Numerous drugs can adversely affect the oral cavity and dentition. Patients who develop oral problems will seek help and treatment from their dentist, pharmacist, or prescribing physician. These clinicians must work in collaboration in order to reverse or resolve the patient’s condition. It may be necessary to discontinue an agent if the oral effects are severe enough. While adverse effects to medications can affect anyone, it is important to recognize that elderly patients, or those with nutritional deficiencies, may be at increased risk for developing iatrogenic oral problems. Patients older than sixty-five years of age are often on multiple chronic medications in order to manage a number of medical conditions, such as diabetes mellitus, arthritis, congestive heart failure, and hypertension.

In order for the physician, pharmacist or dentist to properly assess and manage a patient, a complete medication history must be conducted. It is imperative inquiries be made not only about prescription medications, but also over-the-counter and herbal medication use. Drugs have the potential to affect the oral cavity in a number of ways and this continuing education lesson will specifically reflect on eight conditions. The conditions addressed herein include: xerostomia, intraoral hemorrhage, candidia albicans (oral thrush), gingival hyperplasia, taste changes, tooth discoloration, stomatitis, and ulceration or necrosis. Table 1 provides an overview of common medications and the associated dental or oral side effect. It is important that healthcare professionals understand the impact and severity that medications can have on the oral health of their patients.

**Xerostomia (dry mouth)**

Dryness of the mouth, or xerostomia, results from diminished secretions of saliva. More than 250 medications claim xerostomia as a side effect. Drugs that produce xerostomia as a side effect include anticholinergics, antidepressants, anti-Parkinson’s drugs, antihistamines/decongestants, urinary antispastics, antipsychotics, diuretics, hypnotics, systemic bronchodilators, muscle relaxants, reserpine, methyldopa, laxatives, beta-blockers, narcotics, guanabenz, and clonidine. A more comprehensive listing of drugs associated with dry mouth is shown in Table 2. Medications that produce xerostomia also may increase the incidence of root surface caries (cavities). Medications with significant anticholinergic activity, such as oxybutynin, hyoscyamine, and scopolamine (Table 2), have the potential to cause xerostomia.

Xerostomia is a common complaint of numerous dental patients, especially the elderly patients who take some of these medications on a regular basis for a prolonged period of time. In the absence of medication use in a patient with xerostomia, the dentist is also positioned to screen for medical disorders associated with dry mouth, such as diabetes mellitus. An in-depth review of the patient’s medication history should be conducted. Furthermore, a complete history and physical exam, and lab testing may be necessary to properly diagnosis and treat xerostomia. Upon examination patients with xerostomia may complain of generalized mouth soreness, dry mouth, painful or burning tongue, reduced denture retention, taste changes, difficulty in chewing, and problems with talking and swallowing. Clinical presentation of xerostomia includes oral fissuring, ulceration, and epithelial atrophy. Xerostomia is managed symptomatically by increasing the patient’s water intake, using saliva substitutes, and oral lubricants. Saliva stimulation is a way to manage xerostomia. The patient can be instructed to suck on grape or lemon sugarless gum or candies in order to increase saliva. It is known that the flow of saliva occurs during eating, so another way to increase saliva stimulation is by increasing the frequency of eating small meals. Finally, agents such as citric acid, neostigmine, and cholinergic agents such as pilocarpine and bethanechol can also be used to stimulate the flow of saliva.

**continued on page 3**
BHNewsletter is published quarterly (Winter, Spring, Summer, Fall) as a publication of Behavioral Health Nutrition, a dietetic practice group of the American Dietetic Association. The Spring and Fall issues are published electronically; members receive an email announcement and link for direct access. Newsletters are available on the BHN Website at www.bhndpg.org.

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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

Winter 2010 ...................... November 1, 2009
Spring 2010 ...................... February 1, 2010
Summer 2010 ...................... May 1, 2010

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From the Chair
Andrea D. Shotton, MS, RD

Behavioral Health Nutrition (BHN) Dietetic Practice Group continues to welcome new members each month. It is an exciting year and your membership enthusiasm has spread. Membership has already increased by 10% compared to this time last year. Thank you for your membership recruitment and your diligence in volunteerism for BHN.

Your volunteerism this year has also led to the development of two webinars for BHN members and more on the board as proposals:

- Binge Eating Disorder and Night Eating Syndrome was held on August 20th.
- Nutritional Interventions in Autism: The role of the RD was held on September 8, 2009.

Watch the website under the Education/Events tab and your email notifications for registration.

Proposed webinars:

- November 10, 2009  Addictions and Weight Management in Collaboration with the Weight Management DPG
- February 2, 2010  Nutrition and the Brain

We are excited to hear your comments on the year’s new strategic goals and are especially thrilled if you would like to participate in achieving our 5 year goals. One such goal focuses on members and prospective members to view BHN as essential to their professional success. A strategy to meet this goal is increasing member involvement. Please email volunteer coordinator from the Nominating Committee, Sharon Lemons, MS, RD, LD at slemons@prodigy.net who will match you with a project that is of interest to you. If you are interested in sponsoring or presenting one of the above proposed webinars, detail the information on your volunteerism email to the above addresses.

As BHN moves forward towards the Food & Nutrition Conference & Expo (FNCE) 2009 in Denver, many activities are available for our members. In addition to the FNCE activities, BHN will showcase members’ personal works/products in the Silent Auction. Please consider a product donation. Email donation ideas to ashotton@nutritionalvoices.com.

Remember, BHN is growing, not only in membership numbers, but also on the website, through webinars, student participation, publications, networking alliances, and much more to come in the next 5 years. We continue to look forward to an exciting year of progress towards our growth with you on board!

Your Chair,
Andrea D. Shotton

Are You Seeking a Great Opportunity?
BHN is offering the opportunity to get involved in the future of Behavioral Health Nutrition. If you want to advance skills in the following areas, now is the time!

Volunteers are needed immediately to fill new non-elected positions for:
- Website Editor
- Webinar Coordinator
- Sponsorship Chair

Nominations needed for the 2010 Officers are:
- Chair-Elect
- Secretary
- Nominating Committee

If you would like to volunteer yourself or another BHN Member, please contact Cary Kreutzer, MPH, RD, Nominating Committee Chair at ckreutzer@chla.usc.edu.

Deadline for officer nominations is October 26, 2009.
Intraoral Hemorrhage

Intraoral hemorrhage is another condition which can be drug-induced. Intraoral hemorrhage can be associated with numerous factors such as thrombocytopenia, defective vascular integrity, or alterations in coagulation. A majority of bleeding episodes occur as a result of a decrease in the number of platelets or thrombocytopenia. Numerous agents have been implicated to cause thrombocytopenia including sulfonamides, quinine, quindine, thiazide diuretics, allopurinol, methylodopa, antineoplastic agents, digitalis, heparin, phenytoin, coumadin, and gold salts. Numerous antibiotics such as cephalosporins, penicillin, and tetracyclines have also been associated with intraoral hemorrhage.

Certain patients are at increased risk for developing intraoral hemorrhage. Patients who have cardiovascular disease and are on long term aspirin therapy should be anticipated to have a reduction in platelet aggregation. Also patients who are on long term antibiotic therapy may have a reduction in synthesized vitamin K. Vitamin K is necessary for the production of clotting factors II, VII, IX, and X. Antibiotics reduce the intestinal flora's ability to synthesize vitamin K, which could cause potential oral hemorrhage problems with prolonged use. Alcohol also has the propensity to reduce platelet lifespan, which can lead to bleeding problems. Many patients may be stabilized on warfarin prophylaxis for treatment of venous thrombosis, pulmonary embolism, and thromboembolic disorders. Since warfarin interferes with hepatic synthesis of vitamin K dependent clotting factors, the international normalized ratio and prothrombin time must be closely monitored, especially in patients with perioral hemorrhage.

