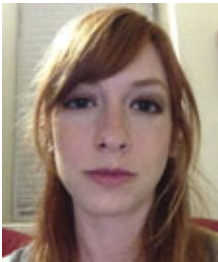


BHN: Fuel Your Brain, Feel Your Best!



Hayley Miller,
MS, RD, LDN

Parental Influences on Body Image – A literature review

By Hayley Miller, MS, RD, LDN



Introduction

Family dynamics and patterns may have an influence on the development of eating disorders. Early research on this topic focused primarily on adolescent females with eating disorders and their mothers. More recent research investigates the role of fathers and their relationships with their daughters on eating disorder development. A dietitian working with adolescents with eating disorders may benefit from investigating the beliefs and practices surrounding meals, eating, and body image within each client's family unit. Body image may be defined by many Medical Dictionaries as the individual's perception of one's physical appearance based on self-observation and reaction of others. Information on the family practices and dynamics assists the dietitian in making recommendations suitable for the clients' improved nutrition within that family system. Information that indicates difficulty with family communication or functioning allows the dietitian to make appropriate referrals to family counseling, multi-family support groups, or higher levels of care.

Influence 1: Maternal Encouragement of Weight Loss

Significant reviewed research has been devoted to the role of the mother-daughter relationship in the development of eating disorders (1,2,3,4). It is often listed as one of the three most common environmental influences, together with peer pressure, media messages (5).

In one study, the perception on the part of adolescent girls that their mothers were encouraging them to lose weight was a predicting factor of disordered eating behavior, even if that was not the intention of the

mother (5). In the same study, symptoms of bulimia were higher in those girls who reported high pressures across multiple aspects of their lives. Exposure to multiple sources emphasizing the physical ideal increased the likelihood of eating disorder behavior. Maternal pressure to lose weight on adolescents of both genders appeared to have a strong influence on adolescents' views of their physical appearances. Boys perceived higher pressure from the media but lower pressure from mothers to be attractive. As such, the perceived pressure predicts greater reports of dieting behavior and fewer reports of bulimic thoughts and behaviors in young men (5).

Because of the thin ideal perpetuated mostly to women, mothers may unknowingly send messages to their children, especially girls, that being thin by dieting is an acceptable behavior. This is based on the traditional role as a mother of being a caretaker and a nurturer of children (6). Studies support the notion that daughters were influenced by parental encouragement of dieting and weight control practices. Mothers more often report counting calories and eating low-fat foods for weight management, but were similar on exercising and more extreme weight loss practices such as fasting and vomiting as fathers (6). Interestingly, daughters reported not paying as much attention to fathers' encouragements to lose weight. Behaviors of parents' extreme dieting practices predicted daughters' use of these practices.

Mothers with eating disorders had lower incidence of breastfeeding their children which decreased fetal attachment. In addition, mothers with eating disorders expressed negative comments during meals but not when infants were playing. In these families there were more arguments at meal



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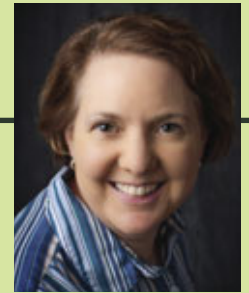
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From the Chair

Mary E Kuester, MA, RD



It is my pleasure to welcome you to the Behavioral Health Nutrition Dietetic Practice Group (BHN) whether you are a returning or new member! In addition, I would like to give a special welcome to those of you who may be students. We are thankful that you have chosen this practice group and value the contributions you make!

We have had a busy and exciting year building our momentum to provide excellent resources for professionals who work in the areas of addictions, eating disorders, intellectual disabilities and mental health. I feel fortunate to be part of an executive committee that is creative, energetic, and dedicated to transforming dreams and ideas into reality. Here is a short list of things that we have done this year for our members:

- Quarterly webinars by members and other leading healthcare professionals for each of the practice areas with the ability to earn CEUs.
- A free webinar for members on Motivational Interviewing.
- The ability to obtain CPEUs through our Quarterly Newsletter.
- Increased presence on social media including Facebook, Twitter, and Pinterest.
- Increased visibility for BHN at the California Dietetic Association meeting in April, 2013.
- BHN member reception at FNCE with Jessica Setnick, MS, RD/LD, CSSD providing talk on eating disorders.
- Published SOP/SOPP for those with Intellectual Disabilities.

There are more things to look forward to in the coming year including:

- BHN member breakfast at FNCE on Monday, Oct 21st (see schedule for details)
- FNCE Spotlight session on the relationship between nutrition and psychiatry given by April Winslow, MS, RDN,
- Resource professionals for each practice area to answer your questions.
- EML to help you connect to other professionals in your practice area.
- Quarterly webinars for each practice area including one free webinar.
- Increased sponsorship of BHN activities to enhance member offerings/ benefits.

By the time you read this welcome, the Executive Committee will have met to set goals for the coming year. I am excited to seeing how the year comes together. I also want to encourage you to get involved with BHN in whatever way works best for you. We are always looking for authors for newsletter articles, speakers for webinars, as well as volunteers to run for office. As always, we are open to suggestions from our members so please feel free to contact me or another member of the executive committee.



BHN Executive Committee Meets in Denver for Leadership Annual Planning.

From Left: Therese Shumaker, MS, RD, LD; Harriet Cloud, MS, RD, LD; Ellen Griffiths, MPH, RD, LDN; Mary Kuester, MA, RD, LD; Lester Rosenzweig, MS, RD, CDN; April Winslow, MS, RDN; Adrien Paczosa, RD, LD; Tegan Medico, MS, MPH, RD, LDN

Parental Influences...

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times leading to a higher incidence of increased childhood anxiety at mealtime. Thus suggesting feeding disturbances in children are specifically linked to those disturbed eating habits and attitudes among their mothers (7). Even if children had low weight, 50 percent of mothers with weight and diet preoccupation restricted their children's intake of sweets, and 30 percent restricted fattening and unhealthy foods (6). These same mothers with diagnosable anorexia nervosa have been reported to underfeed their children, leading to shortness of stature. Lastly, mothers with eating disorders also were more verbally controlling and intrusive and less supportive to their children than mothers without eating disorders

Influence 2: Family Dysfunction

Girls with disordered eating practices came from families with less cohesion, organization, and expression. Also, children from families with low levels of parental caring, low parental expectations, and low familial communication had more disordered eating practices. In addition, if these children were abused physically or sexually, they had higher levels of disordered eating (8).

Families of children with eating disorders reported family difficulties in problem solving, roles, effective responsiveness, and general functioning (9). Eating disorders may share genetic predisposition like other psychiatric disorders.

Influence 3: Inherited Traits

Considerable advances have been made in understanding genetic influences on eating pathology. In-depth reviews of the scientific literature from the University of North Carolina and the Columbia University Medical Center on the genetics of anorexia nervosa, bulimia nervosa, and binge eating disorder include present studies, emerging hypotheses, future directions, and clinical implications (10,11). Studies show that eating disorders aggregate in families.

Personality traits associated with eating disorders include high levels of harm avoidance, stress reactivity, and negative emotions. Negative emotionality may be

defined as one with increased adverse reactivity, inflexibility, irritability, and low levels of cooperativeness and manageability (8). Childhood and parental obesity has predicted risk for bulimia. There is research supporting the idea that depletion of L-tryptophan caused by dieting can trigger depression, concerns about weight and shape, and fear of loss of control of eating (7). Twin studies have supported that eating disorder symptoms can be inherited (7,10,11).

Influence 4: Parental Role Modeling

Modeling is very important to consider when looking at relationships with adolescents and their parents. Research has supported the notion that certain traits in parents are passed down to their children. It follows that if a parent is anxious; the child will either take care of one's parent or will learn through modeling that anxiety is a way to deal with the world. Therefore, it makes sense that if parents rely on children to calm their fears, children may take on the role of caretaker and will neglect their own self-care. Anxious parents of children with anorexia often were most willing to fulfill their own parent's expectations based on family attitudes and judgments (12). Also, strained family relationships can predict development of disordered eating behaviors. It is interesting to note that mothers of girls with disordered eating engage in more disordered eating behaviors themselves. These mothers tend to rate their daughters less attractive than did the mothers of daughters without disordered eating. However, mothers with disordered eating practices did not significantly predict disordered eating in their daughters (8). Thus, family members can model body preoccupation and disordered eating behavior.

