating. When developing the plan negotiate with the patient to determine new foods they may be willing to try however do not include foods the patient is unwilling to eat or unable to keep down.

## Diabulimia

It was reported that 30% of individuals with type 1 diabetes have at some point given themselves less insulin than needed in an effort to lose weight. This behavior can lead to the development of an ED. For additional information on this topic it was suggested to visit [www.gracenutrition.org](http://www.gracenutrition.org). Grace Shih is an RD who has written a book on the topic.

## Team Approach for Successful Treatment

Causes and treatment of EDs are multifaceted and having the treatment team be aligned on treatment goals is very important to support the patient working to recover from an ED. Ms. Shumaker asserted that collaboration is "key" and it's important to "get all the team players on the bus".

## Conclusions

The presentation concluded by reminding participants that EDs often lead to serious medical consequences that can be life threatening. It is critical for patients to receive ongoing medical assessment and intervention, which should take precedent over nutritional and psychological interventions. Due to the complexity of EDs, a multidisciplinary approach is imperative, including psychologists, physicians and dietitians.

**Karen Wetherall, MS, RD, LDN** is the dietetic internship director at the University of Tennessee, Knoxville. She has a private practice working with clients with eating disorders. She is BHN's Resource Professional and Publications Chair. Charlotte Caperton-Kilburn, MS, RD, LDN was a contributor and editor for this article. She is BHN's Chair and has a private practice in South Carolina.

## Increased Glucose Levels in Psychiatric Patients

*Karen Fischer Factor, MBA, RD, LDN*

Research suggests that patients with psychiatric conditions are at risk for developing co-morbidities, such as hypertension, hyperlipidemia, obesity, diabetes as well as metabolic syndrome (1,2,3). Llorente and Urrutia note that the prevalence of both diabetes and obesity can be two to four times higher in people with schizophrenia than the general population (1). The reasons for this are unclear, but may have to do with life style risk factors including poor diet, difficulty accessing appropriate health care, decreased physical activity, decreased consumption of fruits and vegetables, and tobacco use (1). The use of second generation antipsychotic medications may also play a role.

Second-generation antipsychotic medications are reported to cause new health problems such as induced weight gain, increased incidence of diabetes, and metabolic syndrome (4). These medications were developed due to the fact that the first generation antipsychotic medications did not address negative symptoms of psychosis such as apathy, withdrawal, cognitive impairment, and affective symptoms. At the same time, they had side effects such as dystonic reactions, drug-induced parkinsonism, akathisia, and tardive dyskinesia which could compromise patient tolerance of treatment and lead to noncompliance, even though these medications effectively controlled hallucinations and delusions associated with psychosis. Second generation antipsychotic medications are used to treat schizophrenia, bipolar disorder, adjunct therapy for mood disorders, behavioral and psychological symptoms of dementia, psychotic and treatment resistant depressions, autism, behavioral problems associated with developmental disorders, and post-traumatic stress disorder (1).

The medications among the second generation antipsychotics are clozapine, risperidone, olanzapine, quetiapine, ziprasidone, and aripiprazole which were approved from 1989 to the 2000's. These medications more effectively respond to the common symptoms of psychosis and do not lead to extrapyramidal effects, however the metabolic side effects are of concern. Studies indicate that the greatest amount of weight gain occurs with olanzapine and clozapine, whereas the least amount of weight gain occurs with ziprasidone and aripiprazole. Olanzapine puts patients at greater risk for diabetes (3). At the same time, the rate of diabetes

and obesity in the schizophrenic and affective disorders patient population is 1.5 to 2 times higher than the rate in the general population (5). In addition, risk factors such as sedentary lifestyle and lack of access to healthful foods are common attributes among this group (6).

An important part of managing patient's taking these medications is obtaining a personal and family history related to obesity, diabetes, dyslipidemia, hypertension, and cardiovascular disease. It is also important to obtain a baseline height, weight, and umbilical circumference and body mass index should be calculated (1). Weights should be obtained at every follow-up appointment while blood pressure, glucose levels and lipid levels should be checked 12 weeks after starting medication and annually thereafter. Dietitians are an important part of the health care team and can provide education for patients and care givers on nutrition and wellness, potential metabolic side effects of medications and the signs and symptoms of diabetes mellitus. One intervention strategy especially helpful may be assisting clients to identify sources of empty calories in their diets, including added sugar.

Contributing to increased glucose levels and an increased risk for diabetes, added sugars have become a significant part of the American Diet. The Average American eats 350 to 475 calories of sugar each day (7). Added sugars include table sugar, honey, agave syrup, high fructose corn syrup, and other sweeteners with calories. However, the real villains are sucrose (table sugar) and high fructose corn syrup. Table sugar is 50% fructose and 50% glucose whereas high fructose corn syrup is 55% fructose and 45% glucose (8). Therefore, research has found few differences between high fructose corn syrup and table sugar's effect on blood glucose.

Once glucose is digested, it is absorbed across the intestinal cell and transferred to the portal blood for transport to the liver. The liver then removes 50% of the absorbed glucose for oxidation and it is stored as glycogen. Galactose and fructose act as intermediaries in these pathways; glucose exits the liver and is circulated into the bloodstream. There are three regulators of blood glucose,

- 1) amount and digestibility of the carbohydrate,
- 2) absorption and degree of liver uptake, and
- 3) insulin secretion.

In contrast, the liver takes up the entire amount of fructose and very little stays in the blood stream. The liver converts some of the fructose into fat which is then sent into the bloodstream raising the blood triglyceride level. The risk for heart disease is increased by elevated levels of serum triglycerides. Weight gain appears to account for half of the increased risk, the other half may be due to the fact that soft drinks are high in rapidly absorbable carbohydrate soft drinks, made up of high fructose corn syrup converted into fat (8).

Americans are eating 20% more sugar in their diet than in 1970, which is one reason for our high incidence of obesity, diabetes, and heart disease (9). One of the major culprits is soft drinks (10,11,12). In 1965, Americans consumed an average of 12% of their calories from beverages. In 2001, beverages accounted for 21%. They are now the number one source of added sugars in the American Diet (13). The increased incidence of obesity is likely due to liquid calories consumed before a meal; the person does not compensate by eating less at the meal in the same way as with calories from solid food.

Numerous studies have related diabetes, metabolic syndrome, and heart disease to the high consumption of sugar sweetened beverages.

- Harvard researchers tracked more than 88,000 women for 24 years and found that regardless of weight, those who drank at least two sugar sweetened beverages a day had a 20% greater risk of heart disease than those who drank less than one sugar sweetened beverage a month (14).
- In the Framingham Hearts Study, scientists tracked 4,000 men and women and found that those who drank one soft drink per day had a 44% higher risk of developing metabolic syndrome than those who drank less than one soft drink once a day, regardless of weight (15).
- Researchers also tracked approximately 91,000 women for eight years finding that those who drank at least one sugar sweetened soft drink had an 83% higher risk of type II diabetes (16)

In conclusion, psychiatric patients are at high risk for developing co-morbidities, such as hypertension, hyperlipidemia, obesity, and diabetes. RDs are uniquely positioned to obtain the assessment information to inform other healthcare

*continued on page 7*

## Increased Glucose Levels...

continued from page 6

providers of patients that are at increased risk for developing diabetes as well as heart disease. As part of the health care team, dietitians can provide education for people with behavioral health disorders and their care givers on nutrition and wellness for prevention of these at risk comorbid conditions. One likely topic for nutrition intervention is assisting clients to identify sources of empty calories in their diets including added sugar. Drinking one or more sugar sweetened beverages per day is highly likely one of the lifestyle choices not withstanding others, such as smoking, lack of exercise, and use of alcohol and drugs that need to be considered in the treatment of increased glucose levels in psychiatric patients.

