



Setting the Standard for Nutrition in Behavioral Healthcare

## Bipolar Disorder and Nutrition in Adults



by Ruth Leyse-Wallace PhD, RD

### Overview

Bipolar disorder (BD), or manic-depressive illness (MDI), has been recognized since at least the time of Hippocrates, who

described such patients as "amic" and "melancholic." In 1899, Emil Kraepelin MD, German psychiatrist and diagnostician, defined manic-depressive illness and noted that persons with manic-depressive illness lacked deterioration and dementia, which he associated with schizophrenia. (1)

Bipolar disorder, or manic-depressive illness is one of the most common, severe, and persistent mental illnesses. Bipolar disorder is characterized by periods of deep, prolonged, and profound depression that alternates with periods of an excessively elevated and/or irritable mood known as mania. Between these highs and lows, patients usually experience periods of high functionality and can lead a productive life. Patients with BD typically experience recurrent symptoms for many years. The median time to recurrence was 87 weeks, with 24% of patients experiencing an episode by 6 months, 36% by 1 year, and 61% by 4 years. (2)

The age of onset of bipolar disorder varies greatly, from childhood to 50 years, with a mean age of approximately 21 years. Most commence between the ages of 15-24 years. Some patients diagnosed with recurrent major depression may indeed have bipolar disorder and go on to develop their first manic episode when older than 50 years. However, for most patients, the onset of mania in people older than 50 years should lead to an investigation for medical or neurologic disorders such as cerebrovascular disease. (1)

The fundamental problem is a dysregulation of mood, although individuals with

BD often experience a variety of other difficulties, including impulsivity, risky behavior (eg, alcohol abuse, sexual indiscretion, excessive spending), and interpersonal problems. The clinical course is primarily depressive rather than manic: subsyndromal and minor affective symptoms predominate. In one longitudinal study, patients were symptomatically ill 47% of the time with depressive (68%), manic (19%), and mixed (13%) symptoms. (3)

Hypomania may be thought of as a less severe form of mania that does not include psychotic symptoms or lead to major impairment of social or occupational function.

While in the depressed phase patients have a very high rate of suicide and suicide attempts. Approximately 25-50% of individuals with bipolar disorder attempt suicide, and 11% actually commit suicide. (1)

### Genetics

Bipolar disorder is 80%-90% heritable. (4) Twin, family, and adoption studies all indicate that bipolar disorder has a genetic component. First-degree relatives of a person with bipolar disorder are approximately seven times more likely to develop bipolar disorder than the rest of the population.

The strongest associations were detected in genes also involved in biochemical pathways regulated by lithium. The strongest association has been observed within the first intron of diacylglycerol kinase eta (DGKH) gene. DGKH is a key protein in the lithium-sensitive phosphatidylinositol pathway.

In addition, levels of expression of oligodendrocyte-myelin-related genes appear to be decreased in brain tissue from persons with bipolar disorder. Oligodendrocytes produce myelin membranes that wrap

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

### Future Submission Deadlines

Fall 2010..... **August 1, 2010**  
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#### Editor:

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

#### Assistant Editors:

Sharon M Wojnaroski, MA, RD

#### Newsletter Review Board:

Kathy Russell, MS, RD  
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## From the Chair

Kathy Russell, MS, RD

Walking on Sunshine! That's what I'm doing after a tremendous weekend spent with some very dedicated and passionate Behavioral Health Nutrition DPG Executive Committee (EC) members. As we worked through our agenda it was very clear that BHN is moving forward and making our presence known!



*BHN Chair, Kathy Russell, MS, RD, leads discussion on the 2010-2011 Plan of Work*



*Executive committee members attend BHN planning meeting*

Intellectual and Developmental Disabilities, and Mental Illness. We are working to set the standard for nutrition in behavioral health care.

As we move into the new membership year there will be many activities and opportunities for BHN members. Look forward to more Webinars (if there is a topic you would like to learn more about, let us know), a fabulous newsletter filled with educational articles and information about upcoming events, Food & Nutrition Conference & Expo (FNCE) 2010 where BHN will have a Spotlight Session entitled: Overcoming Obstacles in Eating Disorder Treatment. If you are in Boston for FNCE this year, make sure to attend the Member Awards Reception and the DPG/MIG Showcase – we would like to meet you.

BHN knows how important it is to be able to network with each other. To that end we have the BHN listserv that is available to all members. We are also on Facebook. Just type in BHN in the search box and click on our page. There is a lot of information added there daily. Coming soon BHN will also have a presence on the Eatright.org blog page.

I am very excited about the plans that are already in the works, but more excited for what may happen that we don't yet know about. If you are thinking that now might be the time to expand your horizon and be a part of the excitement, please get in touch with me at 734-635-7771 or at [katerussrd@yahoo.com](mailto:katerussrd@yahoo.com). There is a place for YOU!

Respectfully submitted,  
 Kathy Russell, MS, RD, 2010-11 BHN Chair

## Food & Nutrition Conference & Expo (FNCE)

2010 BHN Schedule of Events • Boston Convention & Exhibition Center

**Sunday, November 7, 2010 5:30pm - 7:30pm**

Member Awards Reception  
 Westin Boston Waterfront, Carlton Room

**Monday, November 8, 2010 10:30am – 1:00pm**

DPG/MIG Showcase  
 Boston Convention & Exhibition Center

**Monday, November 8, 2010 3:30pm – 5:00pm**

BHN Spotlight Session  
*Overcoming Obstacles in Eating Disorder Treatment*  
 Debra Johnston, RD and Dena Cabrera, Psy. D

## Call for Topics & Speakers

on Mental Illness and  
 Behavioral Health  
 Nutrition!