Influence 5: Paternal Intrusion

There is research suggesting women suffering with anorexia evaluated the relationship with their fathers as if similar to how one would treat their spouse. These fathers were more intrusive into their daughters' lives and turned to their daughters for support. Fathers can help their daughters feel attractive, competent, and help to validate their emerging identity as women.

If fathers provide too much attention to their daughters, they can seem intrusive or sexually threatening. Fathers may also focus on their daughters and their sexuality because of a failed relationship with their daughters' mothers (12).

In research with fathers of daughters with eating disorders, themes emerge such as distancing self from reality, a history of power and abuse, projected roles within the family, critical of self and troubled relationships within the family, and finally loss emerge (9). Parents who are unwilling or unable to respond to or satisfy children's basic needs create anxiety and insecurity in the relationship. Some children may develop an eating disorder to cause parents to notice them.

Family-Based Prevention Programs

Programs focusing on parenting practices rather than family functioning may help prevent eating disorders (13). Parental connection such as warmth, closeness, and communication decreases the connection between adolescent disordered eating practices and family functioning. A way to protect against eating disorder behavior in children is to develop family events, becoming a friendly parent, and feeling closer to one's children. Parents who modeled appropriate coping skills to deal with stress protected adolescents from becoming susceptible to eating disorders. Families modeling healthy communication, adaptability, problem solving, organization/structure within the family, and unconditional acceptance of family members are associated with fewer eating disorder behaviors in children (12).

One intervention program that promoted body acceptance and helped prevent eating disorders was a six-session life skills promotion conducted on a large sample of children in four Canadian middle schools. The goals of the program were improving self-worth, teaching assertiveness and social problem solving, and education about body image connected with the media and natural variability in body shapes (8). Another program, conducted in California, was eighteen sessions focused on promoting healthy weight regulation practices along education on the resistance of social influence

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Parental Influences...

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regarding dieting and the thin body ideal. These programs made a moderate impact on decreasing negative body satisfaction. It is recommended that dietitians and therapists continue to promote health at every size perspective instead of the thin ideal.

Conclusion

Based on the current body of research, no one can definitively state what does or doesn't cause eating disorders. Eating disorders appear to be multi-factorial in etiology, with potential biological, societal, and familial influences. Parental ideals and behaviors can contribute to eating disorder potential, in addition to other factors such as susceptibility to media messages and peer pressure. Family dynamics contribute to eating disorder development but do not determine it. When evaluating how best to help clients with eating disorders, dietitians should be teamed with other healthcare members and consider as many factors as possible that can be identified as contributing to, exacerbating, and/or perpetuating dysfunctional eating behaviors. Dietitians can then help clients recognize the influences and pressures affecting their eating and teach strategies for improving meal-times, conversations about food and eating, and managing potentially triggering events and situations. Dietitians also play a role in helping parents teach and role-model appropriate eating behavior, expand the focus of health and nutrition to more than body weight, avoid unhealthy or perfectionistic extremes, and protect their children from media messages and peer pressure that emphasize unrealistic weights and weight control practices. Including parents who have been influential in the development of their child's eating disorder can be instrumental in the same child's recovery if they are willing to work with the dietitian and other treatment professionals to learn to relate to

their child and their child's eating and weight in a different way.

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Time to spotlight BHN members who have shown "Excellence in Practice" for each of our four areas of practice and to celebrate one recipient for our "Distinguished Member Award."

Go to www.bhndpg.org/about/awards.asp for BHN awards criteria, guidelines, and forms to nominate members you know to be deserving of these awards.

For questions contact
Therese Shumaker at
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**Application Deadline
is August 1, 2013!**



CPE

CPE credit (1 hour) is available from BHN for the full text version of the article, Parental Influences on Body Image – A literature review. Access the article at <http://bhndpg.org/index.asp> and <http://www.bhndpg.org/moa/cpes.asp> for reading/taking quiz .

Nutritional Treatment for Alcohol Associated Acute Pancreatitis

Kathryn Fulginiti RD, LDN



Kathryn Fulginiti RD, LDN

Pancreatitis

Acute Pancreatitis is identified as an acute inflammatory process of the pancreas, including inflammation, edema, and necrosis of pancreatic tissue. Severe acute pancreatitis can have serious consequences, including diabetes, kidney failure, malnutrition, and death (1). The predominant symptom of acute pancreatitis is abdominal pain, intermittent or continuous, which may vary in intensity. The pain tends to worsen with oral food and fluid intake, and is often accompanied by nausea and vomiting, with subsequent decreased oral intake (2).

Causes of acute pancreatitis include chronic alcohol abuse, biliary issues such as gallstones, hypertriglyceridemia, hypercalcemia, infections, trauma, genetics, and mechanical obstruction to the flow of pancreatic juices (2,3,4). Alcohol is typically listed as the second most common cause of acute pancreatitis, gallbladder disease being the first, with approximately 30-35% of total cases (2,5). Although any person abusing alcohol may develop this issue, alcoholic associated acute pancreatitis predominantly affects young male adults (5). Genetics and environmental factors, such as smoking, may also be contributory (5). However, it is important to note that the minority of patients who abuse alcohol develop pancreatitis (3).

According to The Medical Clinics of North America (5), "proposed mechanisms of acute alcohol induced pancreatitis include sphincter of oddi spasm, precipitation of insoluble protein plugs that obstruct the pancreatic ductules, activation of pancreatic proteases, and overstimulation of pancreatic secretion by cholecystokinin." Ethanol is also involved in sensitizing the pancreas to pancreatitis with its effects on inflammation and cell death signaling that can promote inflammation and necrosis (3). However, there is no definitive method to test for alcohol as the cause of pancreatitis (2).

The exact amount of alcohol abused to cause acute pancreatitis is unknown.

However, most will have a lengthened record of extensive alcohol use (2). Alcohol induced acute pancreatitis typically occurs in patients with a pancreas already damaged by prior alcohol use, who have already established some sort of pancreatic changes. This unfortunately frequently results in the development of chronic pancreatitis. Nevertheless, abstaining from alcohol may delay or even prevent the development of chronic pancreatitis (2,5).

The Pancreas and its Function

The pancreas is a major glandular organ situated in the upper abdomen behind the stomach. It has exocrine purposes, by secreting enzymes to aid in digestion of fats, proteins, and carbohydrates; and endocrine purposes, such as producing hormones that aid in glucose homeostasis (1,4).

Nutrition Therapy

The goal for nutrition therapy for alcohol associated acute pancreatitis includes timely diet advancement without aggravating symptoms, preserving nutrition status and avoiding weight loss, prevention of deficiencies, and beginning proper nutrition support for those as appropriate (6).

Assessment:

A standard nutrition assessment including food/nutrition-related history (including alcohol intake), social/medical history, biochemical and medical tests, and anthropometrics should be conducted. The length of time of inadequate oral intake should be determined, especially to make appropriate recommendations for nutrition support.

Biochemical and Medical Tests:

Serum lipase is typically the key diagnostic indicator due to its high sensitivity and specificity (5). However, other laboratory values that should be reviewed and monitored include serum lipase, serum amylase, aspartate aminotransferase (AST), alanine aminotransferase (ALT), serum glucose, lactic dehydrogenase (LDH), white blood cell

count (WBC), C-reactive protein (CRP), serum electrolytes, blood urea nitrogen (BUN), and creatinine (4,5,6).