**About the Author:** Karen F. Factor, MBA, RD, LDN is currently employed at Central Regional Hospital in Butner, North Carolina. She is a Certified Reviewer/Consultant for a Weight Loss Center under the North Carolina Board of Dietetics/Nutrition. Email: karenfactor@nc.rr.com

## References

1. Llorente M, Urrutia, V. Diabetes, psychiatric disorders, and the metabolic effects of antipsychotic medications. *Clinical Diabetes* 2006; 24(1):18-24.
2. Mackin P, Bishop D, Watkinson HM, Ferrier IN. A prospective study of glycemic status in anti-psychotic-treated patients. *Journal of Psychopharmacology* 2008; 22: 563-566.
3. Rigalleau V, Gatta B, Bonnaudt, et al. Diabetes as a result of atypical anti-psychotic drugs- a report of three cases. *Diabetic Medicine* 2000; 17:484-486.
4. Stein, K. When Essential Medications Provoke New Health Problems: The Metabolic Effects of Second-Generation Antipsychotics. *J Am Diet Assoc* 2010; 110: 992
5. Allison DB, Newcomer JW, Dunn AL, Blumenthal JA, Fabricatore AN, Daumit GL, et al. Obesity among those with mental disorders: A National Institute of Mental Health meeting report. *Am J Prev Med.* 2009; 36: 341–350
6. Jean-Baptiste M, Tek C, Liskov E, Chakunta UR, Nicholls S, Hassan AQ, et al. A pilot study of a weight management program with food provision in schizophrenia. *Schizophrenia Res.* 2007; 96:198–205
7. Smith, Travis A., Biing-Hwan Lin, and Jonq-Ying Lee. *Taxing Caloric Sweetened Beverages: Potential Effects on Beverage Consumption, Calorie Intake, and Obesity*, ERR-100, U.S. Department of Agriculture, Economic Research Service, July 2010. <http://www.ers.usda.gov/Publications/err100/err100.pdf>. Accessed November 9, 2011
8. Mahan KL, Escott-Stump S. *Krause's Food and Nutrition Therapy*. Elsevier-Health Sciences Division, 2007.
9. National Cancer Institute. Risk Factor Monitoring and Methods. Mean intake of added sugars & percentage contribution of various foods among us population, by age, NHANES 2005–06. Available at: [http://riskfactor.cancer.gov/diet/foodsources/added\\_sugars/table5a.html](http://riskfactor.cancer.gov/diet/foodsources/added_sugars/table5a.html). Accessed August 9, 2010.
10. Piernas, C., and B.M. Popkin. Snacking increased among United States adults between 1977 and 2006. *Journal of Nutrition* 2009. doi: 10.3945/jn.109.112763.
11. Malik, V.S., M.B. Schulze, and F.B. Hu. Intake of sugar-sweetened beverages and weight gain: A systematic review. *American Journal of Clinical Nutrition* 2006; 84: 274–88.
12. Vartanian, L.R., M.B. Schwartz, and K.D. Brownell. Effects of soft drink consumption on nutrition and health: A systematic review and meta-analysis. *American Journal of Public Health* 2007; 97: 667–75.
13. U.S. Department of Agriculture, Economic Research Service. Nutrient Availability Data Set. <http://www.ers.usda.gov/data/FoodConsumption/NutrientAvailIndex.htm>.
14. Fung TT, Malik V, Rexrode KM, Manson JE, Willett WC, Hu FB. Sweetened beverage consumption and risk of coronary heart disease in women. *Am J Clin Nutr* 2009; 89:1037-42. Epub 2009 Feb 11.
15. Dhingra R, Sullivan L, Jacques PF, Wang TJ, Fox CS, Meigs JB, D'Agostino RB, Gaziano JM, Vasan RS. Soft drink consumption and risk of developing cardiometabolic risk factors and the metabolic syndrome in middle-aged adults in the community. Framingham Heart Study. *Circulation.* 2007; 116: 480-8. Epub 2007 Jul 23. Accessed November 21, 2011
16. Schulze MB, Manson JE, Ludwig DS, Colditz GA, Stampfer MJ, Willett WC, Hu FB. Sugar-Sweetened Beverages, Weight Gain, and Incidence of Type 2 Diabetes in Young and Middle-Aged Women. *JAMA* 2004; 292: 927

## The Busy World of Down Syndrome

Joan Guthrie Medlen, MEd, RD

Whew! I'm almost dizzy from all the great things happening around Down syndrome the last few months! Of course there are always things happening in advocacy for families and people with Down syndrome. Things that impact my practice in health promotion for people with Down syndrome feel pretty rare. This month I can tell you about three...no, wait...four events that change the landscape for anyone working with people who experience Down syndrome and their families.

### Autism and Down Syndrome

Since the changes to the diagnostic guidelines included the dual diagnosis of autism spectrum disorders and Down syndrome, clinicians have struggled with the diagnostic process. It takes a skilled physician and team to understand the diagnostic overshadowing that Down syndrome can create to hide the existence of autism spectrum disorder. This past October, the results of a 16-year study confirmed the unbiased validity of the DSM for identifying autism in children with Down syn-

drome by comparing diagnoses based on its criteria with scores from a separate tool, the *Aberrant Behavior Checklist – Community (ABC-C)*.

The article was published in the October 2011 issue of *Journal of Intellectual Disability Research*: "Autism spectrum disorder in Down syndrome : cluster analysis of Aberrant Behaviour Checklist data supports diagnosis." NY Ji, GT Capone, WE Kaufmann. *JIDR* October 2011.

### 2011 Health Care Guidelines for Down Syndrome

The last *Health Care Guidelines* for people with Down syndrome was written by a collaborative group of physicians (see Down Syndrome Medical Interest Group below). They were published in the *Down Syndrome Quarterly*, in 1999. In July 2011, the American Academy of Pediatrics released the an updated clinical report for the health supervision of children with Down syndrome. (Bull et al. *Clinical Report – Health Supervision for Children with Down Syndrome*, Pediatrics. 2011. 128:2, pp 393 – 406. )

This new report includes a number of new nutrition-related recommendations including the use of feeding teams for infants, sensory issues for people with Down syndrome, screening for iron deficiency, and the importance of screening for Celiac Disease across the lifespan as well as support for past recommendations related to obesity, constipation, and GERD.

In the following issue, a letter from the Down Syndrome Medical Interest Group was published with a review of the changes, as well as some recommendations to strengthen future guidelines.

The National Down Syndrome Society has published a list of concerns from the article by age groups that is useful for parents to take to their pediatrician and for you to coach parents and support providers regarding possible common health concerns.

