BHNewsletter

Behavioral Health Nutrition
a dietetic practice group of the
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BHN: Fuel Your Brain, Feel Your Best!

IDD Standards of Practice and Performance (SOP/SOPP) Published

The Behavioral Health Nutrition Dietetic Practice Group (BHN-DPG) of the Academy of Nutrition and Dietetics (Academy) has developed and published, in the September issue of the Journal of the Academy, Standards of Practice (SOP) and Standards of Professional Performance (SOPP) for Registered Dietitians (RDs) in Intellectual and Developmental Disabilities (IDD) (1). This long awaited publication began development at a FNCE 2009 Quality Management session by a group of RD's active in the BHN IDD area of practice. This dedicated volunteer group worked diligently though the development process with assistance of the Academy's Quality Management Committee and Scope of Dietetics Practice Framework Sub-Committee. The authors are commended for their knowledge and understanding of the unique aspects of providing services to individuals with IDD that are essential for the RD to effectively deliver nutrition care. The publication includes an overview of nutrition service provision that balances nutrition needs with individual desires, abilities, and supports to achieve quality of life for the individuals served.

The IDD SOP/SOPP workgroup utilized the Academy's Revised 2008 SOP for RDs in Nutrition Care and SOPP for RDs (2) which reflect the minimum competent level of dietetics practice and professional performance for RDs. These standards were the blueprints for the development of this focus area SOP and SOPP for RDs in competent, proficient, and expert levels of IDD practice, see Figures 1, 2, and 3 (1). The SOP in nutrition care in IDD address the four steps of the Nutrition Care Process (NCP) and activities related to patient/client care (3). They are designed to promote the provision of safe, effective, and efficient food and nutrition services, facilitate evidence-based practice, and serve as a professional evaluation resource. The SOPP are authoritative statements that describe a competent level of behavior in the professional role.

These focus area standards for RDs in IDD are a guide for self-evaluation and expanding practice, a means of identifying areas for professional development, and a tool for demonstrating competence in delivering IDD nutrition services. They are used by RDs to assess their current level of practice and to determine the education and training required to maintain currency in their focus area and advancement to a higher level of practice. In addition, the standards may be used to assist RDs in transitioning their knowledge and skills to a new focus area of practice. The "measureable action statements that illustrate how each standard can be applied in practice" were developed with input and consensus of BHN member content experts representing diverse practice and geographic perspectives. The SOP and SOPP for RDs in IDD were reviewed and approved by the Executive Committee of the BHN-DPG, the Academy Quality Management Committee and its Scope of Practice Sub-committee.

> ***These standards can and should be used by RDs in daily practice to consistently improve and appropriately demonstrate competency and value as providers of safe and effective care for individuals with IDD.***

The SOP and SOPP for RDs in IDD are complementary documents and are key resources for RDs at all knowledge and performance levels. These standards can and should be used by RDs in daily practice to consistently improve and appropriately demonstrate competency and value as providers of safe and effective care for individuals with IDD. These standards also serve as a professional resource for self-evaluation and professional development for RDs specializing in IDD practice. Just as a professional's self-evaluation and continuing education process is an

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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.

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Behavioral Health Nutrition
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From the Chair

Therese Shumaker, MS, RD, LD

Greetings BHN Members!! By the time you are reading this, the Academy of Nutrition and Dietetics 2012 FNCE will have just concluded and BHN continues working to help you find value in your membership. I want each member to feel that you are getting what you need with BHN! There are many ways to get connected and the theme this year is "BHN Everywhere". Please visit our website, join us on Facebook or twitter, send us an email and let us know what it is you are looking for. We are currently in the process of changing our mission and vision and developing a new "look", as BHN becomes the go to practice group for information and resources on behavior change. Stay tuned, in the forthcoming month or two, as we expect these actions to broaden our scope and to offer more valuable information and resources to BHN members. A free webinar will be offered this spring on motivational interviewing.

We are looking for people interested in presenting webinar topics on mental health/illness and intellectual and developmental disabilities. If you would like to be considered as a presenter, please send me an email shumaker.therese@mayo.edu The BHNewsletter is also looking for people interested in writing articles for our newsletter, please send an email to Diane.Spear@okdhs.org

This edition of the BHN newsletter is all about fostering professional leadership, value and skills in your nutrition and dietetics practice. Please take advantage of our CPE article which offers the RD practicing in intellectual and developmental disabilities a guide for self-evaluation and a means for professional development and competency. Review articles on what BHN members are saying about counseling skills and the value of the RD in eating disorders practice. Consider your practice as a research opportunity with tips from In Search of Evidence. Check out the Student Corner, on the value that students bring to BHN.

I have been fortunate enough to be a part of BHN since 2007 and I joined because I was interested in learning more about eating disorders and addictions. What I didn't realize then is that I have been given so much more! I now have a network of people, many of whom I consider to be my friends, who share the same passions and goals that I have in my professional career. Joining BHN has been one of the best decisions that I have made in my career! This year as Chair I want to be able to pass on to you what has been so freely given to me. In 2010, I was honored to be selected to attend the Academy's Leadership Institute. This was a wonderful experience, and helped me to explore my leadership qualities. One thing that still stands out in my mind from that experience is that anyone can be a leader! Robin Crow, musician and CEO of his own recording studio near Nashville wrote a great book on leadership entitled "JUMP and the net will appear". The theme of the book in two words is TAKE RISKS!! Crow states that "personal and professional success you experience will always be in direct proportion to the risk you take". If you are willing to focus on your dreams instead of your fears, anything is possible! Being involved in BHN has given me many professional opportunities and has opened doors for me that I never thought were possible, all because I have taken some risks. I hope that this year you open yourself up to take some risks, get involved with this great practice group and you never know, you might be Chair of BHN in a few years!

IDD Standards

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ongoing cycle, these standards are also a work in progress and will be reviewed and updated every 5 years. Current and future initiatives of the Academy as well as advances in the treatment of individuals with IDD will provide information to use in these updates and in further clarifying and documenting the specific roles and responsibilities of RDs at each level of practice. As a quality initiative of the Academy and the BHN-DPG, these standards are an application of continuous quality improvement and represent an important collaborative endeavor.

The SOP and SOPP for RDs in IDD are available online at www.andjrnl.org. For easy access to the documents and CPE credit, go to the BHN Website at http://bhndpg.org/index.asp .

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CPE credit (3 hours) is available from BHN for the full text version of the article, American Dietetic Association: Standards of Practice and Standards of Professional Performance for Registered Dietitians (Competent, Proficient, and Expert) in Intellectual and Developmental Disabilities. Journal of the Academy of Nutrition and Dietetics. September 2012; 112(9): 1454-1464.e35. and the supporting Figures 1, 2, and 3 available online at www.andjrnl.org. Access the article at http://bhndpg.org/index.asp and http://www.bhndpg.org/moa/cpes.asp for reading/taking quiz.