Nutrition Diagnosis:

Examples of nutrition diagnosis include, but are not limited to:

- Inadequate Energy Intake (NI-1.4)
- Predicted suboptimal nutrient intake (NI-1.6)
- Excessive Alcohol Intake (NI-4.3)
- Malnutrition (NI-5.2)
- Altered GI Function (NC-1.4)
- Altered Nutrition Related Laboratory Values (NC-2.2)

Intervention

Appropriate nutrition intervention is dependent on the severity (mild, moderate, or severe) and duration of the disease. Generally with mild to moderate acute pancreatitis, oral intake is restarted within the first few days of hospitalization (3). The rationale of nutrition therapy is to minimize the stimulation of the pancreas, reducing symptoms experienced. Traditionally in these cases, patients receive intravenous fluids (IVF) to correct acid-base shifts and fluid and electrolyte balance. They tend to receive nothing by mouth (NPO) to allow for complete pancreatic rest, advancing as tolerated as symptoms subside to an oral diet (5,6).

There is inadequate data available on how exactly to initiate an oral diet in mild or moderate acute pancreatitis. According to A.S.P.E.N. (7), there does not seem to be any benefit to starting diets with liquids or a low fat oral intake in mild acute pancreatitis. Additionally, "allowing patients free-choice regarding when to begin oral intake and the self selection of foods may offer the advantage of decreasing the length of hospitalizations without increasing the rate of relapse or abdominal pain" (7).

Regardless, a diet with low fat modifications, adequate/high in protein, then

Alcohol Associated Acute Pancreatitis...

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advancing as tolerated is typically prescribed (4). The level of fat constraint should be reliant on the level of abdominal pain and steatorrhea. If fat malabsorption is present, specific supplementation with fat-soluble vitamins is also essential (6). Six small meals per day may also be better tolerated upon solid food initiation (4). Alcohol should be completely avoided, including after recovery. Supplementation with 100 mg thiamine, 1 mg folate, and general multivitamin is also recommended in all those with alcohol associated acute pancreatitis.

Nutrition Support

Nutrition support should be limited to only those with severe acute pancreatitis, significant malnutrition, or those incapable to begin oral feedings within 5-7 days. It is not required for those with mild to moderate acute pancreatitis. Patients should have received fluid resuscitation and are hemodynamically stable (6).

Nutrition Support: Enteral vs. Parenteral

Numerous recent studies have demonstrated the benefit of enteral nutrition support within 24-48 hours of admission after fluid resuscitation to successfully tackle nutrition needs. Enteral nutrition support, as opposed to parenteral nutrition support, for those with severe acute pancreatitis has been shown to reduce:

- Mortality
- Risk of multisystem organ failure/dysfunction
- Gastrointestinal intolerance
- Need for surgical interventions
- Infectious complications
- Costs
- Length of stay
- Severity of symptoms and recovery (3,5,6,8)

According to The International Consensus Guidelines for Nutrition Therapy in Pancreatitis (9), enteral nutrition is generally favored over parenteral nutrition, and should, if feasible, be

started first. According to A.S.P.E.N. (7), the safety of jejunal enteral nutrition in severe acute pancreatitis is currently well documented in numerous prospective randomized trials. Enteral nutrition should be initiated within 48 hours, with continuous infusion favored, and a formula with small peptide based medium chain triglycerides should be considered to improve tolerance (9).

Further recent studies exhibit that postpyloric enteral nutrition feedings is not necessarily required, and nasogastric feedings may be used (9). However, controversy about the appropriateness of gastric enteral feeding for severe pancreatitis persists. There is an obvious need for further research and studies of gastric enteral nutrition and severe acute pancreatitis (7).

Parenteral nutrition support should be provided to patients with severe pancreatitis, who have exhibited enteral nutrition failure, or cannot meet nutrition needs totally by enteral or oral nutrition support (6). Parenteral nutrition support does not stimulate pancreatic secretions. Triglyceride levels should be monitored regularly as intravenous fat emulsion (IVFE) is generally safe and recommended for triglyceride levels <400 mg/dl; however is contraindicated in hypertriglyceridemia.

Monitor

Ability to advance and tolerate oral intake must be monitored, with signs and symptoms of abdominal pain, nausea, vomiting, and steatorrhea reviewed. Weight measurement should be examined regularly to assess hydration and nutrition status (6); as well as biochemical and medical tests such as serum lipase, serum amylase, AST, ALT, serum glucose, LDH, WBC, CRP, serum electrolytes, BUN, and creatinine. Nutrition support and tolerance must be monitored closely.

Summary

Nutrition therapy of alcohol associated alcohol associated acute pancreatitis can be challenging, as the disease can progress towards various courses, dependent on severity and duration of the disease. It is important to monitor and review patient status, and to work with the patient and clinical team to determine the most suit-

able approach towards appropriate nutrition goals and recommendations. Further studies regarding nasogastric enteral nutrition support, and oral diet resumption are needed.

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Susan Allen, RD, CCN

Neurotransmitter Imbalances in Depression: RDs Make a Difference!

Susan Allen, RD, CCN

It is estimated that 6.7% of the U.S. adult population experiences depression and 30.4% of those cases are classified

as severe. Of the millions of depressed adults, nearly two-thirds are women (1). Anxiety and substance abuse are commonly reported by those who experience depression. Clearly, depressive disorders have a major impact on health and society. Advances in medical science have led to the development of new tools clinicians can use to more effectively assess and address mood disorders.

The brain is a complex entity. Unraveling its mysteries will continue for generations to come. Despite this complexity, enough is known about its structure and function to provide foundational understanding of common mental health concerns, including depression. For example, scientists now recognize that mood is primarily controlled by specific regions in the brain that communicate using chemical messengers called neurotransmitters. Feelings of happiness or sadness are ultimately the function of internal biochemistry: chemical messages sent back and forth within the brain.

Through this understanding, the "monoamine hypothesis" was developed by brain chemistry researchers as an explanation for why an individual may feel depressed. In essence, the hypothesis states that depression is due to a deficiency in one or more of the monoamine neurotransmitters, including serotonin, dopamine, and norepinephrine (2). Deficiencies in these messengers imply that the brain regions controlling mood are unable to communicate effectively. The breakdown in communication can then lead to feelings of depression.

Lending credence to the monoamine hypothesis is the observation that most pharmaceutical interventions labeled for the treatment of mood disorders work by enhancing transmission of one or

more of the monoamine neurotransmitters. Selective serotonin reuptake inhibitors (SSRIs) are the most commonly prescribed anti-depressants. The proposed mechanism of action for SSRIs is increasing synaptic levels of the mood-enhancing transmitter, serotonin (2).

At the core of the monoamine hypothesis is the presumption that mood disorders result from deficiencies in various neurotransmitters. A growing body of literature supports the concept that various mental health concerns are, at least in part, rooted in deficiencies of neurotransmitter levels. The concept forces one to ask, what leads to the depletion of neurotransmitters?

The importance of the dietitian's role cannot be underestimated for these patients. Stress, poor diet, genetic predisposition, and even immune status have significant impact on brain function. Diet plays a central role in supporting brain activity. The brain is responsible for making its own neurotransmitters. It does so by converting dietary amino acids into neurotransmitters. Interestingly, many of the nervous system's most important neurotransmitters are derived from essential amino acids, which must be obtained from the diet.

As an example, Tryptophan, one of the nine essential amino acids, is the building block for serotonin. Phenylalanine, also an essential amino acid, is the building block for phenylethylamine (PEA), a transmitter involved in cognition. Phenylalanine is also needed for the synthesis of tyrosine, a conditionally essential amino acid that is the building block for dopamine, norepinephrine, and epinephrine. Recognizing that various types of physical and psychological stressors can accelerate neurotransmitter turnover and coupling this scenario with poor dietary habits that may not supply adequate quantities of essential amino acids, the stage is set for potential neurotransmitter depletion and, possibly, the onset of symptoms associated with neurotransmitter imbalance.