These guidelines are an important tool that validates some of the nutrition-related concerns – and behaviors that lead to their discovery – for dietitians working with individuals with Down syndrome.

continued on page 8

## The Busy World...

continued from page 7

### Down Syndrome Medical Interest Group (DSMIG)

This group has been around for more than a dozen years as a type of collaborative of professionals who have a special interest in health care for people with Down syndrome. At the groups meeting in July, steps were taken to formalize the group as a nonprofit organization, whose mission is to “seek to advance knowledge and understanding of Down syndrome.” Keep an eye on the website: DSMIG-USA.org to learn more about membership and the annual meeting (with CPE) in Washington, DC this July. This group is a great resource for dietitians working with people with Down syndrome and their families. The group focuses on evidence and practice-based health care and health promotion for people with Down syndrome of all ages.

### Down Syndrome Caucus

In October, which is Down Syndrome Awareness Month, Representative Cathy McMoris-Rogers introduced the Down Syndrome Caucus. The mission of the Congressional Down Syndrome Caucus is to educate members of Congress and their staff about Down syndrome. The Caucus will support legislative activities that would improve Down syndrome research, education and treatment and promote public policies that would enhance the quality of life for those with Down syndrome.

This group is the legislative go-to group for hopeful development of centers of excellence in research and clinical care for people with Down syndrome. The members are a dynamic combination of world-class researchers, health care providers, parent advocacy organizations, and families. I am excited to see a focus on quality of care for people with Down syndrome!

Tired yet? These are only a few of the happenings in the area of Down syndrome over the last four months. I've highlighted those that have particular interest for nutrition professionals working with people with Down syndrome, their families, and those who support them. It's an exciting time and an important time to pay attention and get involved.

**Joan Guthrie Medlen, MEd, RD** is the 2011 BHN award recipient for Excellence in Practice: Intellectual and Developmental Disabilities. She is a private practitioner who owns JEM Communications and Phronesis Publishing, which focus on creating practical tools and strategies for people with IDD. Joan lives in Oregon and mother of a young adult with Down syndrome, autism spectrum, and celiac disease.

## Impaired Carbohydrate Digestion and Transport and Mucosal Dysbiosis in the Intestines of Children with Autism and Gastrointestinal Disturbances

Brent L. Williams<sup>1</sup>, Mady Hornig<sup>1</sup>, Timothy Buie<sup>2</sup>, Margaret L. Bauman<sup>3</sup>, Myunghee Cho Paik<sup>4</sup>, Ivan Wick<sup>1</sup>, Ashlee Bennett<sup>1</sup>, Omar Jabado<sup>1</sup>, David L. Hirschberg<sup>1</sup>, W. Ian Lipkin<sup>1\*</sup>

**1** Center for Infection and Immunity, Columbia University, New York, New York, United States of America, **2** Division of Pediatric Gastroenterology and Nutrition, Massachusetts General Hospital, Boston, Massachusetts, United States of America, **3** Department of Neurology, Harvard Medical School and Departments of Neurology and Pediatrics and Learning and Developmental Disabilities Evaluation and Rehabilitation Services (LADDERS), Massachusetts General Hospital, Boston, Massachusetts, United States of America, **4** Department of Biostatistics, Columbia University, Mailman School of Public Health, New York, New York, United States of America

*PLoS ONE* (eISSN-1932-6203) is an international, peer-reviewed, open-access, online publication with reports on primary research from any scientific discipline. *PLoS ONE* is published by the Public Library of Science (PLOS), a nonprofit organization. Accessed November 18, 2011.

### Abstract

Gastrointestinal disturbances are commonly reported in children with autism, complicate clinical management, and may contribute to behavioral impairment. Reports of deficiencies in disaccharidase enzymatic activity and of beneficial responses to probiotic and dietary therapies led us to survey gene expression and the mucosal epithelial microbiota in intestinal biopsies from children with autism and gastrointestinal disease and children with gastrointestinal disease alone. Ileal transcripts

encoding disaccharidases and hexose transporters were deficient in children with autism, indicating impairment of the primary pathway for carbohydrate digestion and transport in enterocytes. Deficient expression of these enzymes and transporters was associated with expression of the intestinal transcription factor, CDX2. Metagenomic analysis of intestinal bacteria revealed compositional dysbiosis manifest as decreases in Bacteroidetes, increases in the ratio of Firmicutes to Bacteroidetes, and increases in Betaproteobacteria. Expression levels of disaccharidases and transporters were associated with the abundance of affected bacterial phylogenotypes. These results indicate a relationship between human intestinal gene expression and bacterial community structure and may provide insights into the pathophysiology of gastrointestinal disturbances in children with autism.

**Full text version of this article is available at:** <http://dx.plos.org/10.1371/journal.pone.0024585>

**Copyright:** © 2011 Williams et al. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited. Accessed November 18, 2011.

**Received:** May 16, 2011; **Accepted:** August 14, 2011; **Published:** September 16, 2011

**Funding:** This work was supported by National Institutes of Health (NS047537), Google.org, Department of Defense, and Cure Autism Now (CAN). The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

**Competing interests:** The authors have declared that no competing interests exist.





Marley Peale Braun, MS

## Student Corner . . . .

### On Your Own: Advice for Starting a Nutrition Practice

By Marley Peale Braun, MS

Thinking of establishing your own nutrition-based practice? Scarlett Ramey, MS, RD of Ramey Nutrition in Seattle, WA has some advice. Scarlett and her team specialize in the treatment of eating disorders and managing type 2 diabetes. With a unique perspective and client-driven methods, these practitioners have been able to grow a small private practice into a thriving and scalable business.

Scarlett Ramey dreamed of becoming a veterinarian, but life events led her in a different direction, and instead she pursued dietetics. Although she enjoyed the science behind nutrition, food wasn't her passion. It wasn't until Ramey worked at a treatment center for eating disorders that she finally found her niche. She recognized that patients with eating disorders share many of the same symptoms that she had seen in sick animals, such as fear, no desire to eat, and a reluctance to trust caregivers. It was then that she realized the profound impact that could be made by gaining the trust of her patients, a skill that she had actually developed in veterinary sciences. Working with this population re-ignited Ramey's passion for care, it wasn't long after applying this realization that her private practice prospered into a successful business.

According to Ramey there are many factors to having a successful nutrition-based business and plenty of mistakes to learn from along the way. Here are some of her suggestions:

**Find something that you believe in and go for it 100%.** If you don't want to work in a hospital because you don't believe in that type of care, then what do you believe in? Figure that out, and you have a business! Ramey's belief was that if she could focus on getting her patients to trust her and open up emotionally, then the challenges related to food would unravel naturally. Her goal was to develop a therapeutic practice that empowered clients to self-heal. Ramey found that these principles can not only be utilized with patients with eating disorders, but also with the management of type 2 diabetes and other medical conditions.

**If your goal or belief goes against conventional wisdom, go with your gut and take risks!** Ramey says that her practice of unstructured therapy and a lack of prescribed meal plans goes against typical treatment for eating disorders. These methods may be unconventional or rebellious to some, but taking risks is part of thinking and acting outside of the box. Setting yourself apart from the pack can contribute to success.