FNCE 2011

BHN Spotlight Session

Contact Charlotte Caperton-  
 Kilburn, MS, RD, CSSD, LDN  
[nflperformance@yahoo.com](mailto:nflperformance@yahoo.com)  
 Volunteers and Suggestions  
 are Welcome!

## Bipolar Disorder

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around and insulate axons to permit the efficient conduction of nerve impulses in the brain. Therefore, loss of myelin is thought to disrupt communication between neurons, leading to some of the thought disturbances observed in bipolar disorder and related illnesses. Brain imaging studies of persons with bipolar disorder also show abnormal myelination in several brain regions. Gene expression and neuroimaging studies of persons with schizophrenia and major depression also demonstrate similar findings, indicating that mood disorders and schizophrenia, may share some biological underpinnings. (1)

### Diagnosis

No laboratory study can be used to confirm the diagnosis of bipolar disorder. Therefore, gathering the history of present and past disturbances of mood, thought, and behavior is critical to properly diagnose bipolar disorder. (5) The conceptualization of a "bipolarity index" is useful in clinical practice with an emphasis on the 5 cardinal parameters: age of onset, course of illness, response to treatments, family history, and current signs and symptoms. (6)

### Comorbidities

Cardiovascular disease is responsible for the majority of excess premature deaths in patients with BD but the highest standardized mortality rate in patients with BD is for suicide. Only lithium has shown efficacy in the long-term prevention of suicide.

Studies have shown that patients with BD are likely to have comorbid psychiatric conditions. These comorbidities include anxiety, impulse control problems, attention deficit hyperactivity disorder, personality disorder, and eating disorders. The prevalence of comorbid substance abuse is as high as 61%, which is greater than the prevalence of comorbid substance abuse seen with any other psychiatric conditions, including schizophrenia, panic disorder, dysthymia, and unipolar depression.

The prevalence of migraine, diabetes, other endocrinopathies, and cardiovascular disease is higher in patients with BD than in the general population. Patients with BD are typically overweight or obese due to a variety of factors, including sedentary lifestyle, poor eating habits, and weight gain associated with psychotropic medications. Similar to other individuals with abdominal obesity, patients with BD are at increased risk for developing the

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**Table 1. Distinguishing Patterns of Behavior in Bipolar Disorder (1)**

Characteristics	Hypomania	Manic Phase	Depression
<b>Appearance</b>	These individuals are busy, active, and involved. They have energy and are always on the go. They are always planning and doing things. Others notice their energy levels and mood changes	Individuals experiencing the manic phase are hyperactive and might be hyper-vigilant. They are restless, energized, and active. They talk and act fast. Their attire reflects the mania. Their clothes might have been put on in haste and are disorganized. Alternately, their garments are often too bright, colorful, or garish. They stand out in a crowd because their dress frequently attracts attention.	Persons experiencing a depressed episode may demonstrate poor to no eye contact. Their clothes may be unkempt, unclean, holed, un-ironed, and ill-fitting. If the person has lost significant weight, the garments may fit loosely. Personal hygiene reflects their low mood, as evidenced by poor grooming, lack of shaving, and lack of washing. In women, fingernails may show different layers of polish or one layer partially removed. They may not have paid attention to their hair. Men may exhibit dirty fingernails and hands. They move slowly and very little. They show psychomotor retardation. They may talk in low tones or in a depressed or monotone voice.
<b>Affect/Mood</b>	Their mood is up, expansive, and often irritable.	The mood is inappropriately joyous, elated, and jubilant. They are euphoric. They also may demonstrate annoyance and irritability, especially if the mania has been present for a significant length of time.	Sadness dominates the affect of individuals experiencing a depressed episode. They feel sad, depressed, lost, vacant, and isolated, hopeless and helpless. When in the presence of such patients, one comes away feeling sad and down.
<b>Thought patterns</b>	Patients in this state are optimistic, forward thinking, and have a positive attitude.	During the manic phase, patients have very expansive and optimistic thinking. They may be excessively self-confident and/or grandiose. They often have a very rapid production of ideas and thoughts. They perceive their minds as being very active and see themselves as being highly engaging and creative. They are highly distractible and quickly shift from one person to another.	Patients are preoccupied with negative ideas and nihilistic concerns, and they metaphorically see "the glass as half empty."
<b>Perceptions</b>	Patients in this state do not experience perceptual disturbances	Approximately three fourths of patients in the manic phase have delusions. The delusional content may be either consistent or inconsistent with the mania. Manic delusions reflect perceptions of power, prestige, position, self-worth, and glory.	Two forms of a major depression are: with psychotic features and without psychotic features. With psychosis, the patient experiences delusions and hallucinations that are either consistent or inconsistent with the mood. In the former, the patient's delusions of having sinned are accompanied by guilt and remorse or the patient feels he or she is utterly worthless and should live in total deprivation and degradation. Hence, the delusional content remains consistent with the depressed mood. In contrast, some patients experience delusions that are inconsistent with the depression, such as paranoia or persecutory delusions.