Leaders are Born and Made

By Diane Spear, MS, RD, LD • BHN Newsletter Editor

While some people may appear to be "born leaders" most leaders are "made" by learning, listening and doing what they were meant to do, especially when passionate about it. Those of us whose role is focused on motivating behavioral change know that such skills can be mastered!

Leadership is not just big acts by single individuals with big titles. According to former Academy President and Academy Foundation Chair, Polly A Fitz, MA, RD, everyone has some leadership capacity and can lead and contribute in many ways. Each of us has within us the power and the responsibility of leadership. How we use this power and fulfill our responsibility is up to each of us.

Leadership opportunities pop up around us at every turn, sometimes when least expected. A strong foundation of leadership skill provides a great return when faced with challenges you didn't ask for. Former Academy President, Sylvia A Escott-Stump, MA, RD, LDN once noted that most effective leadership traits are:

- Being committed to being the best;
- Encouraging input from others;
- Being open-minded;
- Not micromanaging others;
- Being a "calculated risk" taker;
- Having futuristic thinking, and
- Keeping the whole picture in mind, not just your own sphere of influence.

As practitioners in behavioral health these leadership traits are especially critical in our everyday practice approach to counseling and delivery of nutrition services. Successful leadership is ultimately about relationships, to recognize great ideas, support those ideas, get everyone aligned toward the same goal, and break down barriers along the way.

The Academy of Nutrition and Dietetics defines leadership as "the ability to inspire and guide others toward building and achieving a shared vision." In BHN, we share a common vision for optimizing the physical and cognitive health of those we serve through nutrition, nutrition education and behavioral health counseling.

Naturally, BHN is invested in cultivating leaders within the organization, born and made. Those of us who are active members of BHN find that by virtue of our roles in behavioral health, we recognize and value the abilities of our peers and respect the knowledge and skills of others regardless of ability and possible barriers to personal success. In BHN there is something for everyone who desires to foster their leadership potential.

Are you willing to make leadership a professional development goal? Ask for a leadership role in BHN, be it large or small, there are many ways to volunteer. A few ways to get connected are to visit our webpage www.bhndpg.org that highlights volunteer opportunities, contact BHN at info@bhndpg.org or contact any of the officers or members of BHN's executive committee.

This issue of BHN*ewsletter* is intended to embrace a leitmotif of "Value -Skills – Leadership" that exists within our practice group, inspiring BHN members to assess their leadership skills and engage in strengthening them. As a leader, behavior speaks much louder than words!

On a fun note, you might enjoy Alex Knapp's Five Leadership Lessons from Captain James T. Kirk. By applying these lessons, we can lead BHN and your practice into places where none have gone before. http://www.forbes.com/sites/alexknapp/2012/03/05/five-leadership-lessons-from-james-t-kirk/.

Interventions Used in Nutrition Counseling for Eating Disorder Treatment: Survey Results

By Jessica Setnick, MS, RD, CSSD, CEDRD and Michelle Johnson

Reprinted with permission from SCAN's Pulse, Summer issue, 2012, Vol 31, No 3, official publication of Sports, Cardiovascular, and Wellness Nutrition (SCAN), Academy of Nutrition and Dietetics, Chicago, IL.

Nutritional rehabilitation (i.e., medical nutrition therapy) provided under the supervision of an experienced eating disorder dietitian (EDD) is a cornerstone of eating disorder (ED) treatment and recovery. This type of therapy in ED is recommended worldwide by many professional organizations and government entities, including the International Association of Eating Disorder Professionals, Academy of Eating Disorders, American Psychiatric Association, Academy of Nutrition and Dietetics (formerly American Dietetic Association), American Society for Enteral and Parenteral Nutrition, National Institutes of Health, American College of Sports Medicine, Society for Adolescent Medicine, British Dietetic Association, National Collaborating Centre for Mental Health & National Institute for Clinical Excellence (UK), National Health Service (Scotland), and The Royal Australian and New Zealand College of Psychiatrists, among others (1-8). Despite this widespread recommendation, no evidence-based parameters have been established for frequency, duration, or content of individual sessions with an EDD for purposes of ED recovery.

The goals of individual work with an EDD ("ED nutrition counseling") are generally understood to be the restoration of appropriate nutrition-related parameters, such as body composition, nutrient intake, and eating behaviors. However, the procedure (i.e., specific content and interventions) of nutrition counseling remains relatively undefined and is left to the discretion of the individual EDD (2,3,9-11).

This study proposed to describe the educational topics, skills training, and support methods provided by 10 experienced EDDs and reported by their patients, with the aim of providing a basis for a standardized measurement tool, outcomes research, and ultimately education and training of future EDDs.

Methods

The study collected data through the use of two surveys: the Dietitian Survey and the Patient Survey. Survey responses were gathered online over the course of 8 months and compiled electronically. All responses were analyzed using Survey Monkey software.

The Dietitian Survey, consisting of seven multiple-choice questions, was completed anonymously by 10 EDD volunteer participants who responded to an online request posted on the Behavioral Health Nutrition and Nutrition Entrepreneurs electronic mailing lists. Six items on the questionnaire inquired about the dietitian's professional training and experience pertaining to EDs, such as additional training, advanced degrees, years in the field, and percent of practice devoted to EDs. One item included a list of 40 possible interventions and asked respondents to select all of the interventions they might implement when working with individuals with EDs. This list was developed by the author through professional experience.

After completing the survey, EDD volunteers provided the Patient Survey link to current or past patients whom they would describe as "in recovery from an eating disorder." The Patient Survey, which consisted of nine multiple-choice questions and one open-ended question, was available online for a period of three months. The questions elicited information about insurance coverage, referrals made by the EDD, and the reason for initially meeting with the EDD. In addition, the Patient Survey included the question listing the 40 possible interventions that might be provided during nutrition counseling. Patients were instructed to select all interventions utilized by their dietitian.

Results

Dietitian Survey Participants

Ten dietitians responded to the Dietitian Survey. Of these, 70% reported that they worked exclusively or nearly exclusively in the ED field. A large majority of respondents (80%) had been working in the field for more than 10 years, and 50% had been working in the field for more than 20 years. One half (50%) of the respondents held an advanced degree in nutrition and 10% also held degrees in another discipline.

Patient Survey Participants

The Patient Survey was completed by 77 anonymous respondents during the 3-month period it was available online. All respondents reported that their reason for meeting with an EDD was anorexia nervosa, bulimia nervosa, or eating disorder not otherwise specified. Of those who completed the Patient Survey, 59% selected "Anorexia nervosa" as the best description of why they initially met with an EDD, 33% selected "Bulimia nervosa," and 22% selected "Eating disorder not otherwise specified." Nineteen percent also selected "Binge eating disorder" in addition to "Eating disorder not otherwise specified." Patients were given the option of selecting more than one diagnosis, if consistent with their condition when seeking nutrition counseling.