**Staff your office with intelligent, creative people, and listen to their ideas.** Ramey's team consists of several people who help her business diversify and flourish. Shena Washburn, RD, CD is her lead nutrition counselor for eating disorders and approaches treatment with an instinctual eating philosophy. Ramey Nutrition also staffs instructors who teach body awareness, yoga, and fitness on-site in a non-mirrored environment. Ramey says the current treatment schedule of individual, group, and family therapy will soon include a dinner group, with plans underway for an on-site kitchen.

**Consider a private practice versus a company, and decide which you want to pursue.** There's no ceiling of growth at a company, but in a private practice you may have to turn patients away. Ramey says that many people make their private practice businesses viable because they supplement with part-time employment elsewhere.

**Stay current and connected.** Being a member of a Dietetic Practice Group, such as Behavioral Health Nutrition or Nutrition Entrepreneurs, or a local chapter of the American Dietetic Association can help with referrals, networking, and staying current within your field. The day I spoke to Ramey she was preparing to attend an eating disorder conference in Colorado.

Being an innovator in the field of dietetics isn't an easy job, but Ramey says that "If you stay committed to helping your clients, you can't go wrong."

Good luck to everyone on all your future endeavors!

## Research Toolkit Now Available Online, Development Supported by BHN

Are you interested in the latest dietetic research but not sure how to interpret the published data or apply the results to your practice? Do you want to collect outcomes data, but don't know how to get started? A new online Research Toolkit, developed by ADA's Research Committee is available free of charge to ADA members at <https://www.adaevidencelibrary.com/store.cfm?category=13&auth=1>. In addition to providing you with essential information on understanding and conducting research, continuing education credits are available for some topics.

The Toolkit consists of eight content topic areas. Each topic includes text that summarizes important learning points, PowerPoint presentations, practice exercises to reinforce learning, and links to nutrition and dietetics research articles that illustrate content learning objectives. The eight content topics areas will help you:

- Find research that relates to areas of interest
- Critically appraise an article
- Evaluate whether the study design is suitable to answer the research question and test the hypothesis (2.5 CPEs)
- Interpret statistics and determine whether they are appropriately utilized in the study (3 CPEs)
- Apply research to practice
- Determine the first step in a research project
- Develop a good research question with a testable hypothesis (1 CPE)
- Write a research grant

The Research Committee would like to acknowledge the generous financial contributions of the Research, Pediatric, Renal, Weight Management and Behavioral Health Nutrition Dietetic Practice Groups that, in part, made this resource possible.

For more information contact Donna G. Pertel, MEd, RD - American Dietetic Association - NCP Business Manager and Consultant - [ncpslpermissions@eatright.org](mailto:ncpslpermissions@eatright.org) - 203-314-9462 - 312-899-5344 fax

## In Search of Evidence . . .

1. <http://www.ncbi.nlm.nih.gov/pubmed/19558661>

Poloni N, Vender S, Bolla E, et al. **Gluten encephalopathy with psychiatric onset: Case report.** *Clin Pract Epidemiol Ment Health.* 2009; 26(5):16. An open access article.

Many cases of coeliac disease, a gastrointestinal autoimmune disorder caused by sensitivity to gluten, can remain in a subclinical stage or undiagnosed. In a significant proportion of cases (10– 15%) gluten intolerance can be associated with central or peripheral nervous system and psychiatric disorders. A 38-year-old man was admitted for worsening anxiety symptoms and behavioural alterations. After addition of second generation antipsychotic and worsening of his neuropsychiatric conditions, including a frontal cognitive deficit, bradykinesia and difficulty walking, dysphagia, anorexia and hypoferraemic anaemia, extensive laboratory investigations gave positive results for anti-gliadin antibodies, and an appropriate diet led to a progressive remission of the encephalopathy.

2. <http://www.medscape.com/viewarticle/750288?src=ptalk> Posted: 09/28/2011

Leiberman, Jeffrey A. M.D., of Columbia University, **Psychiatric Diagnosis in the Lab: How Far Off Are We?**

“ . . . when it was initiated we anticipated that this iteration of the DSM would incorporate biological markers and laboratory-based test results to augment the historical and phenomenologic criteria that traditionally are used to establish psychiatric diagnoses. Sadly, this has proved to be beyond the reach of the current level of evidence for incorporating into this version of the DSM. . . ”

“ . . . The tests that appear to be emerging as the first to be marketed are ones that are based on the proteomic or metabolomic or biochemical analyses of plasma or cerebrospinal fluid. . . . A second modality that is likely to be implemented for psychiatric diagnosis is that of imaging techniques; here we're talking about both nuclear medicine imaging with PET and MR imaging with either structural,

spectroscopic, or functional imaging applications . . . Finally, genetic testing will also come into play. . . ”

“ . . . in the not-too-distant future, psychiatry will have laboratory-based methods to assist in our diagnoses. This should be an enormous benefit to our field in terms of enhancing the validity and precision of our diagnosis as well as elevating the scientific quality of clinical practice for the benefit of our patients.”

3. <http://www.ncbi.nlm.nih.gov/pubmed/21787433>

Fogaça MN, Santos-Galduróz RF, Eserian JK, Galduróz JC. **The effects of polyunsaturated fatty acids in alcohol dependence treatment--a double-blind, placebo-controlled pilot study.** *BMC Clin Pharmacol.* 2011;11:10.

The lipid fraction of cell membranes consists of polyunsaturated fatty acids (PUFAS), and chronic alcohol use alters it, modifying its permeability, what might contribute for the dysfunctional metabolism observed in the central nervous system of alcohol dependent patients. Eighty patients were divided into four groups of 20 in each group. . The oral supplementation of 2 g PUFAS for 3 months did not significantly differ from placebo in reducing the amount of alcohol ingestion, or OCDs and SADD scores in a group of alcohol dependent patient.

4. <http://www.ncbi.nlm.nih.gov/pubmed/21865568>

Fulgoni VL 3rd, Keast DR, Bailey RL, Dwyer J. **Foods, fortificants, and supplements: where do americans get their nutrients?** *J Nutr.* 2011 Oct;141(10):1847-54. Epub 2011 Aug 24; Free PMC Article

Data from NHANES 2003-2006 (n = 16,110). showed only a small percentage of the population had total usual intakes (from dietary intakes and supplements) below the estimated average requirement (EAR) for the following:

vitamin B-6 (8%), folate (8%), zinc (8%), thiamin, riboflavin, niacin, vitamin B-12, phosphorus, iron, copper, and selenium (<6% for all).

However, more of the population had total usual intakes below the EAR for vitamins A (34%), C (25%), D (70%), and E (60%) , calcium (38%), and magnesium (45%). Only 3 and 35% had total usual intakes of potassium and vitamin K. Enrichment and/or fortification largely contributed to intakes of vitamins A, C, and D, thiamin, iron, and folate. Intakes greater than the UL for niacin (10.3 %) and zinc (8.4%) was found. Without enrichment and/or fortification and supplementation, many Americans did not achieve the recommended micronutrient intake levels set forth in the Dietary Reference Intake.

5. <http://www.ncbi.nlm.nih.gov/pubmed/21840465>

Kałużna-Czaplińska J, Socha E, Rynkowski J. **B vitamin supplementation reduces excretion of urinary dicarboxylic acids in autistic children.** *Nutr Res.* 2011;31(7):497-502.