*Printed with permission by Soreff, Stephen, Lynne Alison McInnes, Bipolar Affective Disorder. <http://emedicine.medscape.com/article/286342-overview>. Updated: Sep 18, 2008*

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metabolic syndrome. In a study of 171 patients with BD, 74% were overweight or obese, and 30% met the criteria for the metabolic syndrome. (2)

### Treatments for Bipolar Disorder

Several issues arise when patients are treated for long periods of time, including suicide risk, management of subsyndromal symptoms (i.e. do not meet the full DSM IV diagnostic criteria), treatment resistance, comorbidities, and adverse events associated with therapies. (2)

The circuits of the brain that modulate mood, cognition, and behavior are not well defined. The database of neuroimaging studies of possible modulating pathways is constantly growing. Studies attempt to determine if/how an association of neurotransmitters acts upon various brain regions and circuits to modify and regulate brain activity, working in unison in several brain regions to regulate thoughts, feelings, and behaviors. Table 2. reflects the putative roles of some CNS neurotransmitters in brain circuits. In particular, serotonin, dopamine, and norepinephrine appear to modify mood, cognition, and sense of pleasure or displeasure. Pharmacotherapy for the regulation of bipolar mood swings is thought to be based on the use of medications that facilitate the regulation of these and perhaps other neurochemicals to restore a normal mood and cognition state. (5)

### Medication and Side Effects

Unwanted side effects may contribute to poor medication adherence, particularly when used for maintenance therapy. Lithium has a narrow therapeutic window, which necessitates frequent drug level monitoring. Adverse events associated with lithium include weight gain, gastrointestinal disturbances, polyuria, impaired cognition, sedation, and other neurotoxic

**Table 2. Neurotransmitters of the Central Nervous system**

Neurotransmitter	Activity Modified
Serotonin	Mood (happy, sad, euthymic)
Dopamine	Pleasure (hedonia, anhedonia)
Norepinephrine	Alertness, energy level (lethargy, frenzy, vigilance)
Acetylcholine	Memory and cognition
GABA	Inhibition of CNS neurons
Glutamate	Excitation of CNS neurons

effects, which result in poor coordination and muscle weakness. The American Psychiatric Association recommends that serum lithium levels be measured every 6 months and that patients be monitored for clinical signs and symptoms of toxicity including tremor, nausea and diarrhea, blurred vision, vertigo, confusion, and increased deep tendon reflexes. (1)

Medication combinations are often prescribed (antidepressants, anti-convulsants, etc).

Carbamazepine is associated with gastrointestinal side effects, cognitive impairment, and skin rash as well as hepatic enzyme auto-induction, which can affect the metabolism of concomitant medications. The most serious side effects associated with carbamazepine are blood dyscrasias, including agranulocytosis and aplastic anemia.

Sodium divalproex has fewer gastrointestinal side effects than valproic acid but has been associated with hair loss, tremor, sedation, cognitive impairment, pancreatitis, polycystic ovarian syndrome, and thrombocytopenia.

The most common adverse events reported in maintenance studies with lamotrigine are headache, nausea, infection, and insomnia. In rare cases, lamotrigine treatment has been associated with skin rash including mild Stevens-Johnson syndrome. (2)

### Non-Pharmacological Treatments

#### Micronutrient Supplements and Symptom Severity

Dermot Gately, PhD and Bonnie J. Kaplan, PhD report on an analysis of self-reported data collected via the internet by adults previously diagnosed with bipolar disorder and taking a multi-vitamin/mineral supplement as well as prescribed medications (mood stabilizers, antidepressants, antipsychotics and/or anxiolytics). The database covered the period from January 2001 to August 2007. Individuals with co-occurring disorders were excluded.

For at least 150 of 180 days participants also completed a Self Monitoring Form consisting of 16 DSM-specified mood

symptoms. Each symptom was rated from 0 (not at all) to 3 (very much) yielding a Mood Severity Symptom score. Analysis included data of individuals reporting symptoms at baseline, 3 months (N=349), and 6 months (N=242). At 3 months there was a 41% drop and at 6 months a 45% drop in mean symptom score. Eight percent of participants reported being symptom-free after six months, 18% reported increased symptom severity. An additional analysis of medication was reported. In general, those on lower medication doses benefitted more than those on higher medication doses. Changes in specific medications were not reported.

Researchers noted that although the data was self-reported, a source of potential bias, there was a high motivation level for reporting, the participants were not compensated for their participation, and neither the researchers nor the universities were affiliated with the company collecting the data. (7)

#### Psychosocial Treatments

Although patients receiving intensive psychotherapy had significantly higher year-end recovery rates (64.4% vs. 51.5%) and shorter times to recovery than patients in collaborative care, evidence suggests that adjunctive psychosocial interventions in bipolar disorder are clinically beneficial and cost effective when used in conjunction with pharmacotherapy. (3)(8) Appropriate adjunctive psychosocial interventions in bipolar disorder have been found to be associated with improved treatment adherence, greater stability, fewer hospitalizations, fewer days hospitalized, less need for crisis interventions, decreased relapse risk, and fewer acute episodes. A positive impact on medication adherence is a major goal of these adjunctive treatments.