A Registered Dietitian (RD) is therefore a vital part of a mental healthcare support team. Supporting a patient's diet and in many cases, the digestive process to ensure adequate translation of protein into amino acids becomes a key issue for core support. In many instances, additional nutritional supplementation, including specific amino acids, may also prove very useful for therapeutic benefit. An RD may choose to acquire additional training in the specialty of supplement use for clinical practice to feel most comfortable recommending supplements. Fortunately, there are many outlets for this training such as free webinars offered by the labs that do the testing for example. Additionally, there are more formal trainings in the specialty of Integrative and Functional Nutrition, which includes the use of supplement as well. If it is accepted that mood disorders may be rooted in a variety of neurotransmitter imbalances and, likely, other contributing factors, what tools exist to sort out the source of an individual's depression and how to resolve it?

Excitingly, neurotransmitter testing is available through clinical laboratories. These lab tests can identify which neurotransmitters might be imbalanced and how severe those deficiencies may be. The collection is a non-invasive, second morning urine catch. The sample is sent to the lab for processing, and the clinician receives a lab report detailing the levels of various neurotransmitters, including the monoamines.

Urinary neurotransmitter testing has been around since the 1950's, however it has taken a few decades to transition from academic investigation to a commercially available clinical tool. Used widely in the specialty of Integrative and Functional Medicine, neurotransmitter testing is more recently gaining acceptance in the mainstream as well. In fact, the use of this type of objective measurement was presented at the American Psychiatric Association's 2012 national conference.

One may question how a urinary measure can reflect brain activity. To

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that end, a number of scientific publications have positively associated urinary neurotransmitter excretion patterns with a host of neuropsychiatric conditions (3). The test is not, at this time, diagnostic for any particular condition. Rather, as a functional assay, it can illuminate imbalances in markers that aid in a diagnosis and provide insight for developing more targeted treatment protocols.

As healthcare professionals, RDs can obtain this neurotransmitter testing for their patients, though this may vary from one lab to the next and from state to state. A few of the labs that offer this testing include Pharmasan, Sanesco, and Labrix. Pharmasan Labs, for example, even offers recommendations for intervention using specific amino acid, vitamin, or herbal interventions that may be useful to regain balance when it is off. The later is of great use for the dietitian in the development of nutritional support protocols. It should go without saying though, RDs are encouraged to work in concert with their patient's prescribing MD in the case where psychotropic drugs are involved.

Individualized medicine is growing in demand, as patients expect treatment protocols custom-tailored to their own unique circumstances. In a time where there is greater expectation on the clinician to deliver a positive outcome, having tools in the toolbox that allow for greater individualization is a welcome addition. This is even more relevant for the mental health arena, where up until this point, there were no

lab tests that could be performed to gain greater insight into the biochemistry of a patient's mood disorder.

While SSRIs are the pharmaceutical standard of care for depression, it is well known that they do not work for everyone. This point, relating back to the earlier comments regarding the monoamine hypothesis, illustrates that depression is far more than simply a serotonin imbalance. As described earlier, other neurotransmitters are involved in mood regulation. Recognizing this, which intervention is ideal for an individual?

Neurotransmitter testing enables the clinician to devise targeted treatment protocols. If a patient presents with depressive symptoms and a lab report illuminates a serotonin deficiency, then a serotonergic intervention may be best suited to this individual. These interventions may include an SSRI, supplemental tryptophan or 5-HTP, and/or a diet higher in tryptophan. On the other side of the coin, if a patient presents with depressive symptoms and a lab report illuminates a dopamine deficiency, then a dopaminergic intervention may be best suited for that individual. These interventions may include a selective dopamine reuptake inhibitor, supplemental phenylalanine, tyrosine or L-dopa, and/or a diet higher in dopamine precursors.

There is value in having an objective measure of brain biochemistry beyond aiding in diagnosis or guiding treatment protocols. A lab test imbalance is a potent, psychological motivator for patients, perhaps compelling them to take action in cases where the wisdom

of the practitioner was not enough. This not only goes for cases of depression, but other mood imbalances, like anxiousness, as well. In fact, this testing has use in a wide variety of patients, including those with addictive or compulsive behavior, eating disorders, and sleep disorders as well.

In summary, advances in brain science are empowering clinicians with tools to more effectively tackle mental health concerns such as depression. With the advent of lab testing and targeted treatment strategies, the likelihood of positive outcomes continues to improve. The Dietitian with a clearer understanding of this testing along with related dietary and supplement protocols will have an expanded role in ensuring their patient's success.

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BRAIN Initiative: Requesting Public Input

The Congressional Neuroscience Caucus recently held a briefing with National Institutes of Health leaders to provide a status update on the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative. The BRAIN team is in the planning stages and is requesting feedback from the public. The Academy will urge the team to evaluate the impact of nutrition and eating patterns on brain development and function.

As part of a new presidential focus on revolutionizing our understanding of the human brain, the BRAIN initiative aims to produce dynamic pictures of the brain that show how individual cells and complex neural circuits interact in both time and space.

The Academy anticipates commenting on the BRAIN team's proposal of work to ensure that the initiative examines environmental factors, such as nutrition, eating patterns and physical activity, to determine their impact on brain activity and development. By uncovering the connection between diet and brain health, registered dietitian nutritionists will be able to better provide nutrition counseling to a variety of clients and patients, including pregnant women, infants, toddlers, children, stroke victims, those who suffer from mental illness and many more.

Autism Spectrum Disorders: Nutritional Strategies and Interventions

Vicki Kobliner, MS, RD, CDN



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Introduction

Autism is a developmental disorder characterized by impaired social interaction, deficits in verbal and nonverbal communication, stereotypical behaviors and unusual or severely limited activities and interests, with the degree of severity and symptoms expressed in each individual being highly variable. As a result, a range of diagnoses exist under the umbrella of Autism Spectrum Disorder (ASD) which includes Autism, Asperger's and Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS). The incidence of ASDs in the United States continues to skyrocket, and is currently estimated to be 1 in 88 American children (and 1 in 54 boys) (1). The lifetime per capita societal cost of this disorder is 3.2 million dollars (2), and this does not even begin to quantify the emotional and physical toll that ASD takes on these individuals and their families.

While the etiology and biological basis of autism has still not been identified, current evidence points to a combination of genetic predisposition combined with environmental triggers. Although the majority of research dollars are directed at identifying genetic markers of autism, emerging data has identified the existence of comorbid medical conditions such as alterations in the gastrointestinal, immune, detoxification, redox regulation and energy generating systems in children on the spectrum. Whether these abnormalities are causative or a consequence of autism remains to be elucidated, but in each case therapeutic nutrition interventions can play a critical role.

Gastrointestinal Health

Autism has been called a gut disorder by some, and parents commonly report that their ASD children experience gastrointestinal (GI) problems at a greater rate than unaffected siblings (3).

The most common presentations include chronic abdominal pain, constipation and/or diarrhea, and symptoms of gastro-esophageal reflux. The incidence of digestive disorders may well be underreported since nonverbal children are not easily able to communicate pain. Self-injurious behaviors such as head banging and the application of pressure on the abdomen are nonverbal cues that discomfort is present. Sleep disturbance has also been reported at a higher rate in autistic children with GI distress.

Many pediatricians have considered the digestive component as simply a "part of autism" and have not treated the underlying gastrointestinal abnormalities. In 2010, the journal *Pediatrics* published a supplemental article entitled "Recommendations for Evaluation and Treatment of Common Gastrointestinal Problems in Children with ASDs" (4). The position of the panel of gastroenterologists who authored the article was that children with ASDs should be evaluated for GI disorders as thoroughly as non-ASD children who present with the same symptoms. In addition, the panel stated that "Pediatricians and other primary care providers [should] be alert to potential nutritional problems in patients with ASDs. Evaluation by a nutritionist who is familiar with nutrition support for individuals with ASDs is recommended if caregivers raise concern about the patient's diet or if the patient exhibits selectivity of intake or is on a restricted diet." Nutritional deficiencies have been identified in patients with ASD, which may be a result of self-limited food choices, malabsorption, and/or restricted diets.