Nutrition Counseling Interventions

Table 1 lists the 23 interventions that were reported by at least 80% of EDDs and at least 50% of patients. These 23 nutrition counseling interventions are sorted by the percentage of EDDs implementing them when working with ED patients (from most to least). Interventions utilized were reported by as many as 100% of EDDs and as few as 40% of EDDs, and as many as 74% of patients and as few as 1% of patients.

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Interventions Used in Nutrition Counseling

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Twelve interventions were used by all 10 EDDs (Table 1). The two interventions most reported by patients (74%) were "Provided a listening ear" and "Improved understanding/acceptance of feelings about food." The top three (sum of response percentages) reported interventions by both EDDs and patients were "Assistance with planning meals," "Improved ability to follow hunger cues," and "Increased calorie intake."

Discussion

This study begins to describe the interventions that EDDs provide and ED patients receive during ED nutrition counseling. The information gathered by this study can be used in a variety of ways. The 23 interventions that are used by EDDs and provided to patients can be used to develop a measurement tool to quantify the effectiveness of nutrition counseling with an EDD and to separate its effects from those that result from other modalities of treatment. It should be noted that this research was limited by small number (10) of participating EDDs and that the questionnaire may have not reflected all possible interventions. Furthermore, the research does not describe which types of patients are most likely to receive the various interventions.

This information from this study can also be utilized to better explain to consumers and other professionals what nutrition counseling with an EDD entails, and why it is important for ED recovery. It can be used to demonstrate interventions that could be implemented in a cost-effective manner, which may be of value to insurance companies and hiring entities. It may also contribute to better training and education of RDs as they begin to work in the ED field.

Current EDDs may use the list to determine skills that may need to be developed, to assess learning needs and skill deficits of current and incoming patients, and to help patients identify their own learning needs and skill deficiencies. It is interesting to note that some of the interventions reported by the majority of patients as being used in their sessions were not reported to be used by all EDDs, such as "Provided a listening ear" and "Improved acceptance/understanding of feelings about food." Perhaps these can be identified as areas in which EDDs can improve their own methods of practice and continue to meet the needs of their ED patients. Further analysis of these data will sort the reported interventions by reported diagnosis in an effort to determine whether beneficial interventions can be prioritized differently based on type of eating disorder.

About the Authors

Jessica Setnick, MS, RD, CSSD, CEDRD is the author of The American Dietetic Association Pocket Guide to Eating Disorders, founder of Eating Disorders Boot Camp and Director of Training and Education for Ranch 2300 Collegiate Eating Disorders Treatment Program.

Michelle Johnson is a Master's student and dietetic intern at UT Southwestern Medical Center in Dallas, TX.

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BHN Speaks at National Conferences

BHN member and speaker stipend award recipient, **Sharon Feucht, MA, RD** presented **"Nutrition and Children with Developmental Disabilities"** at the June 2012 Assuring Pediatric Nutrition in the Hospital and Community Annual Conference in Seattle, WA. Ms. Feucht's presentation included such topics as the definitions, services, and prevalence of children with special healthcare needs. Nutrition-related issues of Down syndrome, attention deficit hyperactivities disorder, and autism spectrum disorders were also discussed. The information presented was real-world, practical application for the clinical setting with an evidence-base to support the recommendations. The Conference offers health care providers and the entry-level or competent RD, with little training in pediatric nutrition, a solid foundation to build upon. In addition to general topics, the Conference includes an in-depth look at pediatric disordered eating and developmental disabilities. Dietitians leave equipped with skills and resources needed to provide quality care to pediatric clients and their families.

Ms. Feucht is a nutritionist at the Center on Human Development and Disability at the University of Washington. She serves as a member of the Child Development Team, treating children with neurodevelopmental disabilities, and supervises trainees in the UW LEND (Leadership Education in Neurodevelopmental and Related Disabilities training program). Ms. Feucht also serves as consultant to two local early intervention centers and edits the *Nutrition Focus* newsletter, a publication about issues

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Academy for Eating Disorders 2012 Report on Eating Disorders

Karen Wetherall, MS, RD, LDN

Recently the Academy for Eating Disorders' (AED) Medical Care Standards Task Force created the 2nd Edition Report on Eating Disorders: Critical Points for Early Recognition and Medical Risk Management in the Care of Individuals with Eating Disorders (EDs). The report is intended to be a resource which "promotes recognition and prevention of medical morbidity and mortality" related to EDs. The task force states that "every attempt was made to provide information based on the best available research and current best practices."

The report is an excellent resource specifically for health care providers but also for the public. It begins with an overview defining EDs and highlighting important facts. Some important points include that weight is only one clinical marker of EDs. Eating disorders can affect men, children, people of all ethnicities and socioeconomic backgrounds, and people with a variety of body shapes. They may go unrecognized even by experienced clinicians, and they can be associated with serious medical complications.

A comprehensive overview of presenting signs and symptoms are reviewed by systems including: cardiorespiratory, dermatologic, endocrine, gastrointestinal, neuropsychiatric and oral/dental issues. Specifics of a comprehensive assessment are listed including what history to inquire about, what to look for on a physical exam and what to investigate in lab and imaging studies. This information is in a format that is very useful to share with medical doctors who may be less familiar with EDs and unsure of what tests to evaluate.

Goals of treatment are identified with significant attention paid to preventing refeeding syndrome and underfeeding. It is noted that EDs are "not merely fads, phases or lifestyle choices. People do not choose to have EDs, even though they may voluntarily engage in risk-associated behaviors such as dieting and/or exercise that my precipitate an ED."

The section titled "Timely Interventions" provides important and realistic information for families and clinicians. It points out that patients with EDs may not report that they have a problem. "This is a symptom of their illness. Patients may minimize, rationalize, or hide ED symptoms and/or behaviors. Their persuasive rationality and competence in other areas of life can disguise the severity of their illness. Outside support and assistance with decision-making will likely be necessary regardless of age". It is also noted that "lab tests can be normal even in the presence of a life-threatening ED. Minor abnormalities may indicate that compensatory mechanisms have reached critical limits."

The final section "Ongoing Management" reports that "optimal care includes a multidisciplinary team approach by ED specialists including medical, psychological, nutritional, and psychopharmacologic services. Families and spouses should be included whenever possible."

The final paragraph urges achievement of appropriate healthy weight warning that "failure to fully restore weight correlates with worse outcomes, and maintenance of the weight restoration strongly correlates with a good outcome. However, there is danger in thinking that a person with an ED is recovered once physical health and weight are restored. Distorted body image and /or ED thoughts may persist despite weight restoration and will likely require longer-term therapy."