Specific types of therapy that have shown efficacy include bipolar-specific cognitive-behavioral therapy, family-focused therapy, interpersonal and social rhythm therapy, and systematic care management. As outlined in Table 4, psychosocial treatments include: 1) psycho-education (pamphlets, books, Web sites, exercises such as life chart;

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**Efficacy refers to benefit shown with a drug in a randomized clinical trial. Effectiveness refers to benefit with a drug in the real world, non-randomized clinical practice.**

Ghaemi, S. Nassir. Wellness and effectiveness: key concepts in treating bipolar disorder. *Maintaining wellness in patients with bipolar disorder: moving beyond efficacy to effectiveness.* Meeting of the American Academy of Clinical Psychiatrists. 2009. [http://www.currentpsychiatry.com/pdf/Supp/SupplCP1010\\_BD\\_2.pdf](http://www.currentpsychiatry.com/pdf/Supp/SupplCP1010_BD_2.pdf) October 2009.

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writing lists of triggers, discussion), 2) problem-solving skills, 3) communication enhancement, 4) cognitive therapy (such as monitoring, examining and changing dysfunctional thinking and behavior associated with undesirable mood states), and 5) promotion of importance of regular sleep and daily routines. (9) **Web-based education: An emerging treatment modality**

The School of Psychiatry in New South Wales, Australia reports on a recently developed free web-based education program concerning bipolar disorder. The purpose of the program is to provide accessible evidence-based information for patients, care-givers and health professionals. The nine-module program had over 8000 visitors in the first six months. A randomized controlled evaluation of the program was conducted. 43% of visitors had bipolar disorder. Seventy-six percent of those starting a module completed the session. (10)

Another web-based intervention known as 'Beating Bipolar' is a psycho-educational program by investigator Danny Smith, MD and Alice Roberts, MD of the Cardiff University School of Medicine. The program is delivered via a web-based system in Cardiff, UK. Begun in June 2009, the primary study outcome is quality of life (QOL). QOL for 100 patients diagnosed with bipolar disorder in South Wales, who have participated in the psycho-educational program, will be compared with those who received treatment as usual. QOL will be assessed immediately following the intervention as well as 10 months after randomization. Secondary outcomes include current depressive and manic symptoms, number of episodes of depression and mania/hypomania experienced during the follow-up period, global functioning, functional impairment and insight. (11) <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2734537/?tool=pubmed>

## Selective Literature Review of Emerging Nutrition Related Treatments

### Cytidine supplements

Targeting the glutamatergic system has been suggested as a promising new option for developing treatment strategies for bipolar depression. Cytidine, a pyrimidine, may exert therapeutic effects through a pathway that leads to altered neuronal-glial glutamate cycling. Pyrimidines are also known to exert beneficial effects on cerebral phospholipid metabolism, cate-

**Table 3. Percent of Patients Taking Olanzapine and Fluoxetine Who Experienced Side Effects Which May Influence Food and Beverage Intake (3)**

Effect	Olanzapine/Fluoxetine Combination (%)	Olanzapine %	Placebo %
Somnolence	21	28	13
Weight Gain	17	17	3
Increased appetite	13	14	5
Headache	14	12	19
Dry Mouth	16	11	6
Nervousness	9	11	8
Asthenia (loss of strength)	13	10	3
Insomnia	9	8	15
Diarrhea	19	7	7
Nausea	12	4	9

*Adapted from Hirschfeld, Robert. Making efficacious choices: The integration of pharmacotherapy and nonpharmacologic approaches to the treatment of patients with bipolar disorder. Meeting of the American Academy of Clinical Psychiatrists. 2009.*

cholamine synthesis, and mitochondrial function, which have each been linked to the pathophysiology of bipolar depression.

A study reported by S J Yoon MD, PhD, and colleagues suggest that cytidine supplementation of valproate is associated with an earlier treatment response in bipolar depression. Cytidine is a structural unit of RNA made up of one pyrimidine base (cytosine, which forms a base pair with guanine) and 1 ribose. Cytidine's efficacy in bipolar depression may be mediated by decreased levels of cerebral glutamate and/or glutamine, consistent with alterations in excitatory neurotransmission. (12)

### Folate, B-12 and Homocysteine

In a study of 197 bipolar patients, 278 relatives and 238 controls, Homocysteine (tHcy) was significantly increased in patients and relatives. In contrast, folate and B12 were significantly lower in patients and relatives. Genotypes of c.1298A>C and c.677C>T were correlated with tHcy, folate and B12. Patients and relatives carrying TT and/or AA and AC genotypes had elevated tHcy and reduced folate and B12 levels. The authors suggested that high tHcy but low folate and vitamin B12 levels may be a risk factor for development of bipolar disorder. (13)

### Lithium and Magnesium

Lithium salts have been in use for the treatment of bipolar disorder for more than 50 years, but their pharmacological mode of action remains a matter of conjecture. Li(+) and Mg(++) share many physico-chemical properties. Not surprisingly, many reported cellular targets for Li(+) action involve Mg(++)-activated enzymes, which are inhibited by Li(+). Duarte Mota de Freitas, PhD and colleagues describe results that suggest that a competition mechanism between Li(+) and Mg(++) ions for Mg(2+)-binding sites in cellular compo-

nents is the underlying theme in putative mechanisms of Li(+) action. (14)

### Choline, ATP and Bipolar Disorder

Phospholipid synthesis for maintaining membrane integrity in mammalian brain cells consumes approximately 10-15% of the total adenosine triphosphate (ATP) pool. Reports of genetic studies, suggest mitochondrial dysfunction and dysfunction in high-energy phosphate metabolism in individuals with bipolar disorder. An increased availability of brain choline may lead to an increase in ATP consumption.