The panel also recommended that a detailed history be taken to identify potential associations between food allergens and gastrointestinal problems and called for further research into the

existence of intestinal permeability and the effectiveness of gluten and casein free diets. Parents report that a gluten-free and casein-free diet (GFCF) positively affects children with ASD, and recent research by Pennisi supports their observations (5). There are multiple theories as to why GFCF improves autistic symptoms, and it is possible that more than one is correct. Children with ASD who present with gastrointestinal disorders may suffer from intestinal permeability and imbalances in the microbiota. This can result in malabsorption of key nutrients, exacerbate food sensitivities and inflammation, and increase absorption of toxins through the intestinal lumen, thereby increasing oxidative stress. Gluten and casein are common allergens which may influence or aggravate these conditions and are also posited to allow opioid peptides to cross the blood-brain barrier. Other dietary interventions, such as low phenol diets, the Specific Carbohydrate Diet, low oxalate diets, and allergy avoidance diets have been utilized with children on the spectrum. A lack of adequate evidence-based data concerning these diets does not allow for a determination of their efficacy in autism. As advised by the expert panel, however, when ASD children present with gastrointestinal symptoms consistent with a disorder addressed by one of the diets above, appropriate nutritional intervention is warranted. Finally, epilepsy presents more commonly in children on the spectrum (6), and in these cases, a low-carbohydrate or Modified Atkins Diet for Epilepsy (MADE) may be indicated.

Probiotics are a tool which may help address the underlying gut imbalances in ASD, since they are essential for normal digestive health (7). They have been used effectively for many gastrointestinal disorders, and a wide

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variety of health issues respond to probiotic therapy. Probiotics can influence the host's immune system, impacting not only mucosal immunity, but overall immune function as well. Alterations in immune balance are additional areas of dysfunction commonly seen in ASD children.

Immune Function

Data from the MIND Institute at University of California, Davis, indicate that more than 70 percent of ASD children have altered immune function. It has been almost a decade since Vargas observed neuro-inflammation in the autopsied brain tissue of autistic subjects (8), characterized by neuroglial activation and increased cytokine production. Neuroglial cells include microglia and astroglia and are the primary cells which support and protect neurons. Increases in microglia are associated with innate immune response and are the main cellular response to dysfunction in the Central Nervous System (CNS). Similar proinflammatory processes were identified in the cerebrospinal fluid of living subjects. More recent studies have identified significantly greater microglial densities around neurons of autistic subjects vs. controls (9,10). The role of microglia in autism is unclear, but since they are key players in the immunoprotection of brain cells, anomalies in microglia may indicate underlying immune abnormalities which ultimately affect the brain. Other evidence of immune derangement in ASD includes increased frequency of otitis media, food allergies and Th1/Th2 imbalances.

Omega-3 fatty acids are frequently used in the ASD population, and while good quality studies are lacking, there is some evidence that essential fatty acids (EFAs) can improve symptoms. In one study by Amminger, omega-3 fatty acids showed an advantage over placebo for reducing hyperactivity and stereotypy (11). While the method of action is not clear, it is theorized that it is the EFAs role in modulating the immune system and plasticity of brain cells that is responsible for observed benefits.

Oxidative Stress

Individuals with ASD are under higher oxidative stress and have reduced levels of antioxidants as compared to controls (12,13). This population has imbalances in reduced vs. oxidized glutathione (a potent antioxidant and critical detoxification compound) due to disruption in the transsulfuration cycle. In the transsulfuration cycle, methyl groups are transferred from methionine to homocysteine, and then homocysteine is converted in a series of steps to glutathione. The process requires vitamins B6 and B12, folate, and magnesium, among other cofactors. ASD children given folic acid and B12 supplementation significantly improved their ratio of oxidized to reduced glutathione (13). Lab values of multiple antioxidant nutrients such as zinc, selenium, and vitamins A and C are lower in this population as well. Gut and brain tissue are sensitive to the effects of oxidative stress, which can also damage mitochondria and lead to impaired energy status and altered gene expression.

Mitochondrial Disorders

Mitochondrial dysfunction was once thought to be a rare disorder but is now identified as a much more common metabolic abnormality in children. Mitochondrial disorders are distinct from mitochondrial diseases, which are caused by genetic anomalies or defects in respiratory chain pathways, and result in much more severe symptoms. In contrast, mitochondrial dysfunction (MtD) is more common and causes less severe symptoms. Lombard first hypothesized that autism may be caused by MtD due to the overlapping symptoms in autism (14). Up to 80% of children with ASD may have mitochondrial dysfunction (15) which could contribute to a number of diagnostic symptoms including cognitive impairment, language deficits, chronic gastrointestinal problems, and increased oxidative stress. Filipek identified significantly reduced levels of free and total carnitine and pyruvate in ASD subjects, with increases in ammonia and alanine, suggestive of mitochondrial dysfunction (see Figure 1 for mitochondrial intermediaries) (16). Supplementation

with levo-carnitine significantly improved several clinical measurements of autism (17).

Cerebral Folate Deficiency

Folic acid is an essential nutrient for numerous biochemical reactions in the body. The active form of folate is 5-methyltetrahydrofolate (5-MTHF) and requires both niacin and vitamin B12 for proper conversion and recycling. Folate is important for de novo synthesis of purine and pyrimidine nucleic acids and is critical during fetal development. It is also a necessary component of the methionine cycle, which affects methylation, and as such, impacts gene expression. Transport of active 5-MTHF across the blood-brain barrier requires the folate receptor FR1, while a secondary pathway utilizes the reduced folate carrier (RFC), which has a greater affinity for folic acid. Cerebral folate deficiency (CFD) syndrome was first described by Ramaeckers (18) and is a neurodevelopmental disorder usually caused by folate receptor autoantibodies (FRAs) that interfere with folate transport across the blood-brain barrier. In one study of 93 children diagnosed with ASD, 75.3% had high serum concentrations of FRAs (19). In 16 of the subjects, the concentration of FRAs was significantly correlated with low 5-MTHF levels in cerebrospinal fluid. Common symptoms of ASD were significantly decreased when CFD was treated with folic acid—when the children with high FRA levels were treated with folic acid supplementation (oral leucovorin calcium) there were significant improvements in verbal communication, receptive and expressive language, attention, and stereotypy. Mitochondrial disease has been associated with CFD. Of note, human folate receptors have been shown to cross-react with the folate receptors found in human, cow and goat milk, which may potentiate folate antibody production. When Ramaeckers (20) trialed a milk-free diet on his subjects, FR1 antibodies were significantly decreased; they became elevated again upon reintroduction of dairy. This provides further support for the use of a dairy-free diet in a subset of children with autism.

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Vitamin D

The hypothesis that low vitamin D levels during fetal development and early childhood are a causative factor in ASD remains speculative at this time, but the importance of vitamin D should not be overlooked. Chronic vitamin D deficiency is pervasive in the United States in both adults and children. Evidence of a relationship between vitamin D and autism includes greater prevalence of autism in areas with greater rainfall and cloud cover, in children born in the spring, and in northern latitudes. Low serum 25(OH)D levels in children with ASD, increased risk of autism in those with darker skin, and increased risk of autism in premature infants have also been observed (21). Clinical trials are underway exploring the impact of vitamin D supplementation during pregnancy on autism rates, but no results are available as of yet.

Take Home Message

In summary, current research indicates that nutrition therapy for ASD can and should be targeted at the underlying nutritional and biochemical abnormalities that affect digestion, immune function, oxidative stress, mitochondrial dysfunction and folate metabolism. It is still not well understood whether these physical and physiological alterations are causal or correlated, but this should not preclude the RD from using the tools in the nutrition arsenal to ameliorate them. Foundational interventions to consider when working with a child on the Autistic Spectrum include: 1) a "clean" diet, free of the chemicals, pesticides, artificial additives, hormones and

antibiotics which may tax poorly functioning detoxification pathways, 2) a diet low in refined and processed foods, low in sugar, and nutrient-dense to reduce inflammation and provide antioxidant support, 3) adequate protein for production of glutathione precursors, 4) removal of inflammatory food allergens that may impair gut function, 5) a trial of a gluten-free and casein-free diet, 6) support with high quality probiotics and essential fatty acids to reduce inflammation and optimize intestinal integrity, 7) vitamin D supplementation when clinically indicated, 8) mitochondrial support or folinic acid supplementation when warranted by evidence of mitochondrial dysfunction or CFD, 9) other specialized diets when indicated.