All information for this article was taken from the Report on Eating Disorders, 2nd Edition. Additional resources, practice guidelines and bibliography can be located on the AED website at: www.aedweb.org/Medical_Care_Standards.

This summary was prepared by Karen Wetherall, MS, RD, LDN. Karen is the BHN Resource Professional for Eating Disorders. She is the Dietetic Internship Director at the University of Tennessee, Knoxville, and a nutrition consultant for Moonpointe a Focus Center for Eating Disorders.

BHN Speaks at National Conferences

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related to nutrition for children with special health care needs.

Ruth Leyse-Wallace PhD, RD presented a session on **"Mental Health: Does Nutrition Make a Difference?"** at the annual conference of the National Alliance for Mental Health (NAMI) on June 29, 2012. The audience was a mixture of people with mental illness, parents and family members who support them, and professional caregivers. Ms Leyse-Wallace was "impressed by the quality of the questions and discussion from the audience" at the favorably attended session of 190 participants. Following her presentation Ruth met an assortment of interested and interesting people, including a man from Israel who has opened five mental health centers there, a student at McGill University who was interested in the possibility of combining her major of psychology with nutrition practice, and a psychiatrist from the U.S. east coast who had been looking for a dietitian and didn't know about eatright.org and the Find-a-Dietitian resource.

After the conference, Ruth was contacted by Hanna Raskin, from the *Seattle Weekly* newspaper for a telephone interview about nutrition and mental health. Such contact and connection as a result of this stipend-sponsored presentation by BHN illustrates the importance and value of this benefit to the DPG and its members.

Ruth Leyse-Wallace, PhD, RD is author of "Linking Nutrition to Mental Health: A Scientific Exploration." and the 2010 recipient of BHN's Excellence in Practice Award for her work in the field of nutrition and mental health.

Both of these sessions were supported by a Speaker Stipend Award from BHN. This valuable member service provides funding for speakers who present on one of BHN's four practice areas. BHN members can apply for up to $400 to support speakers at conferences, meetings, or community events. More information can be found on the BHN website: http://www.bhndpg.org/membership.asp.

Nutrition Counseling Boundaries: Connecting with Patients without Practicing Psychotherapy

Presented by Jessica Setnick, MS, RD, CSSD, CEDRD at the BHN Member Reception in Philadelphia, FNCE 2012

Dietitians know that engaging clients to improve nutrition behaviors requires connection, compassion, and counseling in varying doses. But is there a point when being "a good listener" or simply "being there" for a patient violates our scope of practice? This question occurs to dietitians of all stripes – experienced, novice, hospital-based, independent, and especially those whose main interaction with patients is in a counseling setting.

Marriage counseling, grief counseling, vocational counseling, nutrition counseling – these are all different entities, useful in different situations, practiced by different professionals, even though they are all types of "counseling." I am certain that somewhere out there a dietitian without additional credentials or an appropriate license is knowingly practicing one or more of these therapies, but not the majority of ethical, appropriate dietitians who have expressed to me their worry about accidentally or unintentionally practicing psychotherapy. The reason I don't worry about these dietitians? Simple: The critical difference between nutrition counseling and mental health counseling (hereafter referred to as psychotherapy) is THE TOPIC. Although dietitians use counseling SKILLS and TECHNIQUES, we use them as means to assess and improve NUTRITION and EATING-RELATED parameters and behaviors.

Examples of Counseling SKILLS:

- Active listening
- Reflecting
- Open-ended questioning
- Unpacking
- Validating
- Brainstorming

Examples of Counseling TECHNIQUES:

- Motivational interviewing
- Cognitive behavioral therapy
- Dialectical behavioral therapy
- Acceptance and commitment therapy

Both dietitians and psychotherapists, as well as doctors, nurses, physician assistants, paraprofessionals, and your mom, might use these skills and techniques. There is no law or restriction against a dietitian using counseling skills or techniques in practice, or for that matter in personal life. But when practicing as a registered and/or licensed dietitian, our obligation is to use these tools toward our patients' improved nutrition. The gray area seems to be when food and other areas of life interact, as of course they always do. As long as the "other areas" related back to food and eating, they are within the dietitian's scope of practice. Once the nutrition issues are separated from other issues, those other issues may require referral to another professional or modality outside of the dietitian's role.

NUTRITION counseling topics include the What, When, Where, How and Why of eating and drinking, meals and portions, food shopping and cooking, eating behaviors, nutrition beliefs, weight, lab values, and health. In some cases, the dietitian may be able to EDUCATE on these topics quite directly without touching on any other topics. However once information passes back and forth repeatedly from patient to dietitian and vice versa, COUNSELING occurs.

PSYCHOTHERAPY counseling topics include anything and everything related to a patient's public and private life, including relationships, dreams and nightmares, hopes and fears, life changes, future plans, employment and finances, family, grief and loss, emotions, betrayal, and childhood events. These may or may not be related to food; either way they are appropriately within the realm of psychotherapy.

During the course of nutrition counseling, dietitian and/or patient may also touch on the non-nutrition topics, usually in the domain of psychotherapy, TO THE EXTENT THAT THEY RELATE to the patient's nutrition. This does NOT mean that the dietitian is providing psychotherapy. The dietitian's appropriate response to non-nutrition topics is to discern the aspects that relate to nutrition and refer the aspects that don't onward to the appropriate person or place.

It is always, always, the dietitian who bears the responsibility to stay within an appropriate scope of practice. The patient may choose to bring up any topic of importance to him or her. The ethical dietitian will then ask follow-up questions to determine whether or not this topic is either influenced by or impacting the patient's nutrition, and to steer the conversation in that direction. When a patient brings up a topic that is NOT directly nutrition-related, the dietitian can steer the conversation to a nutrition-related topic by asking:

> "Did that event/situation/person have an effect on your eating?"
>
> "How did your eating issues play a part in the outcome of that situation?"
>
> "What is the connection between what occurred and your eating that day?"
>
> "How would you have wanted that event to influence your eating if you could do it over?"
>
> "What would you want to do differently eating-wise if you are in that situation or with that person in the future?"

If the patient does not wish to talk about the event/situation/person from a nutrition point of view, the dietitian can explain that it is a topic more appropriate for discussion with a counselor, without conveying that the patient has made a mistake. For example:

> "That was a very important event in your week. I don't have the expertise to help you with that issue, so I would like to recommend a counselor who will be able to guide you."

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> "Thank you for sharing those events with me. I appreciate that you trust me with what I know is very personal. But I'm not sure that changing your eating is going to change those events. I think that your counselor will be better able to help you find a solution."