Fifty mg/kg/day of choline bitartrate or placebo for 12 weeks produced no significant differences in change-from-baseline measures in psychological testing, brain choline/creatine ratios, or brain lithium levels over a 12-week assessment period between the choline and placebo groups or within each group. However, oral choline supplementation at this level resulted in a significant decrease in brain purine levels over a 12-week treatment period in lithium-treated patients with DSM-IV (rapid-cycling type) bipolar disorder, which may be related to the anti-manic effects of adjuvant choline. This result is consistent with mitochondrial dysfunction in bipolar disorder inadequately meeting the demand for increased ATP production as exogenous oral choline administration increases membrane phospholipid synthesis. (15) **DHA, EPA and Omega-3 fatty acids**

A double-blind study of thirty patients with bipolar disease and treated with docosahexaenoic acid (DHA) was reported by Andrew Stoll, Director of Psychopharmacological Research at McLean Hospital in Boston. Study patients consumed 9.6 g/day Omega-3 fatty acids for four months. A high ratio of eicosapentaenoic acid (EPA) to DHA ratio was

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desirable (a 3:1 ratio is often reported). The placebo group was given olive oil. DHA supplement served as an effective mood stabilizer.

It is difficult to eat enough actual fish to get this dose. The fishy taste can be reduced by taking with orange juice. Stoll noted that Omega -3 fatty acids should not be used if a person is taking high doses of aspirin or medications such as Warfarin. He also noted that using cod liver or other fish liver oils to achieve high Omega -3 doses could result in vitamin A toxicity. (16)

## Nutritional Care Summary

- Accommodating for characteristics such as irritability, grandiosity, pressured speech, racing thoughts and flight of ideas, inability to concentrate, and distractibility will help dietitians in planning education and counseling during provision of nutritional care. Utilize strategies such as preventing outside distractions during sessions, keeping sessions and any assignments short; patiently persist in bringing discussion back to topic as needed.
- Side effects of medications may include weight gain, increased appetite, dry mouth, diarrhea and nausea. Signs and symptoms of potential lithium toxicity may include nausea, diarrhea, tremor, confusion, blurred vision and vertigo. Document observations or reports of these.
- Blood lithium levels are affected by sodium intake; consistent moderation is recommended. There is a narrow range between effectiveness and toxicity of lithium.
- Absorption of Geodon is doubled in the presence of food; timing of meals and intake of medication is important. A 500-calorie meal is recommended with drug intake.
- Essential fatty acid supplements of DHA and EPA are being investigated for treatment of bipolar disorder and depression. A commonly prescribed dose is 1000 mg/day with a ratio of EPA: DHA of 3:1. It is recommended that higher doses be monitored by physician. Use is contraindicated if patient is on blood thinner such as Warfarin.
- Sodium, magnesium, vitamin B-12, folic acid, choline, phosphorous, glutamine, inositol, and homocysteine are nutrients of interest.
- Psychiatric co-morbidities include eating disorders and substance abuse.
- Medical co-morbidities include meta-

**Table 4. Psychosocial Interventions in the Treatment of Bipolar Disorder: Commonly Used Techniques and Goals (2)**

Intervention	Goals	Techniques
<b>Psychoeducation</b>	Illness awareness Treatment compliance Early detection of prodromal symptoms and recurrences Lifestyle regularity*	Education: Pamphlets, books web sites Exercises; life chart; writing lists of triggers Discussion
<b>Family-focused Psychoeducation</b>	Accept the notion of a vulnerability to future episodes Accept a dependency on mood-stabilizing medication for symptom control Distinguish between the patient's personality and his/her bipolar disorder Recognize and cope with stressful life events that trigger relapse Reestablish functional relationships after a mood episode	Education about symptoms, course, treatment, and self management of bipolar disorder Communication enhancement, including rehearsal of effective speaking and listening strategies Problem solving including identifying specific problems, and the teaching of problem solving skills
<b>Cognitive Therapy</b>	Challenge the patient's beliefs and assumptions about his or her self, the world, and the future that contribute to vulnerability to bipolar disorder	Monitor, examine and change dysfunctional thinking and behavior associated with undesirable mood states Monitor moods and early signs of relapse Develop a plan to deal with prodromal activities Emphasize the need for combined medication and psychological therapies Promote the importance of regular sleep and routine*
<b>Interpersonal and Social Rhythm Therapy</b>	Stabilize daily routines and sleep-wake cycles Gain insight into relationships between moods and interpersonal events Ameliorate interpersonal problems	Review history of illness Track and identify connections between wake time, sleep time, activities, and mood Develop a plan to stabilize social and circadian rhythms by maintaining consistent sleep and wake times and reducing irregular bursts of social stimulation Explore and resolve key interpersonal problems

\* Lifestyle regularity includes goals for a routine concerning meals and snacks, of particular interest to Registered Dietitians  
Adapted from Lam DH et al. Arch Gen Psychiatry. 2003;60:145-152; Colom F et al. Arch Gen Psychiatry. 2003; 60:402-407; and Miklowitz DJ et al. Arch Gen Psychiatry. 2003; 60:904-912; Frank E et al. Arch Gen Psychiatry. 2005; 62:996-1004.  
Printed with permission by Baldassano, Claudia F. [http://www.currentpsychiatry.com/pdf/Suppl/SupplCP1010\\_BD\\_2.pdf](http://www.currentpsychiatry.com/pdf/Suppl/SupplCP1010_BD_2.pdf). Published October 2009.

bolic syndrome and cardiovascular disease, especially in the overweight and obese.