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The Academy of Nutrition and Dietetics and the Commission on Dietetic Registration have approved the optional use of the credential "registered dietitian nutritionist" (RDN) by all registered dietitians.

"Just as our organization included 'nutrition' in our new name in 2012, the option of using 'nutritionist' in an individual RD's credential can communicate the broad concept of wellness, including prevention of health conditions, as well as the treatment of conditions that are part of virtually every RD's practice," says registered dietitian nutritionist and Academy of Nutrition and Dietetics President Ethan Bergman. "The message for the public is: Look for the RD – and now, the RDN – credential when determining who is the best source of safe and accurate nutrition information," Bergman says. "All registered dietitians are nutritionists, but not all nutritionists are registered dietitians.

For more information about the RDN credential, visit www.eatright.org/RDN



April Winslow, MS, RDN

What is Your Label? DSM-5 Update for Nutrition Therapy

April Winslow, MS, RDN, BHN Public Policy Liaison

The birth of the 5th version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) on May 18, 2013 in

San Francisco, CA at the American Psychiatric Association annual meeting was welcomed with criticism and controversy (1). The integrity of the DSM-5 task force members has been challenged due to industry ties that are speculated to have influenced the categorization of symptoms. Additionally, the National Institute of Mental Health (NIMH) has openly criticized the once *bible* of Psychiatry as a book that lacks scientific validity (2). Furthermore, the NIMH is developing Research Domain Criteria (RDoC), that will formulate a Psychiatric research infrastructure based upon pathophysiology, clinical neuroscience, and genetics; rather than symptoms (3). Despite the trauma associated with the introduction of the DSM-5, there are important clinical updates that impact all Dietitians working in the Mental Health arena.

The historical evolution of the DSM-IV to the DSM-5 began in 1999 with a research planning committee. A task force of 27 members, assigned to specific workgroups, evaluated the literature to form consensus statements for grouping symptoms into specific diagnoses. Interestingly, the transition from Roman Numerals (DSM-IV) to an Alpha Numeric digit (DSM-5) was done in anticipation of future revisions of this manual (i.e., 5.1, 5.2, etc.).

It is well documented that diagnosis does not mandate a course of treatment, but rather serves as a guide to understanding contributing factors and underlying defense mechanisms that contribute to a specific clinical manifestation. Each diagnosis has a distinct number (e.g., Anorexia Nervosa: 307.1, Schizophrenia: 295.90, Autism Spectrum Disorder: 299.0, etc.). The severity of the disorder also generates a new diagnosis code (e.g., Major Depressive Disorder, moderate: 296.22 vs. Major Depressive Disorder, with psychotic features: 296.24).

These numbers are ICD-9-CM codes and are used to determine insurance coverage for a client. Thusly, a correct and consistent diagnosis code among the interdisciplinary team is essential for continuous and effective treatment. An upgrade of this system has been established (i.e., ICD-10-CM), but will not go into clinical practice until October 1, 2014 (1). It is important to note the clinical difference between DSM-5 and ICD-9-CM codes. The DSM-5 coding is a clinical translation or symptom presentation; meanwhile, an ICD-9-CM code represents the “problem” being treated. For example, a client with Anorexia Nervosa would have a DSM-5 code of 307.1, but treatment may be ICD-9-CM coded under a variety of medical conditions including *unspecified nutritional deficiency* (269.9), *unspecified protein-calorie malnutrition* (263.9), or *absence of menstruation* (626.0).

A general understanding of the coding process is vital to identification of the key nutritional issues of each diagnosis and serves as a platform for rapport building with your client. Understanding and sympathy for a clients’ struggle is one gift a Registered Dietitian (RD) can offer. The following is a summary of the DSM-5 changes within the specific areas of Behavioral Health Nutrition (1,4).

Mental Illness

- All subtypes of schizophrenia were deleted; there is one diagnosis code: 295.9
- The clinical specifier “with mixed features” can now be added to bipolar I/II/NED (formerly NOS) and Major Depressive Disorder (MDD). Anxiety symptoms can also be added, but not required to have the primary diagnosis.
- Anxiety disorders no longer require the individual recognize their fear and anxiety as excessive or unreasonable.
- Body Dysmorphic Disorder (300.7) is an Obsessive-Compulsive Disorder; however, it could also be coded under Eating Disorders (307.5), if appropriate.

Intellectual Developmental Disabilities

- Mental retardation is now called Intellectual Disability (319)
- Communication Disorders (315.39) replace phonological disorder and stuttering
- The Autism Spectrum Disorders (299) incorporate Asperger Disorder, Childhood Disintegrative Disorder, and Pervasive Developmental Disorder (PDD) rather than each condition having separate diagnosis codes.

Eating Disorders

- Binge Eating Disorder (BED) is an official diagnosis; DSM-IV used this label for research purposes only. Severity of mild, moderate, severe, and extreme are also noted. Obesity does not automatically qualify as BED.
- Anorexia Nervosa (307.1) no longer requires amenorrhea and a specific numerical value to determine “low body weight.” Clinical judgment and weight history patterns are taken more strongly into consideration. The subtypes (i.e., restricting and binge/purge). Levels of remission can also be added as a qualifier.
- The frequency of the binge with Bulimia Nervosa (307.51) has been decreased to once weekly over the last 3 months.
- Pica (307.52) and Rumination Disorder (307.53) can be used for adults, as well as children
- Avoidant/Restrictive Food Intake Disorder (307.59) has replaced “feeding disorders of infancy or early childhood” that was used in the DSM-IV. This diagnosis can be closely tied to Post Traumatic Stress Disorder (PTSD) and can often be misdiagnosed.

Addictions

- Substance abuse and dependence are now one category; with 10 separate classifications for specific substances (e.g., alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, etc.)

DSM-5 Update

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- Gambling disorder (312.31) and tobacco use disorder (292.9) are new
- Caffeine Intoxication (305.9) and caffeine withdrawal (292.0) are outlined

The changes noted are bridging the gap for RD's to have a stronger voice in field of Mental Health treatment. The connection between the nutritional precursors obtained through food and the manifestation of cognitive dysfunction is unknown. However, the fundamentals of biochemistry, medical nutrition therapy, and practical life-skills based counseling have tremendous potential. The stigma attached to these labels serves as one of the primary barriers to treatment.

Your role as a RD in mental health can shift this stigma. The knowledge we hold and disseminate to our clients impacts not only the immediate symptom manifestation, but also those in community with that person. Glucose

stabilization through the inclusion of protein and unsaturated fatty acids has the power to down regulate anxiety. Proper hydration allows for hydrolysis and subsequent improved digestion, so an individual who is recovering from an Eating Disorder can have less bloating; therefore, decreasing feelings of being fat and unworthy of vital nutrition. Myelin repair through the enhancement of fatty acid intake can improve self-efficacy through successful communication between neurons.

The ability of a RD to speak the same language as a Psychiatrist or Therapist adds credibility to our discipline. The awareness of the differential diagnoses within your chosen specialty can support a swift interdisciplinary referral. Moreover, using a common language will allow our field to develop research protocols and begin to show scientific data of the efficacy of nutrition therapy in the Psychiatric population. As the DSM-5 finds its' place within our professional lives and

will continue to change with future revisions, one truth is already validated; RD's are essential to mental health treatment! Use your voice and your knowledge to help those who are unable to help themselves find healing.