Sometimes the dietitian will not realize that a topic of conversation is NOT AT ALL nutrition-related until the patient has explained at length. Regardless of when this becomes clear, or how long has been spent on the topic, the dietitian refers the continuation of the discussion to a counselor. For example:

> "As you were telling me about your sister's wedding, I was thinking that we were going to discuss the food at the wedding and how you felt it affected the goals we have been working on. But I realize now that the topic of the wedding has more to do with your feelings toward your sister. I hope you'll share those feelings with your counselor at your next meeting."

Sometimes the patient continues to talk about non-nutrition topics, and seems not to follow the connection back to nutrition. At these times, the dietitian specifically addresses the need to move away from the non-nutrition topic:

> "I've noticed this topic is at the forefront of your mind today. I appreciate you sharing your thoughts with me, but I'm concerned if I don't change our topic to nutrition now, that we won't have time to work on our goals."

> "I understand that such a dramatic event is going to make anything related to nutrition seem unimportant today. Would you prefer to end our session now and plan to talk about nutrition next time instead?"

The ethical dietitian continues to direct the patient toward counseling, keeping nutrition counseling sessions related to nutrition. Unless the dietitian is also credentialed as a counselor, the dietitian does not take on the role of psychotherapist, even if the patient continues to refuse to meet with a counselor. If the dietitian feels that the patient is unable to progress with nutrition-related topics due to non-nutrition issues, it is appropriate to suspend meetings with a patient until the patient has met with a counselor. Consult with a trusted colleague or supervisor before making this decision.

Ultimately, nutrition counseling includes a relationship between patient and dietitian. This relationship is stunted if the patient is unable to freely bring up thoughts, ideas, and experiences as they come to mind. The competent dietitian keeps the relationship within ethical parameters by setting boundaries between topics appropriate to nutrition counseling sessions and topics unrelated in any way to nutrition. To promote holistic wellbeing and to enhance the effects of nutrition counseling, when these non-nutrition topics arise, the dietitian does not ignore them, but points the patient in the direction of an additional service that will address them. In this way the dietitian can connect with each patient without putting his or her professional ethics at risk.

This talk could be considered negative – all about what not to do and what not to say. But most dietitians I've met already have a dictator in their head, telling them what they shouldn't do, what they already did wrong, and how they're not good enough.

Dietitians don't need to be smaller, quieter, or more submissive. We need to be louder, larger, and in control, because the world is not coming to us open-armed. There are so many barriers in our way- insurance, public perception, want of leadership – that the last thing we need is one more reason not to do what we do best.

If you are a dietitian in this room, if you took the classes, the exam, the jobs… If you jumped through the hoops, accepted your entry-level-pay… If you did what it takes and then came here today, then something called you to be a dietitian. No one in this room got here by accident. All the forces in your life, whether you choose to call them destiny, fate, karma, or God, conspired together to bring you here, to this ballroom, this city, this moment.

So what can I tell you to make this moment here worthwhile? What can I add for those with experience? What can I change for those with regret? For this moment, I turn to the words of Marianne Williamson (1):

> *Our deepest fear is not that we are inadequate. Our deepest fear is that we are powerful beyond measure. We ask ourselves, "Who am I to be brilliant, gorgeous, talented, fabulous?" Actually, who are you NOT to be? You are a child of God. Your playing small does not serve the world. There is nothing enlightened about shrinking so that other people won't feel insecure around you… And as we let our own light shine without words we give other people permission to do the same. As we are liberated from our own fear, our presence automatically liberates others.*

Well-behaved dietitians rarely make history. We must continue to use our skills, and we must continue to advance our cause, because no one else will do it for us. Stop trying to do less than your best because someone told you it's not your job. Stop robbing your patients of all you have to offer. Stop telling yourself "no one wants to hear that from the dietitian." And start valuing each and every thought that comes from your source. And isn't that just what we are asking our patients? To believe that life can be better than this? To believe that our actions can improve on our past? To listen when they hear an inner voice?

When we muzzle ourselves, we give power to those who say "Dietitians all say the same old thing." When we censor ourselves because "It's someone else's job," "They wouldn't want to hear it," or "they'll think I'm overstepping"…

When you speak up, and speak out, you may ruffle feathers, but only those with insecurities of their own. Those who earnestly look for the truth will appreciate the wisdom you bring to the table.

This is the dietitian's sacred gift to impart. The strength our profession empowers us to give. It is wisdom. And it is life-changing, world-changing… but only if we let it. That inner North Star is the dietitian's strength. It is not just a hunch, an instinct or a guess—it's

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a cumulative force born from education, experience, clinical judgment, and AHA! And in some cultures, some centuries, even some workplaces, it has even been called Divine Inspiration. That voice within that says the other members of the team are missing a piece of crucial information or interpreting data incorrectly. That insight that says this person needs a shoulder to lean on, not another critic. That instinct that says, "I don't think this person's problem is food" and makes a referral to a mental health professional; that indescribable part of yourself that "gets it," when other professionals do not. If dietitians decide to stop using our powers, or to hide our gifts from the outside world, then we are choosing to defeat ourselves before the battle starts. For dietitians to be valued in the market place there is never a doubt WE MUST VALUE OURSELVES.

In the words of the ancient Rabbi Hillel, *If I am not for myself, who will be for me? If I am only for myself, what am I? And if not now, when?*

About the Author

Honored Breakfast Speaker Jessica Setnick, MS, RD, CEDRD, served for many years as BHN's Eating Disorder Resource Professional , in 2009 as BHN Chair, and in 2010 was awarded BHN's Excellence in Practice in Eating Disorders Award. She is the inspiration behind EatingDisorderjobs.com and DesperateDietitian.com, and speaks on college campuses through the CAMPUSPEAK speakers' bureau. Jessica serves as Director of Education & Training for Ranch 2300 Eating Disorders Treatment Program.

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Appreciation and recognition is extended to Ranch 2300 for sponsoring Jessica at the BHN Networking Breakfast. Link to slide presentation at http://bhndpg.org

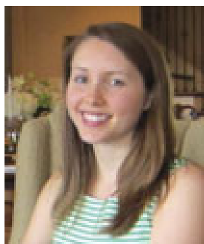
In the BHN Pipeline!