Thrombocytopenia clinically may present as petechiae, which are small round flat dark-red spots caused by bleeding beneath the mucous membranes. The petechiae in the mouth are most commonly found as very tiny bleeding points in the palatal mucosa. In order to diagnose drug induced thrombocytopenia, a platelet count, and medication history need to be conducted. To resolve the thrombocytopenia the dentist or pharmacist may need to contact the prescribing physician in order to discontinue the offending medication.

Dysguesia (taste changes)

Individuals taking any variety of medications may present with subjective complaints of taste changes. Patients may have complaints of a bitter, metallic, unpleasant or altered taste, "medication" taste, complete loss of taste, and decreased taste sensation. There are more than 200 drugs that have the potential to cause changes in taste sensations. Numerous drugs can cause taste changes including clarithromycin, captopril, enalapril, griseofulvin, penicillamine, metronidazole, carbencillin, chlorhexidine, diltiazem, chloral hydrate, gold salts, flecanide, lithium, vitamin D, and sulfasalazine. The most common complaint by patients taking medications is a sense of altered taste.

The mechanisms by which drugs affect the taste sensations vary. Researchers propose three mechanisms involved in medication taste disorders. First, there is the influence of saliva on taste, i.e. the drug itself may be secreted into the saliva, producing dysguesia. Another potential mechanism is the effect of drug metabolites that could possibly interact with taste buds or saliva. Finally, drugs may directly damage the taste buds. There may be age-related effects on taste that can enhance medication taste disorders. The dentist will likely do a complete medication history in patients that present with complaints of taste changes. Once the offending agent has been identified, patients are usually relieved just to know that the medication is the cause of the alteration in taste perception. Fortunately, many medications that cause taste disturbances, such as antibiotics, are only prescribed for a limited time period. However, some individuals may present with severe symptoms and may require a change in their chronic drug therapy (e.g. captopril).

Oral Candidiasis (thrust)

Candidiasis is the most common oral opportunistic infection seen in dental practices. Patients usually present with creamy, white plaques on the tongue and buccal mucosa. When scraped the lesions leave a red, painful ulcerated surface exposed. Immunosuppressed patients such as AIDS and cancer patients may be more susceptible to oral infections since they have defects in cell-mediated immunity. Immunosuppressed patients are more likely to develop complications from candidiasis, such as infection in the esophagus, ulcerations, mucosa perforation and invasive disease. Therefore, candidiasis has the capability to become life threatening in some immunocompromised patients.

Drugs either act locally or systemically to predispose patients to superinfection with Candida albicans. Broad spectrum antibiotics, antineoplastic agents (cancer chemotherapy), corticosteroids (including metered-dose inhalers), and immunosuppressive agents used to prevent rejection of transplant organs are all drugs which have the potential to produce oral candidiasis.

Patients who present with an early Candida infection usually have mild symptoms. The diagnosis of candidiasis is based upon history and clinical exam findings, but is confirmed by the presence of yeast forms or pseudohyphae. Oral candidiasis related to drug therapy can present in various forms. The forms include acute atrophic candidiasis (antibiotic sore mouth), chronic atrophic candidiasis (denture sore mouth), or acute pseudomembranous candidiasis (thrush). Nystatin suspensions or clotrimazole troches are extremely effective in treating oral candidiasis.

It is known that in chronic asthma patients, inhaled corticosteroids are efficacious in controlling symptoms and reducing oral corticosteroid dependency. In order to achieve these outcomes inhaled corticosteroids may need to be used at very high doses. With high doses of inhaled corticosteroids also comes the increased risk of developing oral thrush via local deposition of glucocorticoid. This complication can lead to poor compliance with asthma medications. The use of a metered-dose inhaler (MDI) plus a spacer device, such as an Aerocounter will decrease the incidence of oral-pharyngeal Candida super infections and reduce fungal colonization. It is imperative for the pharmacist, prescribing physician, or dentist to prevent the development of thrush secondary to inhaled steroid use. The use of a MDI plus a spacer device is an easy way to decrease the incidence of oral candidiasis infections in asthma patients. It is also recommended that patients adequately rinse their mouth or brush their teeth following the administration of corticosteroid inhalers.

continued from pg 1

continued on pg 4
**Gingival Hyperplasia (enlarged gums)**

Patients may present to the dentist with gingival enlargement if they have been taking agents such as phenytoin, nifedipine, or cyclosporin A (CsA). Gingival hyperplasia occurs when there is an increased production and growth of normal gingival cells. The affected area becomes larger but maintains its normal form. Gingival hyperplasia occurs in roughly 50% of patients taking phenytoin for the chronic management of epileptic seizures. Within two or three months of taking phenytoin, gingival enlargement presents as a painless enlargement of interdental papillae.

Phenytoin can produce gingival enlargement which is severe enough to completely cover the teeth. The severity of gingival hyperplasia is related to the degree of local irritation and inadequacy of oral hygiene and not generally related to the duration of therapy or dosage. The exact mechanism by which phenytoin induces hyperplasia is not completely understood. However, phenytoin may increase the expression of the gene for platelet derived growth factor B (PDGF-B). When gingival macrophages are exposed to phenytoin they secrete increased amounts of PDGF which may increase the proliferation of gingival cells and alveolar bone cells. Patients who are started on a strict program of oral hygiene within ten days of initiation of therapy may be able to minimize the occurrence of gingival enlargement.

Phenytoin-induced gingival hyperplasia can also be treated surgically. Patients using phenytoin are at risk for gingival hyperplasia, and should be supplemented with 1mg folic acid 1-3 times a day to decrease this side effect.

Approximately 5% of patients taking the calcium channel blocker nifedipine will present with gingival enlargement. Nifedipine induces gingival overgrowth when numerous inflammatory cells replace the collagen of connective tissues. Nifedipine produces alterations of the intracellular calcium levels in gingival cells and can produce local inflammatory factors to elicit gingival enlargement.

Cyclosporin A (CsA) has also been associated with gingival enlargement. CsA is given to transplant recipients in order to prevent transplant rejection. Approximately 25% percent of patients using phenytoin are at risk for gingival hyperplasia, and should be supplemented with 1mg folic acid 1-3 times a day to decrease this side effect.

Patients who are treated with CsA will have some degree of gingival enlargement. Enlargement is correlated to gingival irritants, such as dental calculus, imperfections in dental restorations, dental plaques, and the effects of mouth breathing. Meticulous plaque control before initiation of therapy and during therapy is a preventive measure against gingival enlargement. Plaque control can be enforced and followed by the dental clinician.