For information on public policy issues concerning behavioral health nutrition, contact BHN Public Policy Liaison, April Winslow, MS, RDN at april@ctcnutrition.com. @AprilWinslow

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Please join the BHN EC for our annual awards presentation and program at the Member Breakfast!

Monday, October 21, 2013 from 7:30am-9:00am

Hilton Americas Houston: Meeting Room 335BC

The awards program and breakfast is from 7:30am- 8:00am followed by:

Panel Discussion with BHN Resource Professionals

This is your opportunity to ask questions from our experienced and knowledgeable resource professionals.

Breakfast and 1 CPEU are provided FREE to BHN members attending FNCE;
Non-BHN members may attend for \$25.

Watch your e-mail, BHN's social media and Web site for details on how to register for this event!

**Visit our BHN Booth at the DPG/MIG Showcase
Monday, October 21, 2013**

In the BHN Pipeline!

The Lifestyle Intervention Conference: October 7-9, 2013 at the Belagio Hotel in Las Vegas, NV

By David A. Wiss, MS, RDN, CPT

On June 1, 2013, members of the BHN executive committee met in Denver, Colorado for a strategic planning meeting. One of the primary objectives in the upcoming year is to strengthen our base of competence and expertise with various addictions, including substance abuse and process addictions such as gambling and love. Food addiction continues to be a hot topic, and the American Medical Association has finally classified obesity as a disease. As treatment for addictions continues to grow, RDs or RDN's should be part of the treatment team. Dietitians should be marketing our skills for nutrition assessment, education, counseling, and consulting to addiction facilities nationwide.

As a participant of the 2nd annual Lifestyle Intervention Conference in Las Vegas last year, I was impressed by the vision of addiction industry leaders. While the event offered up to 18 CPE's for RDs or RDN's, sadly there were few dietitians in attendance, and I realized that RDs or RDN's are highly underrepresented in the private sector. Through aggressive networking, BHN secured sponsorship by the Lifestyle Intervention Conference, who has offered our DPG a complimentary booth for the October meeting. David A. Wiss, MS, RDN, CPT, and Therese Shumaker, MS, RD, LD will be representing BHN at the booth by providing information about our DPG to conference attendees, and playing our newly developed "Brain Game". Our goal will be to promote the role of the RD or RDN in private sector addiction treatment. The Lifestyle Intervention Conference will focus on four key areas:

- Advanced Intervention Training
- Employee Assistance Training for Professionals
- Eating and Weight Disorders
- Love, Sex, and Relationship Addictions

There will be several keynote speakers including Dr. Patrick Carnes, a leader in the field of process addictions, and other sessions that address substance abuse and nutrition. For more information and to register, please visit www.lifestyleintervention.org.

If you are planning to attend this conference, please contact David at DavidAWiss@NutritionInRecovery.com. We can always use assistance at the booth. If you are curious to learn more about addictions, Mr. Wiss will be presenting a webinar in September "Nutrition Interventions in Addiction Recovery: The Role of the Dietitian in Substance Abuse Treatment". Stay tuned for addiction info coming your way from BHN and please contact David to get involved in the movement!

Book Review: *Inside Rehab, The Surprising Truth About Addiction Treatment -And How to Get Help that Works* by Anne M. Fletcher, MS, RD

Review by Sharon Salomon, MS, RD

Now there's a book to help health professionals, parents and others understand what rehab is all about and how to go about making an informed choice, *Inside Rehab-The Surprising Truth about Addiction Treatment-And How to Get Help that Works* by Anne M. Fletcher, MS, RD..

Many of you may recognize Anne's name because she is also a registered dietitian and the author of *Sober for Good, Thin for Life, Eating Thin for Life* as well as the former executive editor of Tufts University Health & Nutrition Letter.

Before writing this book, Anne spent several years interviewing professionals in the field of substance abuse recovery, present and former rehab patients and their families. She traveled around the country visiting many rehab sites and, of course, she read everything on the subject.

According to Anne, "The book is an in-depth look at the many problems of the addiction industry. It also offers many questionnaires and resources to help readers find quality help. And the info isn't just based on my opinion-it comes from my visits to 15 facilities across the country, interviews with more than 100 former rehab clients and many of their families and just as many staffers and experts in the field and reviews of scientific literature. My findings have been corroborated by the literature and outside reports."

What Anne has produced is a book of significant importance to anyone whose life has been touched by substance abuse, either personally or professionally.

After reading Anne's book, you'll know how to find a rehab, what the different programs are, how to evaluate them and how much a stay in rehab might cost.

Inside Rehab is an invaluable and unique resource. Every dietitian should have one in her library if for no other reason than to be prepared to offer guidance to the client who admits to abusing more than just chocolate.

(Disclaimer: Anne interviewed our family for this book. Our experiences appear in the book.)

Resource Review: Eating Disorders Training DVD by Jessica Setnick, MS, RD, LD, CSSD

Review by D. Milton Stokes, PhD, MPH, RD

Among the latest of her educational tools, Jessica Setnick, MS, RD, LD, CSSD, offers a DVD resource called "Eating Disorders Nutrition Counseling Student Training DVD." Packed with several sample cases of RD-client interaction, Jessica skillfully demonstrates how to work with individuals who have eating disorders—experiences that many folks outside of our own dietetic practice group probably would never have access to. As an internship director, I find

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Harriet H. Cloud, MS, RD

House of Delegates Report for the BHN-DPG

Harriet H. Cloud, MS, RD

The HOD held its fifth annual virtual meeting on May 4-5, 2013. The mega-issue discussed was the question: How can we as Academy members increase our awareness of food and nutrition insecurity and demonstrate our commitment to take action?

I have found that many of the Academy members are confused by the term food insecurity. It can be defined as uncertainty within a household to have enough food to meet the needs of all its members because of insufficient money or other resources. Our goal is for nutrition security, defined as when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active healthy life.

There were three expected outcomes for the Virtual Meeting

- Delegates will raise member awareness of the prevalence and consequences of food and nutrition insecurity for the nation, including current Academy initiatives
- Delegates will demonstrate commitment and inspire members to take action to improve food and nutrition security at local and state levels
- Delegates will act to support and promote the Academy's policy and advocacy programs that improve food and nutrition security at the national level.

Prior to the actual meeting delegates were provided with many materials that described all of the aspects of food insecurity and the role of the Academy. Some of the important points to consider were:

- 50 million Americans including 8.6 million children were food insecure in 2011. This was an 4.9% increase since 1998.
- Food insecurity is highest in the following groups:
 - Households with children headed by a single woman
 - Households with children headed by a single man
 - Women living alone and men living alone
 - Black, non-Hispanic households
 - Hispanic Households
 - Households with incomes below 185% of the poverty line
 - Households located in principal cities of metropolitan areas.

The national average for very low insecurity is 5.7%. Rates of participation in food and nutrition assistance and emergency feeding programs are sky-rocketing yet dietitians who work in these programs are constantly on edge about retaining their positions due to budget cuts.

After reading all of the materials we were sent prior to the meeting, it was evident what a tremendous issue this is. It is indeed a "mega-issue" and a challenge to the Academy members to put it in perspective for our role. For this meeting we were divided into tables for 4 breakout sessions with dialogue questions to discuss.

On day one the two dialogue questions were

1. What are the barriers that need to be overcome for members to reduce food and nutrition insecurity in their communities?
2. As members, what are our unique qualities and /or contributions to lead efforts to end food and nutrition insecurity?

Additional questions involved

3. as a leader, what is my ethical responsibility (and/or social responsibility) to share knowledge and inspire others to create solutions.
4. How do we inspire/motivate others to action finding solutions to food and nutrition insecurity?

What are the barriers identified by the HOD breakout sessions? There were many but after all the tables summarized and prioritized, the following stand out:

- Lack of awareness of the need and how food insecurity is addressed in the local and state communities as well as at the federal level
- Lack of involvement in community networks working on these issues
- Lack of time to volunteer
- Lack of knowledge on policy, systems and environmental changes related to food security.