On June 15, 2012, ***Zing Bars,*** a line of delicious energy bars created by four registered dietitians in Seattle (including two BHN members, Minh-Hai Tran, MS, RD, CSSD and Kathleen Putnam, MS, RD) launched two new delicious and nutritious flavors: Dark Chocolate Hazelnut and Coconut Cashew Crisp. Both new flavors are gluten, soy and dairy-free and have 10 grams of protein from rice and pea sources. According to these innovative RDs, "Creating new flavors isn't easy and we start by reaching out to our customers. There was a strong vote for the idea of a 'Nutella' Zing bar. We loved the idea of combining chocolate and hazelnut flavors, but knew we had to do it in a healthful way, with no preservatives, artificial oils, and the healthy fat and protein that make Zing the balanced nutrition bar you'd expect from a group of dietitians." Organic, fair-trade dark chocolate was added to hazelnuts, along with Organic agave nectar, high quality rice and pea protein, and a bit of coconut. The Coconut Cashew Crisp bar is made with roasted cashew butter, coconut, Organic agave nectar, and Organic quinoa crisps. "High fiber, heart-healthy, low glycemic ingredients make for another nutritious addition to the Zing family."

www.zingbars.com

Registered dietitian and founder of Nutritioulicious® Jessica Fishman Levinson, MS, RD, CDN developed 55 kid-friendly and nutritionally sound recipes for her newly-released first cookbook, *We Can Cook: Introduce Your Child to the Joy of Cooking with 75 Simple Recipes and Activities* (Barron's, August 2011). Designed to make cooking and eating fun for children and parents, every recipe has step-by-step instructions with tasks for children ages three to six. Jessica was inspired to write *We Can Cook* because she loves seeing the interest and excitement children have when it comes to food. As a dietitian, she believes that teaching children about nutrition and food at a young age is a very important part of child development. She also advocates for children to eat the same food that adults eat, and one way to encourage children to advance their palates is by bringing them into the kitchen during the cooking process. Involving kids in the kitchen at an early age is a great way to introduce them to new foods and help them gain a positive understanding of food and cooking. The recipes in *We Can Cook* were created for children to be an integral part of the food preparation. Rather than parents cooking on their own and placing new foods in front of their children at meal time, if the kids are involved in the cooking process they will be more likely to try the food they made. *We Can Cook* is divided into six chapters based on food groups, including fruit, vegetables, bread, pasta, and grains, meat, fish, and poultry, dairy and eggs, and healthy treats (while not a real food group, no cookbook would be complete without this section!). While there are some kid-favorites like mac 'n' cheese and chicken fingers, there are many recipes that are not staples of children's diets, such as steak fajitas and grilled plums with yogurt sauce. No parent should be a short-order cook, so having recipes the whole family can enjoy will help parents stick to cooking one meal at a time.

To find out more about *We Can Cook* or to order a copy, contact ***Jessica at Jessica@Nutritioulicious.com*** or check out ***http://amzn.to/mUw9vn***.


Caroline Yoder

Student Corner: The Value and Skills Students Bring to BHN

By Caroline Yoder

Joining a dietetic practice group (DPG) is a great way for nutrition and dietetics students to become familiar with specific subsets of the field that pertain to their particular interests. Here at BHN, we are fortunate to have many student members, and we welcome them to participate in all the group's activities.

Student members might feel that they can't get involved in the DPG, perhaps due to limited experience in nutrition or lack of the RD certification. The fact of the matter is that students offer a vast array of unique skills and insights that benefit BHN.

Technological Know-How

One such skill is students' familiarity with technology. A 2010 study estimates that a staggering 98% of college students own a computer, and about 95% have used social networking sites (1). Moreover, a growing number of students write personal or professional blogs. In an increasingly digital age, this comfort with using the Internet and with trying new technologies will not only benefit students' future careers, but also present opportunities for them to interact with and contribute to BHN.

Personal Understanding of Mental Health

The current student cohort also shares the experience of better understanding of psychological disorders. The public awareness of autism disorders has increased in recent years, in conjunction with the spike in diagnosed autism cases. California, for example, saw a 634% increase in the number of autism cases between 1987 and 2003 (2). Similarly, the incidence of eating disorders has increased among the adolescent age group in past few decades (3). With these trends in diagnosis, students of today are more likely to have an understanding of mental illness, perhaps from personal experience, from knowing someone with these conditions, or even just from living in an age when mental health became a greater part of the public consciousness.

The Future of Our Profession

The final and perhaps most important characteristic that students in BHN share is that they are the future of our profession; they will shape the future of dietetics. Most current students are considered to be part of the Millennial Generation, that is, they were born after 1980. Research has just begun to identify the unique qualities of this age group, but preliminary findings indicate that, in general, members of the Millennial Generation aim to gain new skills and seek rapid advancement within their chosen career paths, while still maintaining realistic job expectations (4). These attributes, in addition to those yet to be revealed, will make for a generation of high-achieving and effective dietetic professionals.

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The BHN Student Committee

By David Wiss

David Wiss

BHN Students now has a Facebook group where we share ideas and create opportunities for involvement in the DPG. We are currently updating the Student section of the BHN website (www.bhndpg.org/students) and looking for original contributions of articles relevant to behavioral health nutrition. We are also planning to develop Fact Sheets and other handouts for use by BHN members as well as the public. There are plans to develop a formal mentor/mentee program for students to connect with, and study under BHN RD's. We have started trending #BHN students on Twitter and have built a fantastic social media team. We are always looking for new ways to promote awareness of BHN and are interested in hearing your ideas!

If you're a student looking to become more involved in BHN, you can contact our new Student Liaison, David Wiss at david.wiss.65@my.csun.edu or the Student Newsletter Editor, Caroline Yoder at yoder.cw@gmail.com. We look forward to hearing from you!

In Search of Evidence . . .

Practice-based Research Substantiates RD Value

by Ruth Leyse-Wallace, PhD, RD

Would you like to make your practice a part of meaningful dietetic research—research that could make a difference? Perhaps you feel too busy or maybe you don't know where to start. Explore the Dietetics Practice-Based Research Net-work (DPBRN) and see the possibilities!

DPBRN conducts, supports, promotes and advocates for research in practice-based settings. Practitioners and researchers are brought together to identify research that is needed in practice settings, design top-class research, obtain funding, and carry that research into real-life settings. The Network is composed of dietitians, employed throughout the United States, committed to improving dietetics practice and food and nutrition services. As a practitioner member of the DPBRN, you can submit ideas for research, serve on an advisory group that selects research studies, assist in data collection, utilize your own client-base for data, and help disseminate the results.

Current DPBRN projects include: 1) a descriptive study regarding the research capability of DPBRN members, 2) validation of nutrition diagnostic terms, and 3) evaluation of outcomes from MNT intervention for obesity and other chronic diseases.

If a lack of research experience hinders you from getting involved, rest assured, DPBRN will provide you with all the materials and technical support needed. In fact, research is designed to minimize the patient and provider burden as the focus is on research that can be incorporated into daily practice. For more information on DPBRN and how to join, see the *Journal* article, Blending practice and research: Practice-based research networks an opportunity for dietetics professionals (1).