**Tooth Discoloration**

Numerous drugs are noted to have the capability to produce tooth discoloration. One of the most highly profiled drugs to cause tooth discoloration in young adults is tetracycline. However, other agents such as minocycline, isoproterenol, iron salts, ciprofloxacin, chlorhexidine, and methacycline all have reportedly caused tooth discoloration. It is important for health professionals to be aware of the consequences of using these drugs and how they can affect the oral hygiene of patients. Some of these medications will cause only cosmetic problems with discoloration and others will cause permanent tooth staining. Tetracyclines are most noted for their ability to penetrate bony tissues, especially the growing dentition of young children. Tetracyclines are able to widely distribute throughout the body; therefore, they are able to deposit in the growing dentition and other bony tissues. It is disputable whether tetracycline is specifically incorporated into the dentin or the enamel to produce its characteristic yellow-brownish discoloration. Females, who are exposed to tetracycline during the second or third trimester of pregnancy, may give birth to a child who will develop tooth staining. The teeth will become bright yellow upon development and the stains will eventually turn to gray or brown over time. These effects can also occur in the permanent teeth of children between the ages of two and eight years old who have received tetracycline. In pediatric patients who have received tetracyclines, one-third of them have reports of tooth staining. The staining that occurs in pediatric patients is a permanent tooth discoloration. Discoloration occurs with the greatest frequency when total dosage administration is over three grams or treatment exceeds ten days.

Tooth discoloration occurs when tetracyclines are deposited in calcifying areas of teeth and bone. The mechanism by

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**Table 1. DRUGS THAT AFFECT THE ORAL CAVITY**

| Xerostomia | Anticholinergics, antidepressants, anti-Parkinson’s drugs, antihistamines/decongestants, urinary antispastics, antipsychotics, diuretics, hypnotics, systemic bronchodilators, muscle relaxants, methyldopa, laxatives, beta-blockers, narcotics, and clonidine |
| Intraoral Hemorrhage | Sulfonamides, quinine, quinidine, thiazide diuretics, allopurinol, methyldopa, antineoplastic agents, digitalis, heparin, phenytoin, coumadin, gold, cephalosporin, penicillin, and tetracycline |
| Taste Changes | Captopril, enalopril, griseofulvin, D-penicillamine, metronidazole, carbencillin, chlorhexidine, diltiazem, chloral hydrate, gold salts, flecanide, lithium, vitamin D, and sulfasalazine |
| Candida albicans | Broad spectrum antibiotics, antineoplastic agents, corticosteroids including aerosol MDIs, and immunosuppressive agents |
| Gingival Overgrowth | phenytoin, nifedipine, cyclosporin A |
| Tooth Discoloration | Tetracycline, demethylchlortetracycline, oxytetracycline, chlortetracycline, minocycline, ciprofloxacin, iron, chlorhexidine |
| Stomatitis | Melphalan, thiopeta, doxorubicin, epirubicin, idarubicin, busulfan, procarbazine, dactinomycin, mitoxantrone, methotrexate, flurouracil, cytarabine, etoposide, and gemcitabine |

*continued on pg 5*
which tetracycline is incorporated into the mineralizing tissues is not completely understood. However, it is theorized that a chelate of calcium and tetracycline is incorporated into the mineralized tissues. Depending on the specific tetracycline used, the type and severity of discoloration may vary. Tetracycline and oxytetracycline cause a yellow discoloration, whereas chlorotetracycline produces a gray-brown discoloration. Evidence suggests that all of the tetracyclines, oxytetracycline causes the least tooth discoloration.

Other agents such as minocycline, iron, ciprofloxacin, and chlorhexidine have been documented to cause tooth discoloration. Minocycline is often given to adult patients and adolescents to control acne. Minocycline produces pigmentation changes of permanent teeth when it chelates with iron to form insoluble complexes. Oral iron solutions can cause superficial discoloration of teeth. In this case the discoloration can be removed with proper oral hygiene. Ciprofloxacin given intravenously to infants at doses of ten to forty milligrams/kilogram/day for Klebsiella pneumonia has been associated with tooth discoloration. A greenish discoloration which could not be removed was noted when infants teeth developed. Finally, chlorhexidine tooth staining occurs in fifty percent of patients after a few days of use. The most common side effect of oral chlorhexidine mouth rinse is the formation of yellow-brown stains. Fortunately, the staining that occurs with chlorhexidine can be removed by professional cleaning.

**Stomatitis**

Stomatitis is an inflammation of the mucous lining of the mouth and is characterized as painful, generalized erythema. Severe cases of stomatitis can develop into ulcers. The most common cause of nonspecific stomatitis is the use of antineoplastic agents. Agents which have the potential to cause stomatitis include melphalan, thiopeta, doxorubicin, epirubicin, idarubicin, busulfan, procarbazine, dactinomycin, mitoxantrone, methotrexate, fluorouracil, cytarabine, etoposide and gemcitabine. 

Chemotherapeutic agents are frequently used to treat a wide array of malignant neoplasms, and oral complications due to chemotherapy are often overlooked. Oral complications due to antineoplastic agents can jeopardize the effectiveness of treatment by allowing development of a focus for infection.

Additionally, patients may not eat, or may discontinue further chemotherapy treatments due to the development of stomatitis. Oral/dental care is often overlooked in cancer patients until a problem such as stomatitis occurs. Clinicians can have a great impact on cancer patients treated with antineoplastic agents by recommending meticulous dental care prior to, during, and after treatment begins.

Antineoplastic agents do not have the ability to differentiate between rapidly growing malignant cells and normal cells. Normal cells most affected by anticancer drugs are the ones with the highest turnover rate including hair follicles, gastrointestinal mucosa, and bone marrow. Over time the antineoplastic agents cause the oral mucosa to become thin. The atropic mucosa is more susceptible to stomatitis and ulceration due to the rubbing of the mucosal surfaces on one another, or on adjacent teeth. Mild forms of stomatitis can be managed by cleansing the oral cavity with a soft tooth brush and rinsing with a saline solution. Mouth rinses such as Kapectate® have been successful in decreasing the patient's discomfort.

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**Table 2. IATROGENIC CAUSES OF XEROSTOMIA**

<table>
<thead>
<tr>
<th>Category</th>
<th>Example Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antihistamine</td>
<td>Benadryl (diphenhydramine), Claritin (loratadine)</td>
</tr>
<tr>
<td>Anticholinergic</td>
<td>Atropine (atropine), Benadryl (diphenhydramine)</td>
</tr>
<tr>
<td>Antidarrheal</td>
<td>Kaopectate®</td>
</tr>
<tr>
<td>Antihypertensive</td>
<td>Minipress (prazosin)</td>
</tr>
<tr>
<td>Antipsychotic</td>
<td>Xanax (alprazolam)</td>
</tr>
<tr>
<td>Antineoplastic</td>
<td>Cytarabine, etoposide and gemcitabine</td>
</tr>
<tr>
<td>Anti-Parkinson</td>
<td>Sinemet (carbidopa with levodopa)</td>
</tr>
<tr>
<td>Anticonvulsant</td>
<td>Valium (diazepam)</td>
</tr>
<tr>
<td>Anti-Psychotic</td>
<td>Accutane (isotretinooin)</td>
</tr>
<tr>
<td>Antineoplastic</td>
<td>Chlor-Trimeton (chlorpheniramine)</td>
</tr>
<tr>
<td>Antidiarrheal</td>
<td>Imodium AD (loperamide)</td>
</tr>
<tr>
<td>Antihistamine</td>
<td>Claritin (loratadine)</td>
</tr>
<tr>
<td>Antihypergesic</td>
<td>Asendin (amoxapine)</td>
</tr>
<tr>
<td>Diuretic</td>
<td>HydroDIURIL, Maxzide (triamterene and hydrochlorothiazide)</td>
</tr>
<tr>
<td>Sedative</td>
<td>Dalmane (flurazepam)</td>
</tr>
</tbody>
</table>

**Table 2 continued on pg 6**
Oral Ulceration and Necrosis

Ulceration and necrosis of the oral mucosa occurs when patients use medications that are not intended for topical therapeutic use or they are taking medications incorrectly. The classic “aspirin burn” is a good example of what can happen when patients try to self medicate. Aspirin is one of the best-known locally toxic substances to oral mucous membranes. When a patient has a toothache they may try to relieve the pain by placing an aspirin in the mucobuccal fold opposite the toothache. However, the tissue exposed to the aspirin will become white and depending on the severity of tissue destruction, the lesions may be scraped off. Once the lesion is scraped off, the result is a painful bleeding area. Drugs capable of producing stomatitis can potentially produce reactions that are severe and lead to ulcerations. Drugs capable of causing ulceration or mucosal necrosis include aspirin, phenylbutazone, indomethacin, silver nitrate, hydrogen peroxide, isoproterenol, phenols, acids or alkalis, and potassium chloride.