Urinary dicarboxylic acids are connected with energy production, intestinal dysbiosis, and nutritional individuality in autistic children. With the hypothesis that vitamin B2, vitamin B6, and magnesium supplementation is effective in reducing the level of dicarboxylic acids in the urine of autistic children , investigators investigated the levels of succinic, adipic, and suberic acids in the urine of autistic children before and after vitamin supplementation.

Thirty children with autism received magnesium (daily dose, 200 mg), vitamin B6 (pyridoxine; daily dose, 500 mg), and vitamin B2 (riboflavin; daily dose, 20 mg) for a period of 3 months. (See table below.)

Compiled by Ruth Leyse-Wallace, PhD, RD  
San Diego, California, email: rthlys@cox.net

Dicarboxylic Acid	Before supplementation	After supplementation
Succinic, acid	41.47 ± 50.40 µmol/mmol creatinine	9.90 ± 8.26 µmol/mmol creatinine
Adipic acid	15.61 ± 15.31 µmol/mmol creatinine	2.92 ± 2.41 µmol/mmol creatinine
Suberic acid	15.61 ± 15.31 µmol/mmol creatinine	2.57 ± 3.53 µmol/mmol creatinine

## “Cook for Life” Photo by VA RD wins JADA Contest and Promotes Hands-on Nutrition Education

The winning photo for the 2011 *JADA* (*Journal of the American Dietetic Association*) cover photo contest is “Hands-on Nutrition Education” by Renée Hoffinger, MHSE, RD, LD, of the North Florida/South Florida Veterans Health System in Gainesville, FL. The photo will appear on the cover of the July 2012 issue of the *Journal of the Academy of Nutrition and Dietetics* (*J Acad Nutr Diet*, formerly *JADA*), as well as in the 2013 *J Acad Nutr Diet* calendar. To see the photo, follow this link: <http://www.adajournal.org/web/files/images/journals/yjada/winners.pdf>

The photo, inspired by 13 years of cooking with Veterans and the recent launch of a new “Cook For Life” series with outpatients at the Gainesville, Florida division, as well as the national VA NFS “Healthy Kitchens” initiative, aimed to highlight the importance of this “emerging trend” in dietetics.

In a statement submitted with the photo, Renée wrote: “Hands-on nutrition education is the wave of the future for RDs and those they serve. Rubbing elbows with clients in the kitchen helps to demystify those diet orders, translate theory into practice, and provides opportunities to taste new foods

in a non-judgmental, supportive, fun atmosphere. This does wonders for the therapeutic relationship, overcomes resistance, increases motivation and self-efficacy, while literally internalizing the lessons, all resulting in greatly improved outcomes.

At the North Florida/South Georgia Veterans Health System we have been conducting hands-on cooking classes with residents in rehab for substance abuse for over 13 years. Participants are shown in this photo with ingredients (the center piece is a lemon cucumber from a friend’s garden), and dishes cooked up in class, including “peachy quinoa” and “vegetable variety”.

The concept of a mandala of hands, food, and utensils came to Renée while vacationing this past summer. When she returned to work, the photo took at least three photo shoot sessions and multiple patient Veteran volunteer hand models to complete. Although a former stickler and “analog” holdout, Renée admits to some minor digital fixes: the tablecloth wrinkles were retouched out and the wooden spatula was resized to improve design. A framed copy of the Cook for Life mandala hangs in the residents’ group room and is a source of pride

and reminder to the Veterans of the vital role of nutrition in healthy recovery.

The *JADA* cover photo contest was launched in 2009 as a way to connect members with their journal. Each year members are invited to submit photos depicting any area of food and nutrition. This year (2011), 66 qualifying photos were submitted. Initial judging by a panel of ADA Staff, Representative Members, and Publisher’s staff rating each photo on a list of criteria such as impact, creativity, and technical quality narrowed the field down to 12 finalists. The winning photos were chosen by members who visited and voted at the *JADA* booth at FNCE 2011 in San Diego. Keep an eye on The Academy member newsletters and the *J Acad Nutr Diet* website for information about the next annual photo contest.

**Renée Hoffinger, MHSE, RD, LD** is the BHN 2008 award recipient for Excellence in Practice in Addictions and currently serves as the Resource Professional in Addictions, one of four practice areas of BHN.

Congratulation Renée from your BHN friends!

**eat right.**™ American Dietetic Association

## New Name, Same Commitment to the Public’s Nutritional Health

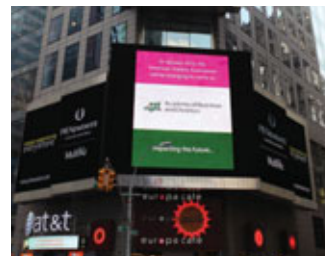
In January 2012, the American Dietetic Association will be changing its name to:

**eat right.**® Academy of Nutrition and Dietetics

*The Academy of Nutrition and Dietetics quickly and accurately communicates our identity – who we are and what we do.*

*The Academy of Nutrition and Dietetics is the right name. And this is the right time.*

Sylvia A. Escott-Stump, MA, RD, LDN  
ADA President 2011-2012



For more information on this exciting news, visit [www.eatright.org/Members/namechange](http://www.eatright.org/Members/namechange)

# Behavioral Health Nutrition Dietetic Practice Group Annual Report • 2010-2011

## **BHN: Setting the Standard for Nutrition in Behavioral Health Care**

It was a privilege to serve as Chair for the Behavioral Health Nutrition (BHN) Dietetic Practice Group for membership year 2010-2011. During this year, we accomplished much and made definite progress toward meeting the goals of BHN's strategic plan. Through the efforts of many, BHN made strides in meeting our vision, which is to "Impact the nutrition of the behavioral health populations we serve."

While it is impossible to include all of the efforts of the BHN Executive Committee (EC) and members, I have attempted to summarize the many ways in which we have worked toward our goals. I will first highlight our Strategic Plan progress and then will provide more general highlights from membership year 2010-2011.

### **2010-2011 Strategic Plan Progress**

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

#### **Strategies**

1. Establish Registered Dietitians as preferred providers of behavioral health nutrition services mandated/paid for by government entities by 2014.

#### **Tactical highlights met in 2010-2011:**

- The Chair and Public Policy Liaison continued to investigate potential opportunities to highlight the services and skill set of the Registered Dietitian to regulatory and accreditation agencies.
2. Establish eight strategic alliances after identifying opportunities for BHN Registered Dietitians to collaborate with other Behavioral Health organizations and broaden system of publication by 2014.

#### **Tactical highlights met in 2010-2011:**

- A new Public Relations Director was appointed.
  - BHN members promoted BHN at regional and local behavioral health meetings.
  - Sponsorship template revised.
3. Introduce BHN to one health care professional organization per year (i.e. nurses/practitioners, MDs, PAs, OTs, etc.)

#### **Tactical highlights met in 2010-2011:**

- Webinar coordinator, Chair, Public Relations Chair continued to investigate what type of podcast would best promote the BHN Registered Dietitian.

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

#### **Tactical highlights met in 2010-2011:**

- EC members were encouraged to seek out potential sponsors. Sponsorship income remained stable.
5. Introduce/Expose 10 didactic programs for dietetic students to Behavioral Health Nutrition each year.