Table 1. Measurable Scientific Concepts of Mental State: (2)

- Mood
- Arousal
- Activation
- Vigilance
- Attention
- Sleep
- Motivation
- Effort
- Perception
- Memory
- Intelligence

Table 2. Examples of Theories used by Clinical Dietitians:

- Behavior Change Theory (3)
- Social Cognitive Theory (4)
- Stages of Change Theory (5)
- Theory of Reasoned Action (6,7)
- Self-Efficacy & Locus of Control (8)

Figure 1. Domains within The Metaparadigm of Clinical Dietetics (9)

- Reference Person
- Human Condition
- Practitioner Actions/Attitudes
- Practitioner Actions
- Practitioner-Attitude
- Client Actions/Attitudes
- Client Actions
- Client Attitude
- Practitioner Environment
- Client Environment
- Nutraceuticals
- Research survey

Research Toolkit

Another valuable resource is the online Research Toolkit, developed by the Academy of Nutrition and Dietetic's Research Committee. It's available free of charge to members at https://www.adaevidencelibrary.com/store.cfm?category=13&auth=1. Whether you need a refresher or tools for career enhancement, the Toolkit can help. Some of the topics will help you:

- Read and interpret research articles
- Understand research designs and statistical analyses
- Outline the steps of a research project
- Apply research to practice
- Write a research grant
- Evaluate a study design and test the hypothesis (2.5 CPE)
- Interpret statistics (3 CPE)
- Develop a good research question

Explore the Possibilities

Additional options for RD involvement in research may be found in collaboration with research projects within facilities where one is employed, or by teaming up with other BHN members who serve similar populations who have similar observations and questions. Research by Registered Dietitians may involve abstract topics (beliefs or values), concrete topics (laboratory values, test scores), or be descriptive, observational (cohort, cross-sectional, and case-control studies), qualitative/measureable (Table 1) , quantitative, a systematic review of literature, a meta-analysis, or experimental in form and purpose. Research by RDs should be science-based and either theoretical and/or hypothesis-driven (Table 2). Research may be in any of the seven domains of The Metaparadigm of Clinical Dietetics which have been validated as domains of concern to the profession (Figure 1).

Participating in research related to your personal practice can be incredibly rewarding. It can benefit patient care, justify RD consultant hours, and add to the profession-specific body of knowledge.

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Practice-based Research Substantiates RD Value

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Research helps prove the value of dietitian services, in turn, increasing the demand for services, providing job security, and affording new opportunities.

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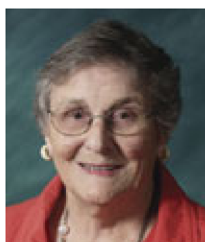
BHN-DPG Delegate's Report

Harriet H. Cloud, MS, RD



During FNCE, The House of Delegates meeting included discussion of two important issues for the Academy of Nutrition and Dietetics and the entire membership. This was the first meeting of the HOD for me as your newly elected delegate, and I am excited to be representing BHN-DPG. I believe that the inclusion of practice groups in the HOD is a wonderful opportunity.

The first issue that received extensive dialogue and reviewed by the delegates over the summer is entitled: Public Health Nutrition: It's Every Member's Business. The background paper related to this issue was developed by a committee appointed by Sylvia Escott Stump in 2011 to address enhancing the relevance of public health nutrition within the Academy and increasing the Academy's visibility within the broader public health community. The committee was specifically charged to develop an action plan which would include a dialogue session on public health nutrition within the HOD.

Part of the interest in public health nutrition is related to the Patient Protection and Affordable Health Care Action passed in 2010, the Supreme Court ruling that upheld most of the law, and predictions of changes in health care delivery systems with greater emphasis on prevention of disease. Nutrition plays a major role in disease prevention as well as treatment and could provide additional opportunities for RD's.

The discussion with the HOD includes asking how our members can seize opportunities in the changing health care environment and provide leadership in public health nutrition and community nutrition. Other expected outcomes include members becoming leaders by working in policy development, assessment, assurance, advocacy, environmental change, education and programs and services. The third outcome involves preparing members to meet the needs in public health nutrition and community nutrition.

An action plan has been developed with specific timelines and HOD discussion during FNCE one of the first steps. The task force on this issue has recommended that arriving at a consensus on the definitions of community nutrition and public health would be a starting place.

Many of the members of BHN-DPG have worked in public health programs involving children and adults with mental health and developmental disabilities. This is a mega-issue that should be of great interest to us. By going to the Academy Website www:eatright.org you can click on governance, HOD and FNCE to read the full documents.

The second issue addressed by HOD at FNCE involves the ***Visioning Report*** Moving Forward – A Vision for the Continuum of Dietetics Education, Credentialing and Practice. This is the report provided by the Council on Future Practice created in 2008. The report is extensive with no action taken during the HOD meeting other than discussion. In a nutshell, the report has 9 recommendations which include beginning practice with an advanced degree from an Accreditation Council for Education in Nutrition and Dietetics (ACEND) accredited program, creating a new credential for the baccalaureate degree graduate, supporting an RD name change, and phasing out the current DTR credential.

Much of what is being recommended has been discussed extensively in the past and will require a great deal of discussion and thoughtful consideration now. The full report is on the Academy website following the same directions for the Public Health Nutrition report. Whenever change is proposed, many divisions of the Academy will be involved and member input is necessary. As your delegate, I will keep you informed as information is provided, and will look forward to receiving your concerns, questions, and suggestions.

Harriet H. Cloud, MS, RD
BHN HOD Delegate
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Caffeine, Nicotine, Nutrition: Practical Implications for Substance Abuse Recovery

By David A. Wiss, BA, CPT

Caffeine and nicotine have been referred to as "social drugs" (1) because of their ability to induce pleasurable sensations. They are often used together for their synergistic effects. Nevertheless, all mood-altering substances have the potential for abuse, as tolerance and dependence develop over time. Because these substances are widely available, individuals can self-administer potent forms legally. Some drug and alcohol treatment centers do not allow the use of "social drugs", however other treatment centers allow their residents to utilize these substances without any formal regulation. According to Dekker (2), caffeine and nicotine are often used as a breakfast substitute for individuals in recovery, which may have adverse effects, particularly later in the afternoon.

Prolonged caffeine and nicotine intake, toxicity and dependence are associated with a wide range of psychiatric and substance use disorders (1). In addition, the concentration-dose ratio of caffeine appears to be three to fourfold as high among nonsmokers compared to smokers (3). This higher ratio suggests that smokers require three to four times the dose of caffeine to achieve the same plasma caffeine levels. Johnson, Strain, and Griffiths (4) documented that caffeine ingested pretreatment attenuated the subject-rated positive effects of high doses of intravenous nicotine. Researchers concluded that caffeine has complex interactions with nicotine that are dependent on multiple factors including chronicity of caffeine consumption and history of other substance abuse. In practical terms, caffeine may operate as a cue for smoking, and this relationship is commonly seen in clients with a history of abuse.