Conclusion

Hundreds of medications have the capability to cause adverse effects within the oral cavity. Drugs have the potential to cause conditions such as xerostomia, intraoral hemorrhage, oral candidiasis, gingival overgrowth, taste changes, tooth discoloration, stomatitis, ulceration and necrosis. It is imperative that health professionals understand the severe complications that medications can have on the oral health of their patients. Pharmacists can educate physicians and dentists on the adverse effects drugs have on oral health. By making health professionals aware of the drug consequences, preventative measures can often be implemented before a problem begins. In order to properly manage patients, a complete medication history including prescription medications, over-the-counter medications, and dietary supplements must be conducted. A thorough medication history may enable the healthcare team to identify the offending agent.

About the Author: Darrell Hulisz, RPh, PharmD is Associate Professor of Family Medicine at Case Western Reserve University School of Medicine in Cleveland, Ohio. Address correspondence to Dr. Hulisz at the University Family Medicine Foundation, 11100 Euclid Avenue, Cleveland, OH 44106

References


50 Year Members to be Recognized!

BHN Members who over the past fifty years or more have been members of the American Dietetic Association will receive special recognition at BHN’s member reception and awards during ADA’s Food & Nutrition Conference & Expo (FNCE). Plan to join in this special time to honor such dedicated dietitians!

BHN’s 50+ year members are:

- Barbara Gaffield, MS, Virginia, member since 1949
- Laverne Anderson, RD, Michigan, since 1947
- Harriet Cloud, MS, RD, Alabama, since 1946
- Shirley Ekvall, PhD, RD, CD, Ohio, since 1957
- Dorothea Meagher, RD, LD, Oregon, since 1950
- Elaine Sasso, RD, Illinois, since 1958
Poor Oral Hygiene Linked to Aspiration Pneumonia

By Diane M Spear, MS, RD, LD

According to a growing body of evidence, oral bacteria, poor oral hygiene and periodontitis increase the incidence of pulmonary infections and aspiration pneumonia in high-risk subjects. Indicators for increased risk of these conditions include:

1. Dependent on others for oral care
2. Missing a large number of teeth or have dentures
3. Limited hand dexterity
4. Limited mental capacity
5. Neurologically impaired affecting muscles and nerves involved in swallowing
6. Diagnosed with multiple medical co-morbidities
7. Receiving enteral nutrition as a primary source of nutrition
8. Dry mouth or xerostomia, and
9. Immunosuppressed or ventilator dependence

The environment of the oral cavity can change rapidly with changes in health status, medications and/or dependency on others for oral care. Without regular oral hygiene or when oral care is suspended during hospitalization or surgical procedure, periodontal disease develops quickly.

The oral cavity can become over-laden with gram-negative bacteria, staphylococcus aureus and yeast within 48 hours. The immune system under stress cannot sustain itself against this bacterial onslaught, leading to systemic disease. Over time, ongoing oral infections can lead to pain with chewing, refusal to eat, and loss of teeth, making it difficult to eat solid foods high in protein and fiber. Further weakening of the immune system increases the risk that pneumonia will develop from even small amounts of aspirated bacteria. When these bacteria are aspirated due to dysphagia, a decreased level of consciousness, poor positioning, etc., the immunocompromised person develops aspiration pneumonia.

Researchers have found that oral care can decrease aspiration pneumonia rates. However, healthcare professionals, patients and caregivers do not always understand the need for oral care, indicating the need for improved education, established protocols and training. No one protocol meets the needs of people in all settings. Such protocols should be developed by a team of health professionals to provide expertise, education and support. Ideally, the team developing such a protocol would include a speech and language pathologist, nurse, respiratory therapist, registered dietitian, and nursing assistants who in some instances perform the care.

An oral hygiene protocol begins with determination of the usual or standard care practices, identification of persons at risk and those that need assistance, followed by a good assessment tool and team examination of those identified to be at risk. The protocol needs to include procedures for replacing and/or changing suction equipment, using soft-tipped yankauer catheters, and cleaning techniques for ventilators and other equipment. Standard care practices form the basis of any one person’s oral hygiene program as illustrated in Table 1, whereas interventions are individualized while incorporating ways to improve the nutrition and overall health in the at-risk patient. The dietitian should include in the nutrition assessment of the at-risk patient a physical assessment of the oral cavity and current oral care practices as part of the nutrition status evaluation. Recommendations may include standard protocol practices and/or referral to a speech pathologist or healthcare team as deemed necessary. The plan for nutrition care should address the person’s protein, calorie, fluid and fiber needs as well as need for mechanically altered foods such as meat/meat substitutes, fruits, vegetables, and whole grain foods.

### Table 1. Steps to Good Oral Care and Typical Interventions

<table>
<thead>
<tr>
<th>Step</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Brushing</td>
<td>Removes dental plaque</td>
</tr>
<tr>
<td>2. Swabbing</td>
<td>Removes oral debris and secretions, stimulates the oral mucosa</td>
</tr>
<tr>
<td>3. Suctioning</td>
<td>Removes loosened dental plaque, debris and oral secretions to decrease bacterial load</td>
</tr>
<tr>
<td>4. Moisturizing</td>
<td>Soothes and hydrates the lips and oral tissue</td>
</tr>
</tbody>
</table>

**About the Author:** Diane M Spear, MS, RD, LD, serves as Newsletter Editor for BHNewsletter. She directs nutrition services for the Oklahoma Department of Human Services, Developmental Disabilities Services Division in Tulsa, OK. Diane.Spear@okdhs.org

**Resources:**
BHN Excellence in Practice Awards for 2009

On Behalf of BHN officers and members, thank you for your dedication to this profession and to our Practice Group. Congratulations on this most deserved award! Awards will be presented at the BHN Member Reception held in conjunction with ADA’s Food & Nutrition Conference & Expo (FNCE) 2009 in Denver. Don’t miss the opportunity to meet and congratulate these acclaimed dietitians!

Excellence in Practice: Intellectual and Developmental Disabilities

Ann Overmyer, RD, CD

Ann Overmyer is recognized for her dedication and leadership in the promotion of nutrition and health for people with intellectual and developmental disabilities. Ann began her behavioral health nutrition practice in 1986 consulting in long term care nursing facilities and with a group home company. In the early 1990s she realized a desire to focus her practice in the area of IDD.

Currently Ann’s practice serves 18 agencies that are composed of 101 IDD group homes, two early Head Start programs and a community mental health center with two group homes and a crisis center. Her practice has grown to include four RDs who assist in these endeavors.