#### **Tactical highlights met in 2010-2011:**

- Student newsletter editor submitted articles to the Student Scoop.
- Provided publications to didactic programs at discounted pricing.

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

#### **Strategies**

1. Electronic Mailing List (EML) membership will increase to 50% in 5 years.

#### **Tactical highlights met in 2010-2011:**

- BHN EML advertised on website, in welcome letter, and on Facebook page.
  - EML participation increased 30% this year.
2. Increase member participation through volunteerism.

#### **Tactical highlights met in 2010-2011:**

- Volunteer Coordinator now a permanent role within the Nominating Committee.
  - Volunteer Coordinator contacted members wishing to be involved in BHN via telephone interview.
  - All EC members forwarded names of BHN members wishing to be involved to the appropriate EC Chair.
  - Opportunities for volunteering were posted in the newsletter, website, EML, Facebook, and Twitter.
3. Behavioral Health Nutrition DPG is viewed as creating the future of behavioral health nutrition practice.

#### **Tactical highlights met in 2010-2011:**

- Produced webinars that incorporated knowledge for each of BHNs four practice areas.
4. Increase membership by 10%.

#### **Tactical highlights met in 2010-2011:**

- BHN participated in the DPG/MIG showcase at FNCE.
  - Increased membership to 1485 (~8.3% increase from 2009-2010)
5. At least 10% of membership will participate in BHN educational opportunities to increase expertise in behavioral health nutrition.

#### **Tactical highlights met in 2010-2011:**

- Continued to offer 1 CPEU for participation in live webinars.
- Produced three live webinars with a recording of each via the website that included all four practice areas.
- Advertised educational opportunities in the newsletter, on the website, EML, Facebook, and Twitter.
- Published educational articles in all four practice areas in the newsletters.
- 133 members participated in live webinars (~9%).
- 161 members purchased publications, recorded webinars and mp3 recordings for further educational opportunities (~10.8%).
- Total members participating in educational opportunities was ~19.8%.

6. Increase student participation by 10% annually.

#### **Tactical highlights met in 2010-2011:**

- The "Student Corner" in the BHN newsletter was published in all newsletters.
- BHN members encouraged to become student preceptors.
- BHN approved three student surveys for distribution on the EML.
- Increased student membership to 208 (~17.5% increase from last year.)

### **Additional Highlights from 2010-2011**

#### **Publications**

- Thanks to the dedication of Newsletter Editor, Diane Spear, MS, RD, LD and all of our member contributors, four wonderful newsletters were published. In an attempt to decrease costs, all newsletters were published and sent electronically.
- The *BHN Newsletter* now offers members one-time free opportunity to advertise their product or service when an article is submitted and published.
- Sales of BHN Publications continue to do well:
  - *Psychiatric Nutrition Therapy: A Resource Guide for Dietetic*

## BHN Anual Report

Continued from page 12

- *Professionals Practicing Behavioral Health Care* (CD Rom) - 61 sold 2010-2011
- *The Adult with Intellectual and Developmental Disabilities: A Resource Tool for Nutrition Professionals* (CD Rom) – 39 sold 2010-2011
- *Nutrition and Addiction* (Book) – 22 sold 2010-2011
- *Children with Special Health Care Needs, Pocket Guide for RDs* in process of being updated in collaboration with PNPg DPG. Thanks to Andrea Shotton, MS, RD, LDN for her hard work.
- Completion of the *Standards of Practice and Standards of Professional Performance (SOP/SOPP) in Disordered Eating and Eating Disorders* thanks to Mary Tholking, MEd, RD, LD and her team including Amanda Mellowspring, MS, RD, CEDRD, LD/N; Suzanne Girard Eberle, MS, RD, CSSD; Roberta Pearle Lamb, MPH, RD, LD; Eileen Stelfelson Myers, MPH, RD, LDN, FADA; Christina Scribner, MS, RD, CSSD; Reba Faye Sloan, MPH, RD, FAED; Karen Balnicki Wetherall, MS, RD, LDN.
- Significant progress toward the completion of the SOP/SOPP for IDD.
- Updated the advertising prospectus.
- BHN members have participated in the development of a section on Adults with IDD for ADA's Nutrition Care Manual.

### Member Services

- Posted leadership openings on the EML, website, Facebook, Twitter, and in the newsletter providing members with many opportunities to serve.
- Resource professionals continued to respond to e-mails, phone calls, and EML inquiries.
- Member networking was strong via EML, Facebook, and Twitter.
- Distinguished Member Award presented to Ruth Ann Foiles Brunet, MPA, RD; Excellence in Practice – Eating Disorders ~ Karen

Wetherall, MS, LDN, RD; Excellence in Practice – Addictions ~ Lisa Beckley Barrett, RD; Excellence in Practice – Mental Illness ~ Marilyn Ricci, MS, RD; Excellence in Practice – Intellectual and Developmental Disabilities ~ Joan Guthrie Medlen, RD, MED.

- Hosted member reception at FNCE.
- Awarded three Speaker Stipends to Jessica Setnick, MS, RD, CSSD, LD, Betty Lucas, CD, MPH, RD, and Beth Ogata, MS, CD, RD, CSP to subsidize cost of presentation in BHNs practice areas.
- Several member generated surveys were approved and conducted via the EML.

### Meetings

- Reached over 750 ADA members at the BHN coordinated FNCE 2010 priority session: Overcoming Obstacles in Eating Disorder Treatment presented by Dina Cabrera, PsyD, and Debra Johnston, RD. The quality of the session was rated 4.27 (Average of all = 3.95).
- Members donated books and resources to the ADAF Silent Auction for FNCE 2010.
- Volunteer leader Sharon Lemons, MS, RD, LD honed leadership skills at the Leadership Institute.
- Cinde Rutkowski, MA, RD, FADA represented BHN at the ADA Public Policy Workshop.
- Leslie Schilling, MA, RD, CSSD, LDN represented BHN as our House Delegate.

I offer my many thanks to all who have volunteered their services to BHN during 2010-2011. It has been a wonderful year and I am confident that incoming Chair, Charlotte Caperton-Kilburn, MS, RD, CSSD, LDN is continuing to lead us toward accomplishing our goals.