- Consensus-based guidelines for monitoring for Bipolar Disorder from the International Society for Bipolar Disorders (2009) include the following:
  - Medical, family, and substance use histories;
  - Waist circumference, body-mass index, or both;
  - Blood pressure;
  - Fasting glucose and fasting lipid levels;
  - Blood count and levels of electrolytes, urea, and creatinine;
  - Liver function tests; and
  - In women, risk for or capability of

becoming pregnant.

- Further parameters are specified for individual drugs. For example, lithium treatment requires taking baseline levels of thyroid-stimulating hormone (TSH) and calcium. (17)

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### About the Author:

Ruth Leyse-Wallace, PhD RD is a BHN member living in San Diego, California. She is author of "Linking Nutrition to Mental Health: A Scientific Exploration." Lincoln, NE: iUniverse Press; 2008. email: RthLys@cox.net Web page: www.RuthLeyseWallace.com Blog: <http://nutritionandmentalhealth.wordpress.com>

# Lighter & Free from the Inside Out – That's Bob Wilson, DTR

Interviewer, Renee Hoffinger, RD, LD

BHN member Bob Wilson enjoys his role as a Dietetic Technician, Registered (DTR) who applies nutrition science knowledge to each client's situation thru education and counseling. Bob's practice provides a clear illustration of how the RD/DTR team can function efficiently in the behavioral health practice arena. Bob has written and self-published a workbook on mindful, balanced eating, well-being and weight loss. He also teaches and provides lifestyle coaching on diet and health. Bob received the Award of Excellence in Practice by the Oregon Dietetic Association in 1987 and nationally in 1996 by the American Dietetic Association. The BHN newsletter team recently spoke with Bob to find out more about his life, work, and philosophy.

**BHN: Please tell us a bit about your career path. What is your background and what possessed you to get involved with your current work?**

BW (Bob Wilson): I graduated from Portland State University with a bachelor's degree in Biology, and then went on to earn an associate's degree in Dietetic Technology from Portland Community

College. My primary area of practice over the past 20 years has been in health education services with a national health maintenance organization. During this time I sought training in the stages of change to guide effective behavior change in clients, motivational interviewing and other behavior change counseling strategies. My personal experience in overcoming addiction, eating disorder, losing 250 pounds and keeping them off for the past 37 years helps me to be an effective tour guide, supporting clients' journeys as they explore their behavior and emotional changes. As "someone who has been there," I can share key transformative wisdom. How did I make lasting changes? I found that success at living addiction-free requires learning a series of new skills.

Through my varied career in food service, research, adult behavioral weight management and, worksite wellness, I have presented at a variety of dietetic and health promotion conferences, schools, churches, and community groups, as well as on local television, about wellness and practical nutrition. All this experience has led me to develop my own wellness and lifestyle

coaching business, to create my own holistic wellness website, and write a book!

**BHN: Do you work in concert with registered dietitians?**

BW: My life has been immeasurably enriched by my dietetic training and my full participation in the dietetic community and the community at large. In each work setting I've enjoyed close collaboration with RDs, learning immeasurably from each one. I have come to the realization that such collaboration of diverse strengths and skills ultimately benefits our clients. I look to RDs for nutrition science knowledge and enjoy my role as a DTR who applies the knowledge to each client's situation thru education and counseling.

**BHN: What type of clients do you work with and how do they come to you?**

BW: Teaching at the HMO in the Department of Health Education Services, I co-developed with an RD the curriculum and materials for the *Mastering Weight Management (MWM)* program. MWM is a comprehensive 8-week program for adults that also include two telephone coaching sessions. The program covers

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## Lighter & Free

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the entire scope of life-long weight management. Members of MWM frequently re-take (or repeat) the class several times to prolong support. Live webinars are currently being developed by me and an RD for members who live far away and for promoting life-style maintenance. Clients may contact me or are often referred by a clinician considering them for bariatric surgery (60% of our clients are referred in this manner) and typically may weigh 200-700 pounds.

My other area of practice is my own holistic wellness and weight management coaching (in person and via telephone) business. Adult clients contact me after seeing my website or Playbook. I work in collaboration with an RD to address any areas that are out of the DTR scope of practice (such as any complex metabolic conditions). I also refer to other health professionals.

### **BHN: What are the goals of this work and some of the strategies you use to help clients achieve their goals?**

BW: As the journey of self-exploration unfolds, clients discover how to practice the art of holistic, dynamic, mindful and compassionate self-care that can transform all addictions into lasting well-being. Clients learn how to become their own unconditional friend—for themselves—just as they have likely been doing for other people in their lives.