Active in the Indiana Consultant Dietitians (ICD) and Indiana Dietetic Association (IDA), Ann has been instrumental in the inclusion of nutrition services in the Money Follows the Person program for the State of Indiana. This program is funded through The Centers for Medicare and Medicaid Services (CMS) for the purpose of reducing nursing home occupancy by 25% by 2011. She has represented ICD and IDA at the stakeholder and committee meetings held with the Indiana Division of Aging from October 2006 to 2007. Ann was recognized by the Indiana Dietetic Association with the Honored Dietitian Award during the annual meeting held in April 2009. Ann is a 1976 graduate of Ball State University, Muncie, IN.

Ann’s reply to the news of her BHN Award was, “BHN has provided support and a network of RDs with similar interests that have been invaluable. I enjoy my practice. It’s not a job, it’s a passion.”

Excellence in Practice: Eating Disorders

Roberta Pearle Lamb, MPH, RD, LDN

BHN is pleased to name Roberta Pearle Lamb as the recipient of its 2009 Excellence in Practice: Eating Disorders Award. Roberta is the Director of Nutrition Services at Walden Behavioral Care in Waltham, Massachusetts, including development and integration of nutrition services at multiple levels of care in eating disorders service. As the director of Walden’s Mastering Balance, an integrative treatment program for treating binge disorder and night eating syndrome, Ms. Lamb has applied her understanding of the factors that cause and complicate overeating and appetite dysregulation to program development in the most underserved area of eating disorders.

With more than 24 years experience as a dietitian, Roberta has counseled thousands of patients who have tried everything from the “no-fat” to the “no-carb” to the “cave man diet” in an effort to improve personal wellness. Armed with degrees in food, nutrition and dietetics from New York University and nutrition science specialization from UCLA, Roberta has dedicated her career to understanding the factors that cause and complicate weight and eating disorders.

At Walden, Roberta has worked with an energetic and resourceful team of professionals to develop and present seminars focused on innovative treatments for eating disorders. She believes that people need an individualized approach to help them achieve their personal health goals, factoring in their distinctive styles of handling life’s day to day challenges.

Roberta currently serves on the American Dietetic Association’s Standards of Practice (SOP) Committee for Eating Disorders and has been invited to speak at the upcoming national meeting of the Binge Eating Disorders Association.

Excellence in Practice: Mental Illness

Sharon Wojnaroski, MA, RD

Recipient of the award for Excellence in Practice in Mental Illness, Sharon Wojnaroski, became interested in the effect of food on mood, cognition and behavior while a student at Michigan State University. As a senior dietetic student she participated in a study which required students to follow specific diets for a two week period. Food intake records were kept and analyzed (manually!) along with urine and blood analysis by each student participant. Sharon was intrigued by the changes in her own mood, and cognition, as well as that of some of her classmates.

She became an active member of the BHN practice group in 1980 while director of dietetics at a large center for the developmentally disabled. Later Sharon moved to a large specialized geriatric hospital for the mentally ill. In these settings she recognized the need for a Registered Dietitian as an integral part of the individual treatment team. Much of her next twenty years were spent working to develop and promote standards for minimum Registered Dietitian staffing within mental health facilities.

Sharon now provides nutrition services to long term care organizations and adults with mental illness. She served as 2006-2007 Chair of BHN, authored the Mood Disorders, the Behavioral Health Nutrition section in the American Dietetic Association’s Nutrition Care Manual 2008, and was a contributing author to Psychiatric Nutrition Therapy, Dietitians in Developmental and Psychiatric Disabilities, American Dietetic Association, 2006.

“Be involved with both dietetic professional groups and other professional groups” Sharon urges. “There is always something to be learned from others and life is more fun when you are involved.”

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STUDENT CORNER. . . .

Securing Dietetic Internship Rotations in Behavioral Health Care
By Deonna Hughes, BS

As I embark upon my own dietetic internship, I hope to have the opportunity to experience nutrition practice included in the BHN Mission: Empower BHN members to be the food and nutrition experts in the areas of Intellectual and Developmental Disabilities, Eating Disorders, Mental Illness and Addictions. But how does one seek out supervised practice outside of the rotations required by the Commission on Accreditation for Dietetics Education (CADE) of the American Dietetic Association (ADA)? Dietetic internships are not required to offer rotations focused on nutrition care in these areas of behavioral health. While all internships must fulfill the competencies defined by CADE, each internship has its own mission and goals which shape the focus of the rotations (1). Many programs plan a one to two week rotation in which the interns can focus on an area of interest. In those cases it may be possible for a student in conjunction with their program director to identify a site with a behavioral focus.

Shena Washburn is a recent graduate from the dietetic internship of California Polytechnic State University San Luis Obispo (Cal Poly). Shena is interested in working with those with eating disorders, but her internship did not have a rotation focused on ED. To gain experience in this area, Shena worked with her director, Susan S. Swadener, PhD, RD, to seek out supervised practice at the Comprehensive Eating Disorders Program at the Lucille Packard Children’s Hospital at Stanford. Cal Poly interns take the first initiative and contact the potential preceptor to inquire about a rotation.

If the preceptor accepts, Dr. Swadener has the contracts department of Cal Poly send an affiliation agreement to the appropriate administrators of the facility. CADE requires all dietetic internships to have written agreements, or contracts, with the facilities offering supervised practice (1). According to Dr. Swadener, some facilities want the internship director to sign the facility’s own contract which can come with many complications, most commonly the issue of worker’s compensation. Attending a facility that an intern has visited in the past is often a streamlined process, but there are times when a director may help an intern set up a new contract. According to Shena, setting up the new agreement required “a lot of communication and paperwork sent back and forth.”

Taking the initiative to contact potential preceptors is also recommended by Louise Peck, PhD, RD, clinical coordinator of the Graduate Coordinated Program in Dietetics of the University of Washington. When contacting potential preceptors, Louise suggests that interns communicate their goals and objectives and inquire about special projects they could complete for the facility. The written agreement with the facility should be in place at least a few weeks before the start of the rotation, but two to three months prior is preferred. Therefore, interns should begin contacting potential preceptors about three to four months prior to the rotation.

Interns interested in working with those with intellectual and developmental disabilities and special health care needs may be interested in the Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program. LEND is funded by the Maternal and Child Health Bureau and is offered in 31 states and the District of Columbia (2). The LEND programs are long-term graduate level interdisciplinary traineeships, with many offering training for registered dietitians, but some programs may accept dietetic interns for a brief rotation. While all LEND programs have the same major objectives, each has its own focus and different opportunities to offer (2). Beth Ogata, MS, RD, CD, a nutritionist with the University of Washington (UW) LEND, says the UW LEND has been able to accommodate for brief rotations interns who showed great interest and motivation, but the most common obstacle has been to make the timing work for both LEND and the intern. If a rotation cannot be established, seeking out small projects (outside of the internship) with LEND staff could be another way to gain invaluable experience in this area of nutrition. Be sure to contact the LEND closest to you before you plan too far ahead; some LEND programs do not have a nutrition focus and not all programs with a nutrition focus will be able to accept dietetic interns.

In summary, plan ahead and start communicating your interests to your director early. If you plan on applying to dietetic internships in the future, research the current contracts of the internship to determine if the facilities have dietitians who work with persons who have eating disorders, mental illnesses, intellectual and developmental

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From the Listserv . . .