After all of the discussion on barriers, the consensus was that the three top barriers for the Academy from the HOD perspective were

1. lack of awareness by food and nutrition professionals, the public, and resources awareness,
2. Understanding current economics and education of life skill, which includes prioritizing and planning, budgeting and cooking, and
3. nutrition education was the last major barrier.

The second issue discussed on day one was "What are the unique qualities and contributions of food and nutrition professionals to lead efforts to end food and nutrition insecurity?"

- Build relationships with legislators to be asked to serve on committee appointments
- Serve on state hunger organizations
- Provide nutrition education that is appropriate for the client
- Teach people food competency skills (food purchasing, storage, preparation, meal planning)
- Media skills with the newspapers, television appearances, and website development.

On the second day of the Virtual Meeting, the break-out sessions had assigned topics for discussion which included the following:

1. What are the opportunities in my community that will effectively overcome each barrier?
2. What community resources (organizations and/or individuals) can I potentially collaborate with?

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Student Corner:

California Dietetic Association (CDA), Santa Clara, CA, 2013

David A Wiss, MS, RDN, CPT, and Priscilla Schaper, BA

BHN's presence at the California Dietetic Association this year in Santa Clara, CA was a huge success! David A Wiss, MS, CPT, and April Winslow, MS, RDN, worked together staffing the booth. I was honored to represent BHN at the exhibit, which was a combination of exhausting and exhilarating. The BHN Student Committee spent months compiling questions from our experts at BHN to use in the "Brain Game". Thank you to everyone who submitted questions as well as references! We had puzzling trivia from all four areas of the practice group! April is an excellent team member and she will be speaking at FNCE this October in Houston, TX. The Brain Game will be at FNCE as well!

The 2013 CDA was our first opportunity to use the new BHN banner bearing the current logo and tagline "Fuel Your Brain, Feel Your Best". We also had new BHN stickers that we gave to every Brain Game participant, many of whom applied it directly to their badge. The exhibition was open for two hours on Thursday night and four hours on Friday afternoon. In those six hours combined, nearly 200 CDA participants played the Brain Game, which kept us very busy. There was one very challenging question about Prader-Willi Syndrome that kept getting picked and there were multiple, often humorous answers. Several participants came back to play more than once! On Thursday night we had 52 winners and on Friday we had 68 winners. Winners received an electronic version of the BHN Spring 2013 Newsletter. Many RD's were thrilled to discover that BHN existed.

I also had the chance to engage with other professionals and to promote the inclusion of Registered Dietitians or Registered Dietitian Nutritionists into addiction treatment. Many dietitians appeared interested in finding out more about working in this area. On Friday afternoon, Dr. Kannike-Martins, PhD, RD discussed the relationship between nutrition and addiction,

sharing her knowledge, experience, and clinical insight. She received positive feedback from those who attended. We welcome Dr. Kannike-Martins as the new BHN Addiction Resource Professional! She works in Los Angeles, CA and will continue to collaborate. More information about Addictions is coming soon!

Lastly, I want to thank the other dietetic interns and BHN Students who stopped by the booth to help out! The Los Angeles District (LAD) of the California Dietetic Association also had a presence at the booth. We asked one member of the BHN Student Committee, Priscilla Schaper, BA, about her overall experience at CDA and she reported:

I chose to attend the CDA conference this year to network, attend informative sessions, and to get a feel for what the future holds for careers in nutrition and dietetics. The conference proved to be a very valuable experience and worthwhile investment. One of my favorite sessions was Dr. Christopher Gardner's "Omnivore's Dilemma" which discussed the modern food movement, where it is headed, and the incredible variety of influences impacting our food system. Dr. Gardner pointed out that the idea of "health" is not a strong motivator for improving dietary behavior. External motivators of societal health and global health (e.g. sustainability) may be more powerful and effective in eliciting dietary change for some individuals. In addition to the excellent presenters, I also enjoyed the CDA exhibit hall, which hosted a wide variety of booths with dietitians and food-service professionals. I spent some time at the Behavioral Health Nutrition booth, which exposed me to some new areas in dietetics. I was fascinated by the "Brain Game", which tested my knowledge on behavioral health issues. These exercises increased my awareness of the impact dietitians can have in different areas of



David A. Wiss, MS, RDN, CPT, and April Winslow, MS, RDN, make a strong presence for BHN at the California Dietetic Association Expo in Santa Clara, CA.

mental health. I am curious to learn more about the connection between nutrition and addictions. Finally, the new student reception served as an additional networking tool to meet fellow students from other programs as well as current dietetic interns and directors. I am excited for my dietetic internship!

Although I had many highlights during my time at CDA, my favorite part was the feeling of community. Despite the varying educational backgrounds of attendees, number of years in the profession, or area of practice, we all had one thing in common: a passion for nutrition and dietetics. I look forward to attending more conferences in the future and am happy to hear that CDA will be in the greater Los Angeles area in 2014. Hopefully BHN will be at the conference again, by then I will be much more knowledgeable in behavioral health issues and will excel at the Brain Game!

About the Authors: David A. Wiss, MS, RDN, CPT, has been the BHN Student Committee Chair for the 2012-2013 year. His primary interest is in addictions and research. David is a member of the BHN Executive Committee, serving as Membership Chair. David works in Los Angeles, CA and can be contacted at davidawiss@nutritioninrecovery.com or on twitter @davidawiss.

Priscilla Schaper, B.A., is a Nutrition and Dietetics graduate student at California State University, Northridge (CSUN) with a B.A. in Psychology from the University of California Los Angeles (UCLA). Contact her at pschaper@ucla.edu.

In the BHN Pipeline

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it difficult to place interns and undergraduate students with RDs or RDNs specializing in eating disorders because of confidentiality and sensitivity. Jessica's video helps reduce this problem. In fact, the expertise and mastery Jessica demonstrates with patients who have eating disorders is transferrable: the skills can be used with any population when the RD or RDN is counseling, coaching, and educating. She covers a variety of problems and concerns, including referring to a mental health counselor and how to manage the issue of skipping meals. The DVD also comes with a PowerPoint, sample PES statements, charting forms for a nutrition practice, and a list of additional resources. This is a must-have DVD that I will recommend to my fellow educators and practitioners in eating disorders, nutrition therapy, and coaching as well as dietetic interns and students. It's available at www.understandingnutrition.com.

HOD Report

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3. How can we influence and facilitate sustainable change to minimize or eliminate food and nutrition insecurity?

All of this discussion was carried out in break-out sessions with many suggestions for activities the Academy could initiate as well as projects at the state level, local level, and DPG level. As a result of the overall dialogue a motion was developed and passed by the House. The motion was as follows;

Therefore, be it resolved that the House of Delegates requests the following short term activities designed to increase member involvement to be completed:

- Establishment of a web page devoted to the issue for use by members
- Publication of articles detailing Academy member involvement to address the issue

- Development of education/motivational programs (Webinars, FNCE) for distribution throughout the Academy

The HOD also requests the appointment of a Food and Nutrition Security Task Force composed of delegates and DPG members to develop action plans for each of the following: individual member, DPG and MIGs, Affiliates, Public Policy Panels. The outcomes of the motion will be shared with the HOD in spring 2014.

This is an important issue and has many implications for the clients we serve, many of whom undoubtedly have food insecurity as a problem. My email is harriet.h.cloud@gmail.com. I look forward to any comments.



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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: \$25.00**



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: \$25.00**

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: \$18.00**



To order, visit

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

NEW! Academy of Nutrition and Dietetics Pocket Guide to Children with Special Health Care and Nutritional Needs



This pocket guide was developed through collaboration of the Behavioral Health Nutrition and Pediatric Nutrition dietetic practice groups of the Academy. This updated version contains the essentials to nutrition management in a comprehensive interdisciplinary approach to medical management of CSHCN. Up to date scientific evidence has been translated by the authors and editors into tables and practice guidelines for dietetic professionals.

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