The goal is for clients to see their lives as a sacred whole, an ecosystem that is influenced by culture and interconnected relationships. They develop wisdom and discernment about moment-to-moment choices. Clients come to understand how each choice affects their body, mind (and brain biochemistry), emotions, cravings, and spirit—how everything is connected and interdependent. When off track they learn to explore the reasons and develop solutions.

The primary goal is to empower clients to become loving caregivers to them self—to learn how to nurture themselves *from the inside out*. How does a person learn these essential lifestyle skills? What's the process? Clients start where they are because they can't be anywhere else! Using motivational interviewing and positive feedback, meditation and mindfulness skills, clients are encouraged to listen for the answers they already have inside. Students are empowered as they come up with their own positive and practical plans. They *go inside* to chart their own course. In doing so, they discover skill

power, not will power! A daily personal check-in is used to find answers and develop self-understanding. Gradually a witness-self is developed that sees patterns of success or self-sabotage and helps plan alternatives as they self-monitor and set goals.

### **BHN: So it sounds like a fairly deep, introspective process....**

BW: Yes, it takes great courage and introspection. Once clients get the hang of it, they begin to ask themselves: What are my personal obstacles? Do I have any overwhelming circumstances? Needs? Environments that cause problems? What are my patterns? What have I tried and learned? How would my life be different if I explored new resources to manage an area better? Am I ready? What might I need to change? What support would I need to go forward? What are my strengths? What has worked for me in the past? What would be fun to learn about? What resources might be used to sustain my journey towards increasing health and vitality?

Clients learn that to transform themselves they must come to self-understanding; the factors that have led to imbalance and when in relapse, learn self-restoration skills. They begin to do a compassionate and wise self-assessment, and then explore skills that allow them to restore harmony and make lasting changes. Realistically, this process of exploration takes time, for many people, one to three years or more. Weight issues are very complex to unravel. It took awhile to get to where they are now, and it will take awhile to make changes. They discover skills that promote weight maintenance. Practice doesn't make perfect—it makes permanent!

### **BHN: Typically, what kind of client outcomes have you seen as a result of working with this approach?**

BW: Clients' average weight loss is 0.5 – 2 pounds per week (4-16 pounds for 8-week program). Client evaluations note many holistic health improvements: discovery of enjoyable, tailored activity plans to boost quality of life, energy and endurance; increase in perceived sense of self-efficacy and self-esteem, better understanding of their inner hungers for food, rest, and self-nurturing (from those skills

clients report managing emotional eating more effectively, applying healing nutrition guidelines as they practice eating with awareness and pleasure); reduction in blood pressure and diabetic medications, better food-portion management, planning/eating simple healthier meals and snacks throughout the day, increase in self-management, problem-solving skills and realistic thinking, more effective relapse management, developing ongoing support systems, practicing positive self-talk to overturn negative thoughts, utilizing non-food rewards, and journaling to identify what does and does not work for them. Overall, they learn sustainable self-care practices for their day-to-day lives. Follow-up studies have shown that utilization rates drop post intervention, however the more lifestyle skills or new behaviors practiced, the more likely it is that members will maintain weight loss and feel overall health improvement. New data is currently being recorded for further study.

The success of this program resides in the fact that people choose to be healthy not because the RD/DTR/MD said so, but because they're more open to loving and respecting themselves. They get to a point of desiring a free heart and mind from personal distress by learning to release self-judgment and become *their own* best friend. Out-of-balance living is transformed through compassionate self-care. Success comes in discovering how to balance self-care with service to others, and in nurturing an unconditional friendship with their self.

### **BHN: Any other tips you have applied in this program that you think might be of use to other dietetic practitioners?**

BW: To promote practice and self-mastery following a session, I send personalized e-mails with pertinent resources, articles, videos, support channels, and motivational ideas, using hyperlinks to provide easily accessible support. Clients have found them to be extremely valuable for their exploration. The RD/DTR can set up a Word document with common link areas to facilitate this process.

For more information visit Bob's web site at [www.balancedweightmanagement.com](http://www.balancedweightmanagement.com) or contact him at [nutribob@comcast.net](mailto:nutribob@comcast.net)

### **Join us, won't you?**

Sign up and gain FREE access to hundreds of members and their expertise through the member-only BHN listserv! We have a wonderful exchange of information, ideas, and resources. Find practice supports and prompt responses to challenging questions. To subscribe to the BHN LIST Electronic Mailing List (EML):

- Send an email to BHN Membership Chair, Julie Lovisa at [assistU@bhndpg.org](mailto:assistU@bhndpg.org)
- Include First Name, Last Name, Email Address
- Please title the subject of the email as BHN LIST SUBSCRIBE

**Legislative and Public Policy  
Committee Report  
House of Delegates  
Spring 2010  
Retrieved 05-27-10;  
Summary of ADA Reports**

The Legislative and Public Policy Committee commended the House of Delegates for its timely work on and support for improving nutrition services in health-care reform. Congress has ramped up action on the reauthorization of the Child Nutrition Act. On March 24, the Senate Committee on Agriculture, Nutrition and Forestry unanimously report the Healthy, Hunger Free Kids Act of 2010 out of committee. This bill contains several ADA recommendations and provides \$4.5 billion in new funding but falls short of meeting President Obama's request of funding a \$1 billion per year increase in child nutrition programs. ADA is working on reaching that goal by telling the House of Representatives to include the President's budget recommendation in their child nutrition reauthorization proposal. ADA encourages the delegates to bolster their state's grassroots efforts. Read the weekly *On the Pulse* e-newsletters and Wednesday's *Policy Initiatives and Advocacy Reports* for message updates and calls for action. And be certain to try ADA's updated version of Grassroots Manager when corresponding with your members of Congress.