Subject: Choices versus Dietary Restrictions for Medical Reasons.
By Paula Cushing, RD, IDD Resource Professional

The originator of this e-mail conversation is a BHN member dietitian who works at a large psych facility that includes a 40 bed ICF/MR unit. An issue in her facility that came up in a recent survey was related to addressing higher functioning clients with obesity who are prescribed therapeutic diets to facilitate gradual weight loss. Many of the clients had expressed dissatisfaction to the surveyors in regards to dieting. Efforts to resolve this issue included building in lower calorie snacks, extra salads and vegetables to the diet; however this change had still not satisfied many of the clients who continued to express their desire to have the restrictions lifted so that they can consume junk food.

The question to the Listserv: How do you deal with an individual’s right to choose versus having dietary restrictions for medical reasons?

Response 1: The “important to” versus “important for” question is a difficult one for dietitians who work with individuals diagnosed with intellectual/developmental disabilities (IDD). The balance between consumer rights which they clearly have and health is a tough issue and very challenging for dietitians. I suggest offering choices and pose the question “Is it possible to include a junk food item choice once a week?” When a person is not able to make choices, it takes away their control over their own life, so the more choice you build into the situation, the more the person will feel that he or she is a part of their living environment. It requires balancing the “important to” and “important for” equation in tandem with the policies of the facility.

Response 2: Consider asking the clients along with their conservators/legal representatives if they would like to meet on a regular basis to discuss health issues and ways to manage weight as well as food items and snack options they would like to see on future menus. Forming a committee of clients is a great way to obtain their input and let them know that their choices and opinions are being heard. The approach to resolve this issue may vary depending on whether the person lives in a group living situation like an ICF/MR which is more structured, a group home or in a family home or supported living home or apartment in the community.

Response 3: Including the entire team within a facility is important. Explore if the desire for junk food is part of the diagnosis, such as “compulsive overeating” or OCD which can manifest as a desire for unhealthy amounts of specific junk foods. Unfortunately there are individuals who feel there is nothing wrong with gorging daily on unhealthy food choices, are not interested in “that healthy stuff,” and think anything else is a violation of their rights.

Response 4: I suggest asking staff to model the expected behavior by not gorging on food themselves. It might be helpful to build a controlled choice piece into the menu but also with an element of control for the clients. If we as practitioners can impact families early by gaining their trust when it comes to the feeding relationship, resolving future dietary issues will be easier. Some people most likely persevere on junk food as their choice and right, because they have been living with the food police too long resulting in behaviors that may take a lifetime to correct.

Response 5: Music and environmental therapy for food habits and addictions can be helpful. In addition, healthy lifestyle modeling by role models or mentors can make a difference. This requires a team effort by hospital staff, family, and friends of clients. Verbally joking about eating unhealthy or watching too much television with unhealthy food commercials may reinforce the drive to eat or want junk food. Support staff who model the desired behavior as part of their job create a positive environment.

This interesting listserv discussion brought to the attention publications that may help dietitians when addressing the issue of choices versus dietary restrictions.

The article “Whose Choice is It? A

Help a Dietetic Student Interested in Behavioral Health Nutrition

Become a preceptor for student dietitians and provide opportunities to experience the practice of nutrition in behavioral health care. The Commission on Dietetic Registration (CDR) is offering the Dietetics Preceptor Training Program to help preceptors of dietetics students prepare for and excel in their important role. It includes learning modules, self-assessment and case based activities. The training program is free for preceptors of dietetic students and has been approved for 8 CPEUs. To register for the course, visit the Education Director website at the following link: http://cdrnet.educationdirector.com/ and follow these steps:

1. Click on “New User”
2. Enter your first name, last name, e-mail address, a username and password and click on “Save”
3. Then you will be at your home page. To view courses click on the “Catalog” tab.
4. Click on the course you would like to view. If you would like to sign up for the course, click the “Register” button on the top right of this screen.

Student Corner... continued from pg 9

disabilities, or addictions. Consider contacting internship directors to inquire about your interests; internship directors may have connections not mentioned in their web sites that could open the door to new opportunities.


About the Author: Deonna Hughes is a student member of BHN and the student assistant newsletter editor. She is currently a graduate student of the Nutritional Sciences Program at the University of Washington (UW). Deonna will be enrolled in the UW Dietetic Internship starting January of 2010. She currently works as a research assistant at UW and as a dietetic technician at Seattle Children’s Hospital.
From the Listserv...
continued from pg 10

Primer on Making Informed Choices” by Daniel Baker, PhD located at http://www.disabilitysolutions.org/newsletters/files/six/6-2.pdf prompts us to ask three questions:

- Do they understand their choices?
- Do they understand the consequences of their choices?
- Are they making a choice a reasonable person would make?

Our job as a health professional is to engage in meaningful education activities to help influence their understanding of the power and effect of their choices. Another publication that was recommended is Dr. Herb Lovett’s book, Learning to Listen. Lovett indicates “The real issue is not so much choice as allowed choices; they just make them. Power. Most ordinary people are not

Suggestions from BHN publication, The Adult with Intellectual and Development Disabilities: Generic rules need to be avoided and individual wishes considered. The person’s food choices, although considered unhealthy, should be included in the diet plan when possible and in moderation. Caregivers need to use encouragement strategies that span the person’s daily life, including environmental management, cooking methods, eating behaviors and approaches to lifestyle changes.

Involve the person in menu planning, making a grocery list, and grocery shopping. Approaches might include availability of a “free food” selection, reasonable quantities of food available, one-day’s supply of food in individualized settings, or a “Majority Food Rule” when needed, and strategies to obtaining a pleasing and enjoyable eating environment.

Strategies to healthy cooking methods and food selection might include methods of reducing fat, sugar and salt, increasing the fruit, vegetable and whole foods selection, trying new foods or recipes each week, or reducing use of processed or convenience foods.

Encouragement strategies for healthy eating behaviors may include the person choosing where and when to eat, how to make the eating environment calm and relaxing, implementing re-directional strategies or options, using easy and fun methods for controlling portion size and food selection such as “the plate method,” “plate of many colors,” a menu

Pick-list, and methods for self-monitoring. Determine what things can and cannot be controlled, then develop methods or strategies that do not impinge or restrict the person’s access or ability to choose. Certain “rules” could be considered such as no eating while traveling in the car, cook just enough for one meal only, store or freeze leftovers immediately, remove serving dishes from the table, remove plates from the table as soon as meal or eating is finished, or change the seating arrangement at the table and get involved in activities rather than snacking.

Lifestyle changes are often the most challenging to achieve and maintain. Like most of us, people with IDD need structure in their lives, but want the right to choose and some unstructured time to do what they like. Approaches to consider include an active daily life routine with lots of things to do and options to choose from, including fun activities not labeled as “exercise” that get the body moving and engaged. Why not explore the community for healthy lifestyle options in which to become actively involved? Everyone has points of motivation; find out or assist the person to realize what motivates them and explore various ways to utilize these motivators into making healthy choices and living healthy.

Live Long – Live Healthy
Healthy eating guidelines for people with Intellectual and Developmental Disabilities

A diet for healthy living gives you what you need every day. It keeps you well. It gives you enough energy to do the things you want to do.