*Respectfully Submitted,*

*Kathryn Russell, MS, RD*

*2010-2011 Chair, Behavioral Health Nutrition DPG*

## BHN May 2010 Financial Report

BHN 5/31/2011	MONTH 12 ACTUAL	MONTH 12 BUDGETED	VARIANCE AMOUNT FROM BUDGET	YTD 12 ACTUAL	YTD 12 BUDGETED	VARIANCE AMOUNT FROM BUDGET
<b>REVENUE</b>						
MEMBERSHIP DUES	2,993	2,630	363	33,244	31,560	1,684
MEETING REGISTRATION FEES	1,747	0	1,747	6,782	0	6,782
PUBLICATION SALES	0	313	(313)	1,507	3,756	(2,249)
ROYALTIES	0	0	0	0	0	0
ADVERTISING	0	0	0	700	0	700
GRANTS/CONTRACTS	0	0	0	0	0	0
MISCELLANEOUS RECEIPTS	0	2,000	(2,000)	0	10,000	(10,000)
INTEREST INCOME	(207)	0	(207)	5,612	0	5,612
<b>TOTAL</b>	<b>4,532</b>	<b>4,943</b>	<b>(411)</b>	<b>47,844</b>	<b>45,316</b>	<b>2,528</b>
<b>EXPENSES</b>						
PUBLICATIONS	0	0	0	0	0	0
LODGING	0	2,000	(2,000)	4,200	7,125	(2,925)
SUBSISTENCE	1,181	1,710	(529)	2,695	4,139	(1,444)
TRANSPORTATION	467	5,334	(4,867)	8,912	11,334	(2,422)
PROFESSIONAL CONSULTING	0	0	0	520	0	520
POSTAGE	23	32	(9)	803	784	19
TELECONFERENCE EXPENSE	11	13	(2)	101	216	(115)
DEPRECIATION	0	0	0	0	700	(700)
OTHER EXPENSES	84	400	(316)	2,420	2,788	(368)
MEMB DUES/SEMIAR FEES	0	1,038	(1,038)	0	1,038	(1,038)
CREDIT CARD FEE	156	44	112	975	528	447
OUTSIDE SERVICES	767	451	316	2,672	6,612	(3,941)
HONORARIUMS/AWARDS	0	150	(150)	1,659	1,250	409
AUDIO VISUAL	0	0	0	226	600	(374)
FOOD SERVICE	0	0	0	2,322	1,850	472
PRINTING /COPYING	941	0	941	6,208	7,900	(1,692)
WORD PROCESSING	0	0	0	400	0	400
<b>TOTAL</b>	<b>3,629</b>	<b>11,172</b>	<b>(7,543)</b>	<b>34,112</b>	<b>46,864</b>	<b>(12,752)</b>
<b>EXCESS (DEFICIT)</b>	<b>904</b>	<b>(6,229)</b>	<b>7,133</b>	<b>13,732</b>	<b>(1,548)</b>	<b>15,280</b>

## BHN Awards September, 2011

By Kathryn Russell, MS, RD – Past Chair

How fortunate BHN is to have such an abundance of members from which to choose for the annual awards! To me, having the opportunity to select the awardees is the best job requirement of being a past chair of our practice group. Talking to these wonderful leaders, pioneers, champions, and advocates was such a privilege.

The 2010-2011 Awardees are:

### **Distinguished Member**

#### **Ruth Ann Foiles Brunet, MPA, RD**

Ruth Ann Foiles Brunet has been an active member in BHN (formerly DDPD) since 1979. She has served as chair of the practice group at least twice and has been active on various committees throughout her years in the group. Ruth Ann has spent her career and now her retirement as an advocate for persons with disability. She has worked in the areas of IDD and Mental Health. She spent several years as the Chief Dietetic Consultant for the Michigan Department of Mental Health where she was a mentor and resource for the other dietitians working throughout the state in psychiatric hospitals and centers for the developmentally disabled. While employed in Michigan, Ruth Ann developed and implemented nutrition and food service "Rules and Regulations in Community Based Facilities." Her knowledge was also shared in the DDPD Toolbox of which she was co-editor. It is with much honor and respect that the Distinguished Member award is presented to Ruth Ann Foiles Brunet.

### **Excellence in Practice – Intellectual and Developmental Disability**

#### **Joan Guthrie Medlen, M Ed, RD**

To say that Joan Medlen works with passion in the area of IDD would be an understatement! Joan is currently self-employed as the owner of Phronesis Publishing and as a nutrition and lifestyle coach for persons with and without developmental disabilities. She has to her credit many publications, presentations, and awards. In 2009 she was the recipient



Karen Wetherall, MS, RD, LDN (left), Marilyn Ricci, MS, RD (center), and Joan Guthrie Medlen, MEd, RD, LD (right); not pictured) Lisa Beckley Barrett, RD, and Ruth Ann Foiles Brunet MPA, RD.

of the Exceptional Meritorious Service Award from the National Down Syndrome Congress. Joan is a frequent poster on BHN's e-mail forum and provides information that we can all use, regardless of our area of practice. Joan was also part of the team that developed the SOP/SOPP for Dietitians working in IDD and the BHN Resource Manual for IDD. The award for Excellence in Practice for Intellectual and Developmental Disability is given to a most deserving Joan Guthrie Medlen.

### **Excellence in Practice**

#### **– Eating Disorders**

#### **Karen Wetherall, MS, RD, LDN**

Karen Wetherall has an extensive history in the area of Eating Disorders. She has been an active committee member developing the SOP/SOPP for eating disorders that was published in the August, 2011 JADA. She is currently the BHN Resource Professional for Eating Disorders and the Publications Chair. For the past 17 years Karen has been the Dietetic Internship Director at the University of Tennessee in Knoxville training over 130 dietetic interns about eating disorder assessment and treatment. Karen has a passion for educating others about enjoy-

ing food and movement. She supports self-care of a healthy mind, body, and spirit. Karen has made numerous contributions to the prevention and treatment of eating disorders and is very deserving of BHN's Excellence in Practice award.

### **Excellence in Practice – Mental Illness**

#### **Marilyn Ricci, MS, RD**

Marilyn Ricci has made it her business to place emphasis on nutrition and mental illness. Throughout her career Marilyn's work has included BHN's areas of practice. She is currently working as a consultant dietitian and a SAMSHA Grant Consultant. She has developed and facilitated nutrition trainings with peer mentors, nurse case managers, and case clinicians for three mental health facilities.

Marilyn is a volunteer on the NAMI National Board and has a long history with NAMI. To her credit are many publications and presentations regarding nutrition and mental illness. Marilyn is a true advocate for persons with mental illness and BHN recognizes her contributions with this award for Excellence in Practice.

### **Excellence in Practice – Addictions**

#### **Lisa Beckley-Barrett**

Addictions is an area that very few call their area of practice and yet we all deal with in some ways. Lisa Beckley-Barrett has devoted much of her career to working in the area of nutrition and addictions. Lisa is a long time member of BHN and has served our practice group in a variety of roles. Many of you may have completed the CE program that Lisa wrote: "Diet, Addiction, and Recovery." For her contributions to both patients and professionals BHN awards Lisa Beckley-Barrett the Excellence in Practice award in addictions.

As you walk away from this article, think about who you would like to nominate for the 2012 awards! Nomination forms are available in the member only section of the BHN website at [www.bhndpg.org](http://www.bhndpg.org).

Recognition is given to the many BHN officers, executive committee and DPG members for making BHN's Member Reception and Awards a great success. A look at the evening activities, members and memories are available on the BHN website at [www.bhndpg.org](http://www.bhndpg.org).

## In the BHN Pipeline!

Renée Hoffinger, MHSE, RD, LD, BHN's resource professional for addictions, has written ***The Recovery Diet***, due to be published by Adams Media in January 2012. The book is essentially a practical nutrition handbook for people at any stage of recovery from alcoholism (although definitely applicable to other chemical addictions, too). A distillation of Renée's 18 years of working with Veterans in recovery, the book's premise is that what you eat is vital to staying in recovery and giving you the best shot at many more healthy years while in recovery. Written in a personable, accessible, and empowering style, *The Recovery Diet* takes the reader through the damage wrought by alcohol, the goals of diet in recovery, how to optimize health via diet in the face of medical concerns common to those in recovery, as well as practical strategies for "putting it all together in the kitchen", complete with 12 weeks of menus including two new recipes for each day. Sidebars attempt to address many of the questions posed by those in recovery: "Doesn't the alcohol burn off during cooking?" "Are there foods that are good for sex?" "How can I eat well on a budget?" "How do I build muscle mass?" "What do all the numbers mean when I get my cholesterol checked?" "Is there anything I can do to heal my liver?" and so on.