Caffeine

Caffeine is not limited to coffee, tea, chocolate, and sodas. Supplemental caffeine is used in "energy drinks", and caffeine pills are readily available and inexpensive. Energy supplements often contain as much as 300 mg of caffeine per serving. "Caffeinism" starts at 600-750 mg/day, with 1000 mg/day and above defined as toxic (5). Toxicity occurs when increasing amounts are added to chronic intake and leads to wakefulness, restlessness, anorexia, vomiting, dehydration, seizures, and tachycardia (6). Dehydration exacerbates confusion, agitation, and poor concentration.

Coffee and tea have been shown to inhibit the absorption of iron in food, a nutrient needed by many individuals in recovery from drug abuse (7), particularly menstruating females. Combining caffeine with nicotine can increase gastric secretions and lead to gastric irritation (8). High coffee intake is associated with increased plasma levels of low-density lipoproteins and total cholesterol. The duration and quality of sleep are also affected by caffeine, which can have a significant impact on the body's ability to recover from alcohol and drug use.

Nicotine

Nicotine is a highly addictive drug most frequently inhaled through cigarettes, while other forms of combustible and chewing tobacco have high nicotine content. From 2000 to 2011, consumption of cigarettes in the US decreased 32.8% while consumption of non-cigarette combustible tobacco such as loose leaf or cigars increased by 123.1% (9). The electronic cigarette (e-cigarette) now allows individuals to consume nicotine in public places where smoking is illegal. Novy, Hughes, and Callas (10) have found that recovering alcoholic smokers were more nicotine dependent and had more internal barriers to quitting compared to non-alcoholic smokers.

Nicotine increases metabolism and acts as an appetite suppressant (11), and can remove the unpleasant effects of hunger. Nicotine compromises the senses of taste and smell, affecting food intake and therefore all areas of nutrition (8). Smokers have a tendency to choose hyper-palatable snack foods and are less likely to enjoy the taste of fruits and vegetables, creating significant barriers for successful nutrition interventions. Smoking also increases the levels of free radicals in the blood stream. Plasma vitamin C levels are lower in smokers independent of dietary vitamin intake, as are total carotenoids (2). Smokers should increase their intake of antioxidant rich foods such as carrots, sweet potato, red pepper, and other fruits and vegetables, rather than supplements. Avoid the "quick fix" approach whenever possible.

Interactions

Since abstinence is the hallmark of recovery programs, numerous authors have concluded that individuals in recovery should abstain from "social drugs" entirely. More realistically, the timing of caffeine and nicotine cessation or reduction should be assessed on an individual basis. Both substances have known interactions with psychiatric medications such as clozapine/Clozaril and olanzapine/Zyprexa; therefore abrupt alterations in daily intake may have psychopharmacological effects for patients taking these medications (3). Caffeine intake and smoking may also alter the metabolism of selective serotonin reuptake inhibitors (SSRIs) such as fluoxetine/ Prozac, sertraline/Zoloft, and citalopram/Celexa (12). Psychotropic agents also have known effects on appetite and weight. For many patients, the first few months of sobriety are not the optimal time to drastically alter caffeine and nicotine intake, particularly when neuropharmacologic medications have been prescribed. Dietitians should always be aware of drug interactions when dealing with the substance abuse population.

Current Cessation and Reduction Options

Complete abstinence from caffeine is not indicated for all clients. Withdrawal from caffeine should be managed gradually, as headaches, drowsiness, and lethargy are common side effects (5). Caffeine causes peripheral vasodilation but vasoconstriction of vessels in the brain, leading to its use a headache

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remedy (8). Limiting caffeine intake to a maximum of 450 milligrams per day (roughly 3-4 cups of coffee) is a reasonable starting goal for individuals in early recovery (2).

Prescribing options to help people quit smoking include nicotine replacement therapy patches, chewing gum, sublingual tablets and spray, bupropion – an oral noradrenergic antidepressant and varenicline – an oral nicotine receptor partial agonist (5). However, the majority of smokers who eventually quit do so without formal treatment, as most smokers are unwilling to attend formal cessation programs (13). Nicotine Anonymous has spread across the globe since its inception in the early 1980's and offers assistance without dues or fees (14). An average weight gain of 4 to 5 kg (8-10 lbs) is common following cessation of smoking and is another reason for recidivism (6), increasing the need for dietitians in treatment settings. Meanwhile, implementing a "dieting" approach to weight control while trying to quit smoking may worsen rather than improve cessation goals (2).

Discussion

There are special considerations when working with individuals in recovery from alcohol and drugs. Using scare tactics based on reports of adverse health outcomes such as cancer, cardiovascular, and pulmonary disease may be counterproductive. Strict avoidance of caffeine during early recovery may make nutrition appear to be punitive rather than a helpful component of recovery. Most people in recovery will need to draw their own conclusions based on their own experiences. If information alone was sufficient to promote recovery from substance abuse, recovery rates would be much higher and treatment programs would be better recognized and utilized.

There is a growing body of evidence that suggests nutrition education during substance abuse contributes to positive outcomes (15,16). Dietitians that are trained in nutrition education for addicts can assist substance abuse clients on the path towards behavior change. By focusing on the role of physical health in the process of recovery, clients may be better positioned to make informed choices about what they consume. By highlighting the negative impact of caffeine and nicotine on nutritional status, patients may be more open to reducing or quitting these habits. Nutrition education and counseling can become an effective adjunctive approach towards caffeine and nicotine cessation or reduction. Using motivational interviewing techniques, the dietitian can highlight the discrepancies between current behaviors and overall treatment goals (17,18).

By focusing on the benefits of a healthful lifestyle and the negative nutritional consequences of caffeine and nicotine, dietitians can promote behavior change favorable to recovery from alcohol and drugs. Complete avoidance may not be necessary during early recovery and may lead to relapse. Caffeine and nicotine can assuage the early stages of recovery, a period of new emotions, anxiety, and uncertainty. Clients should be reminded "first things first" and encouraged to consider the possibility that cessation is a secondary goal. Caffeine intake may not need to stop abruptly, but it can be successfully monitored and reduced. Incorporation of an exercise program may facilitate this process. An attitude change that is essential for long-term recovery must come from within, and new knowledge about the impact of nutrition on physical recovery is a good start.

For more information on the nutritional implications on caffeine and nicotine and tips for cessation or reduction, please refer to the BHN Publication *Nutrition & Addictions: A Guide for Professionals* and the BHN DVD *Psychiatric Nutrition Therapy,* both available in the publications section of www.bhndpg.org.

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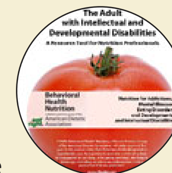

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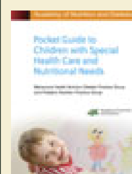

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