A live long-live healthy diet has . . .
- All the nutrients that most healthy people need. Nutrients are things like protein, vitamins & minerals needed for your body to work properly, keep you from being sick and help you to feel good.
- Foods that you like and that are good for you. You do not have to eat foods you hate, but eat many different kinds of food and be willing to try new foods for fun! Some things that taste good do not have nutrients your body needs, like cake and soda pop. Think before you eat these foods . . . will they help you live a long and healthy life? A little junk food is OK for parties, but eat only one serving along with healthy foods.
- Lots of fruits & vegetables and whole grains. These foods have many of the nutrients you need. Half of the food you put on your plate should be fruits and vegetables with lots of color (red, yellow, green, blue). Whole wheat bread, brown rice, popcorn, corn bread, oatmeal and bran cereal have whole grains. They are healthier than white bread, white rice, and sugary cereal.
- Clean and safe food. Germs can grow in food and make you sick. Cold foods like cheese, milk, lunch meat must stay cold until you eat them otherwise put them in the refrigerator. Always keep meat cold and in the refrigerator before cooking. Hot foods like chili and roast chicken must stay hot until you eat them otherwise put them in the refrigerator.
- Energy to move your body. The foods you eat give your body the energy to move. If you do not use the energy, you might gain weight or get sick. If you eat good food, exercise and move, your body will work right and you will feel good.

YOUR NUTRITION RIGHTS
You have the right to:
- a diet that meets your body’s needs and keeps you healthy
- a diet that follows your beliefs
- safe food that is served in a pleasant way
- a diet with many kinds of fresh, whole foods
- choose foods you will or will not eat
- know about your special needs and foods that work for you
- be part of a group that decides how you should eat and stay healthy
- be respected and treated fairly by food and nutrition professionals, and
- expect support from providers to be healthy

Live Long - Live Healthy and Your Nutrition
Rights are adapted from Eat Well to Feel Well: continued on pg 12
Excellence in Practice: Addictions

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

In her 31 years as a dietitian in behavioral health, Dr. Anne Hatcher has found the correlation between nutrition and behavior to be especially fascinating. She began working with addicts and counselors in 1978 when hired to teach a course in nutrition to students preparing to be addiction counselors. Completing a doctorate in Nutrition and Psychology in Clinical Practice supported her endeavors exploring the topic. She serves as co-director of the Center for Addiction Studies at Metropolitan State College of Denver and instructs courses in ethical and legal issues, pharmacology of drugs and alcohol, infectious disease and addiction, counseling skills, client record management and principles of addiction treatment. These courses are designed to meet requirements for certification of addiction counselors in Colorado. Nutrition information is integrated into the courses as an aspect of treatment as well as the physical effects of nutritional imbalances on the addictive process.

In addition to teaching, Dr Hatcher has worked as a consultant with addiction treatment agencies in metro Denver and has taught workshops in nutrition and addiction over the last 20+ years to professional organizations and colleges in several states.

Dr. Hatcher previously served as the Addictions Resource Dietitian for BHN, has written numerous newsletter articles, and prepared the initial draft of Nutrition and Addictions, a Guide for Professionals. She has authored two chapters in Psychiatric Nutrition Therapy: A Resource Guide for Dietetics Professionals Practicing in Behavioral Health Care and revised the addiction section of the Nutrition Care Manual for the American Dietetic Association.

Dr. Hatcher suggests the study of addiction and the brain has shown that addiction is as a long term chronic condition with the same incidence of relapse as for clients with diabetes, hypertension and asthma. The skills dietitians have developed to work with long term chronic health conditions will serve them well when working with this population.


Resources:
2. Montana Disability & Health Program, 2005, The University of Montana Rural Institute
3. Standards of Care: Nutrition for Adults with Intellectual or Developmental Disabilities, Wise Choices Food Pyramid, and Menu-AIDDs Nutritional Health Promotion for Community-dwelling Adults with IDD. Available at: www.goodnutritionideas.com
5. National Center for Physical Activity and Disability: http://www.ncpad.org/
7. Healthy People 2010 Objectives for People with...
The Sober Kitchen – Recipes and Advice for a Lifetime of Sobriety


Reviewer: Renée Hoffinger, MHSE, RD

The Sober Kitchen is essentially a cookbook but oh, so much more. The author, Liz Scott, a professional chef, herself in recovery, warms the cockles of this dietician’s heart with her affirmation of the vital importance of the role of diet in recovery. She hopes the reader will discover how “including good food in the recovery process may play a significant and overlooked part in its success,” recognizes that “food has the ability to comfort and heal…physically, emotionally and spiritually” and extols the “power of food to enhance our lives.” Having worked in the field for 15 years I agree totally with her assessment that so many addicts have neglected this area of their lives for so long that food as a tool for self-nourishment, self-efficacy, and emotional healing is key to recovery.

With the recovering addict as the target audience, the author divides recovery into three fluid stages and offers advice and recipes appropriate to each phase, promoting gradual dietary changes. In Phase 1 the focus is on easing the acute symptoms of withdrawal, getting and keeping sober by staving off cravings, replenishing nutrients, and staying hydrated. She supports this with recipe sections of refreshing beverages and comforting, nutrient-packed soups. During Phase 2 she cultivates healthy eating patterns and kitchen skills supportive of the new lifestyle. This includes “soulsatisfying” dishes: recipe reduxes of traditional comfort foods, leisurely breakfast dishes and semi-decadent desserts. In Phase 3 she promotes lifelong maintenance with “food as preventive medicine” enhancing your health with whole foods and maintaining a healthy weight, with sections on salads, vegetarian dishes, and foods high in phytochemicals, as well as non-alcoholic makeovers of dishes with names she wouldn’t even say aloud in Phase 1.

Throughout, the book is sprinkled with compassionate encouragement, demystifying of food lore as well as the science of addiction, basic and not so basic culinary skills, as well as answers to questions such as: is it true that alcohol burns off in cooking? (hardly!), can eating a poppy seed bagel result in a positive drug test? (one bagel, probably not; one poppy seed danish, probably yes), do wine vinegars contain alcohol? (no). Of special note to RDs are the sections on glycemic index, wine-free ways to increase polyphenols, omega-3s and her encouragement of assertiveness in uncovering just what is in your food at restaurants. Although not specifically footnoted, most of the scientific information is referenced in the bibliography.

What I appreciate most about the book is that it led me to greater understanding and tweaking of my own dietetic practice (which includes running a food program and cooking classes at a residential rehabilitation program). The author’s philosophy is more forgiving than my own: while clearly recommending nutritious snacks in Phase 1 to stabilize glucose levels and mood, she offers that giving into sugar cravings “may help us to stay sober and get through a most difficult and trying time.” Scott’s justification that it’s better to drive with a bag of Ruffles next to you instead of a six-pack” did win me over a bit. She sees the self-compassion in shortcuts when “from scratch” won’t cut it, thus a section on “making the most of canned soup and mixes” by doctoring them to improve taste and nutritional content. This inside view alerts us to possible triggers to avoid, such as blenders formerly used to prepare mixed drinks.

The steady focus on the social and emotional aspects of food is poignantly articulate. The author differentiates between establishing a positive relationship with food versus relying on food to make us feel good. She preaches mindfulness, enjoying the making of food as well as the eating, and the power of food to bring people together and create new, happier memories and encourage love, support and healing. These are all things that we, as “clinical” dietitians, sometimes fail to remember.

The most unfortunate omission is the lack of nutritional analyses for any of the recipes. This would have been very useful for the majority of people who need to watch calories, fat and/or sodium. Also, the blanket encouragement of fish on the basis of omega-3 fatty acids alone with no proviso concerning choices based on pollutants and environmental effects is surprising considering her later discussion of organics.