*The Recovery Diet* can serve as a good primer for dietitians new to the specialty of substance abuse. It covers all the basics

and places diet in the overall healthy sober lifestyle package. The chapters can be used as class modules, sections as springboards for discussion in recovery groups. For any RD wanting to branch out into hands-on nutrition education (aka "Food Rehab"), *The Recovery Diet* can be an inspiration and practical guide. It is replete with the nuts and bolts of food shopping, setting up a kitchen, menu planning, and healthy cooking. The recipes focus on nutrient-dense, low fat, minimally processed foods with a variety of colors, textures, and tastes with realistic time frames for preparation. Non-plant based recipes include suggestions for preparing a vegetarian version when feasible.

And of course, *The Recovery Diet* is an excellent book to recommend to people in recovery to reinforce whatever level of nutrition counseling you are able to provide. The 12 weeks of menus are presented as inspirational signposts but for those who prefer a strict road map it is detailed and long enough to get them through difficult terrain.

*The Recovery Diet: A Groundbreaking, Scientific Approach to a Healthy Life While Recovering from Alcoholism* will be available in both book and electronic (Kindle) form. It is already available for pre-order from several on-line bookstores, in the U.S. and abroad, and can be ordered through local bookstores, as well.

## BHN would like to feature you in BHNewsletter!

Whether it's your unique product or service, or a recent recognition, please send highlights to Milton Stokes at [miltonbhn@yahoo.com](mailto:miltonbhn@yahoo.com). News will be considered for follow up interviews and possible inclusion in the column In the BHN Pipeline.

## Legislative Link

Cinde Rutkowski, MA, RD  
BHN Public Policy Liaison

The Academy of Nutrition and Dietetics continues to be active in lobbying Congress to communicate the Food & Nutrition issues important to its membership. The Academy's priorities in the 112th Congress include:

- **The Preventing Diabetes in Medicare Act** – This bill would authorize reimbursement to Registered Dietitians for Medical Nutrition Therapy services to clients with Pre-Diabetes.
- **The Preserving Access to Life-Saving Medication Act** – This bill increases the authority of FDA to monitor potential medication shortages. Currently there is no defined time frame for alerting medical providers and patients of anticipated medication shortages.
- **The Access to Frontline Care Act** – This bill offers college tuition assistance to medical professionals, including Registered Dietitians, who practice for a minimum of 2 years in an underserved area after graduation.

- **The National Diabetes Clinical Care Commission Act** – This bill would create a Commission of agencies involved in Diabetes care to improve quality of care by compiling resources.
- **The White House Conference on Food and Nutrition Act** – This bill would establish a White House Conference on Food and Nutrition to develop hunger fighting tools to improve nutritional health in the United States.

### What we can do:

- Read the *Eat Right Weekly* policy update notices at <http://www.eatright.org/publications/eatrightweekly/Default.aspx>
- Contact The Academy DC office with your questions at [adapac@eatright.org](mailto:adapac@eatright.org); <http://www.eatright.org/ADAPAC/content.aspx?id=7644>
- Inform your legislators of the importance of the above, <http://www.eatright.org/members/actioncenter.aspx>

# BHN: Setting the Standard for Nutrition in Behavioral Healthcare

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

**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

**Goals:** 1. The public recognizes, trusts, and chooses our members as the experts in behavioral health nutrition.  
2. Members and prospective members view BHN as essential to their professional success.

**Academy of Nutrition and Dietetics website:** <http://www.eatright.org>

**BHN website:** <http://bhndpg.org>

**BHN practice standards:** <http://bhndpg.org/moa/practice/index.asp>

## Behavioral Health Nutrition Executive Officers 2011-2012

### Chair

*Charlotte Caperton-Kilburn, MS, RD, CSSD, LDN*  
South Carolina 901/409-4411  
[nflperformance@yahoo.com](mailto:nflperformance@yahoo.com)

### Chair-Elect

*Therese Shumaker, MS, RD, LD*  
Minnesota 507/281-8047  
[shumaker.therese@mayo.edu](mailto:shumaker.therese@mayo.edu)

### Past-Chair

*Kathy Russell, MS, RD*  
Michigan 734/635-7771  
[katerussrd@yahoo.com](mailto:katerussrd@yahoo.com)

### Treasurer

*Cary Krutzer, MPH, RD*  
California 323/361-3830  
[CKrutzer@chla.usc.edu](mailto:CKrutzer@chla.usc.edu)

### Secretary

*Charlene Dubois, MPA, RD*  
Michigan 616/895-5021  
[climoge@hotmail.com](mailto:climoge@hotmail.com)

### Nominating Committee Chair

*Patricia Novak, MPH, RD*  
California 818/645-1093  
[PatriciaNovakRD@gmail.com](mailto:PatriciaNovakRD@gmail.com)

### Membership Chair

*Milton Stokes MPH, RD, CDN*  
Connecticut 917/697-7614  
[miltonstokes@gmail.com](mailto:miltonstokes@gmail.com)

### Publications Chair

*Karen Wetherall, MS, RD, LDN*  
Tennessee 865/974-6256  
[kbalnick@utk.edu](mailto:kbalnick@utk.edu)

### Public Relations Director

*Adrien Paczosa, RD, LD*  
Texas 512/547-9274  
[adrien@LiveWellNutritionTherapy.com](mailto:adrien@LiveWellNutritionTherapy.com)

### DPG Delegate:

*Leslie P. Schilling, MA, RD, CSSD, LDN*  
Tennessee 901/758-8103  
[leslie@schillingnutrition.com](mailto:leslie@schillingnutrition.com)

### Manager, DPG/MIG Relations:

*Mya Jones*  
Academy of Nutrition and Dietetics  
312/899-4852  
[mjones@eatright.org](mailto:mjones@eatright.org)

### Resource Professionals Addictions

*Renee Hoffingeer, RD*  
Florida 352/374-4478  
[hofuman@bellsouth.net](mailto:hofuman@bellsouth.net)

### Eating Disorders

*Karen Wetherall, MS, RD, LDN*  
Tennessee 865/974-6256  
[kbalnick@utk.edu](mailto:kbalnick@utk.edu)

### Intellectual and Developmental Disabilities

*Melody Rankin, RD, LD*  
Oklahoma 405/414-4424  
[mrankinrd@gmail.com](mailto:mrankinrd@gmail.com)

### Mental Illness

*Linda Venning, MS, RD*  
Michigan 248/735-6711  
[jvenning@twmi.rr.com](mailto:jvenning@twmi.rr.com)

### Student Liaison

*Laura Steele*  
Kansas 816/6799748  
[laf.steele@gmail.com](mailto:laf.steele@gmail.com)

**A complete list of BHN Executive Committee members and volunteers is available at [www.bhndpg.org](http://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>**