This book should be on the bookshelf (and in the kitchen) of every RD who works in recovery. While we, as RDs, have lots of information, we are not all equally adept at translating theory into practice in the kitchen. The Sober Kitchen is like a community education cooking class, pleasantly, gently encouraging all willing readers that (as Chef Gustave exhorts in that adorable movie “Ratatouille”) – “Anyone can cook!”

Reviewer: Renee Hoffinger, MHSE, RD is BHN’s resource professional for the addictions practice area and recipient of the BHN 2008 Excellence in Practice Award. She is employed at North Florida/South Georgia Veteran Health System.

Renee.Hoffinger@va.gov
Book Review: Cognitive Behavior Therapy and Eating Disorders

By Christopher G. Fairburn, DM, FMedSci, FRCPsych
The Guilford Press, 2008
Reviewer: Roberta Pearle Lamb, MPH, RD, LDN

In his latest book, Cognitive Behavior Therapy and Eating Disorders, Dr. Christopher Fairburn explores a new frontier in eating disorders treatment with the help of what he calls “a variety of clinicians of various professional backgrounds.” Surprisingly, none of the contributors appear to have a background in nutrition, a knowledge base that is instrumental in assessing biochemical imbalances, which may affect cognitions, levels of depression and anxiety.

That is not to say Dr. Fairburn’s book suffers from cursory research or a lack of perspective. Rather, Dr. Fairburn’s thorough and nuanced approach to treating eating disorders has made him one of the world’s most respected authorities on the subject. Furthermore, the cognitive behavioral and interpersonal treatments for patients with eating disorders that he helped develop have demonstrated validity in clinical trials and been adopted in clinical practice internationally. This work follows his CBT treatment model for bulimia nervosa (CBT-BN; Fairburn, 1981), which has been advanced, trialed and modified to be effective across the full range of eating disorders. The goal of cognitive behavior therapy and eating disorders (CBT-E) is to help people with eating disorders to identify and modify their cognitive distortions that contribute to the behavior they want to change.

Given that this revised and refined treatment has demonstrated efficacy across a range of eating disorders and has even been applied to overeating, which may be the most frequently seen problem by outpatient dietitians, it is important that dietitians are well-versed in the theory and practice of CBT-E. CBT-E clearly provides effective means for optimizing outcomes and helping patients achieve their personal weight goals. Dr. Fairburn appears to support the notion of a variety of professionals being trained in CBT-E, indicating that “no specific professional qualifications are required to practice CBT-E.” He states, however, that “the therapist should be well informed about psychopathology in general and eating disorder psychopathology in particular.” Such knowledge is needed for all members of the treatment team however may be somewhat unfamiliar to dietitians new to the field of eating disorders. Hence, Dr. Fairburn’s recommendation for case supervision is especially applicable and useful for dietitians.

The guide presents useful theory, guidance and detailed examples for treating individual cases of eating disorders. Most useful is Dr. Fairburn’s thoughtful review of the issue of diagnosing eating disorders. While dietitians do not diagnose, they can be more effective when they understand the evidence to support a transdiagnostic view for the possibility of overlap between diagnostic criteria and treatment options. For example, the designation of eating disorders not otherwise specified (ED NOS) accounts for more than 50% of eating disorder cases. If, for example, the core psychopathology of the eating disorder is expressed as over-evaluation of shape and weight, that clearly impacts eating habits. Dr. Fairburn outlines how dietary restraint can be addressed as a cognitive distortion, but CBT-E might be overlooking an important piece of treatment. Input from a dietitian is critical to assessing the degree of nutrition compromise, making recommendations to correct imbalances, and outlining reasonable interventions for effective treatment. These nutritional modifications may refer to dietary interventions beyond energy intake.

Nonetheless CBT-E is clearly the pre-eminent, cutting-edge treatment for eating disorders and co-occurring disorders. This guide is clearly written and user friendly, offering practical guidelines and suggestions for managing complex cases and vignettes that demonstrate effective treatment interventions. In addition, the book offers excellent resources at the end of each chapter and appendices for assessing eating disorders and psychosocial impairment.

Review: Roberta Pearle Lamb, MPH, RD, LDN serves as the Eating Disorders resource professional for BHN. She is the director of nutrition services at Walden Behavioral Care in Waltham, MA and the director of Walden’s Mastering Balance program, an integrative treatment program for treating binge eating disorder and night eating syndrome. Roberta also maintains a private practice in Wellesley, MA. She can be reached at rpl@wnnutritioncoach.com.

BHN Schedule of Events
American Dietetic Association’s Food & Nutrition Conference & Expo (FNCE)
Hyatt Regency Denver at Colorado Convention Center

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

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

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

Tuesday, October 20, 2009
8:00am – 9:30am
Procedure Development & Implementation of Behavioral Health Nutrition Practice Standards: Open Discussion; Room 605-607
New Public Policy Advocacy Educational Briefings to be Announced!

The American Dietetic Association (ADA) will soon announce new advocacy educational briefings, with CPEUs, for Public Policy Workshop attendees. Using a Webinar format, the status of ADA’s issues and the current environment will be provided with up-to-the-moment resources for communicating with Congress on key messages. In order that our messages are timely, specific and appropriate for the nation’s top decision makers on food, nutrition and health, ADA has decided to conduct a series of “fly-ins” where one or two ADA advocates come to Washington to meet with their states’ congressional delegations at critical moments in the consideration of our issues. These Washington meetings will complement the district in-person calls taking place across the country.

ADA continues to advocate that the appropriate goal for health reform must be improving the health of Americans and thus, policies that keep people healthy and prevent disease must be central to our efforts. ADA’s basic message remains that nutrition is fundamental to basic health and nutrition interventions. Nutrition counseling or services by a registered dietitian can prevent, delay onset, manage and offset many costly diseases and conditions. Nutrition is the cornerstone to all quality prevention programs.

The 2010 Public Policy Plenary Session will take place on Monday, March 22.

Please check www.eatright.org/ppw and http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/advocacy.html for information regarding public policy efforts and how to be an advocate for the profession.

Check out http://www.eatright.org/cps/rde/xchg/ada/hs.xsl/10988_10974_ENU_HTML.htm for useful resources for contacts with U.S. Representatives and U.S. Senators. This information is the most up to date documents on health reform and other issues. ADA’s weekly e-newsletter “On the Pulse,” distributed each Friday, provides important insights on current public policy work. Also, look for a summary of On the Pulse on the BHN list-serv each week.

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

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

Future Webinars Planned

Watch for BHN’s webinar opportunities to gain knowledge and interact with nutrition professionals on behavioral health issues. The following webinar topics have been scheduled along with proposed webinar and topics for 2010.

November 10, 2009
BHN Webinar in collaboration with Weight Management DPG, Addictions and Weight Management

February 2, 2010
BHN Webinar, Nutrition and the Brain
Behavioral Health Nutrition
Executive Officers 2009-2010

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

Call for Speakers on Eating Disorders for FNCE 2010 BHN Priority Session!
Contact Kathy Russell at katerussrd@yahoo.com
Deadline is 11/1/2009
Volunteers and Recommendations are Welcome!

BHN: Setting the Standard for Nutrition in Behavioral Healthcare

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

Mission: Empower BHN members to be the experts in
- 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.

ADA website: http://www.eatright.org
BHN website: http://bhndpg.org