The Legislative and Public Policy Committee is among twenty-one ADA committees and task forces that provide updates to the House of Delegates (HOD) prior to the fall and spring House of Delegates meetings. Full reports of this and other ADA committees and task forces can be downloaded using the following ADA Web site pathway: Members > Governance > Reports and Minutes or direct link: <http://www.eatright.org/Members/content.aspx?id=8347>.

To learn more about ADA's priority areas in public policy and advocacy efforts go to [www.eatright.org/advocacy](http://www.eatright.org/advocacy)

**Do you have a product or service you would like to publicize?**

**Have you written an evidence-based article you would like to share?**  
BHNNewsletter reaches more than 1300 members quarterly.

**Let me know! Diane Spear, MS, RD, LD,  
BHNNewsletter Editor  
[www.newsletter@bhn.org](http://www.newsletter@bhn.org)**

# Elevate Your Level of Practice and Increase Your Value!

By Becky Dorner, RD and Linda Delahanty, MS, RD  
ADA Research Committee, September 2009

For some practicing dietetics professionals (RDs/DTRs), mention of the word "research" makes them want to turn and run in the opposite direction. But please don't stop reading now! If you do, you'll miss out on great information about why research is important to every day practice and how you can increase your value as a professional, develop your career skills and elevate the level of your practice. As a practitioner or business owner/entrepreneur, you may feel that research does not apply to you, but research is relevant to every practice setting. Improving your understanding of how to read and interpret research findings and applying research results to your practice can boost your career and yield incredible benefits for your customers, patients and clients.

## The Value of Research in Daily Practice

Research has applications to almost all areas of dietetics practice, making a solid research background vital to the work of RDs/DTRs. For example, research is driving the development of Centers for Medicare/Medicaid Services (CMS) interpretive guidance for surveyors. These guidelines will be used to determine compliance with regulatory requirements in the areas of nutrition, unintended weight loss and pressure ulcers. The newly published guidelines for surveyors are based on research findings,

or when sufficient evidence is lacking, on standards of professional practice. This has important implications for dietitians who work in long term care settings, as well as acute care because the Joint Commission often follows CMS' example with regard to survey guidance and interpretation. Understanding the research on which regulatory guidelines are based and revisions to the rules can help you provide the best care possible and assure that your facilities pass inspections.

In clinical practice, your ability to communicate and apply evidence-based research can improve the quality of care and client/patient outcomes, as well as establish the RD as a critical component of cost effective health care. Outcomes research can drive client referrals to the RD, increasing inpatient consults and outpatient referrals, which can help support the need for maintaining or increasing staffing patterns and salaries. Moreover, understanding and using evidence-based research in your communications with other health professionals will increase your credibility and the likelihood that you will be included in research collaborations in your practice area. The bottom line is that research helps us prove the value of RD services, which can increase demand for our services and provide job security!

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### Why Research is Important to Dietetics Practice

**Promotion of Professionalism** – ability to communicate the research evidence supporting medical nutrition therapy, counseling approaches, nutrition education strategies, etc to other medical professionals, the media and the public enhances credibility and respect of practitioners and profession

**Promotion of High Quality of Care for Clients, Patients and Consumers** – research contributes to evidence supporting specific interventions and approaches that are most likely to benefit clients, patients and consumers; research helps to improve quality of care, delivery of care and outcomes

**Improves Decision Making** – helps take the "guess work" out of how to practice and guides evidence-based communications and practice

**Identifies Needs** – identifies nutrition risk factors and needs that can guide intervention strategies, influence legislation and public policy, and drive research funding

**Research Provides New Opportunities** – New frontiers in research like the Human Genome Project and related research studies, are forging new opportunities for dietetics practitioners that can be great starting points for advances in dietetics practice

**Supports Continued Funding for Programs** – cost-benefit research supports continued funding for programs through achievement of desired outcomes/attainment of benefits (ex: WIC) and quality improvement

**Insurance Coverage** – the likelihood of receiving reimbursement is increased when medical nutrition therapy is evidence-based

## Elevate Your Level of Practice

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If you are a dietitian who has your own business, keeping up with the latest information and research can help elevate the level of your practice by increasing your credibility, proving your worth to clients and enhancing your professional value. Your credibility and value as an entrepreneur or as a business owner is based on your willingness to stay current with the research and information relevant to your business/industry. Whether your clients are health care providers, the media, industry or patients, they all value your knowledge, guidance and assistance in helping them communicate and implement evidence-based nutrition recommendations and standards of care. Ultimately, this translates into customer satisfaction; and customer satisfaction translates into more business.

Employers are most impressed with those who are willing to go the extra mile in staying up-to-date with research findings that can translate into improving our nutrition care services and systems. Staff who integrate cutting edge research into practice are more valuable to their employers because they help build a credible reputation and can generate more business.

### 10 Ways for BHN Members to Get More Involved in Research

1. Use the Evidence Analysis Library (EAL) and identify new EAL topics for which BHN could provide/seek financial support
2. Solicit and publish research focused articles and updates in BHNNewsletter
3. Spotlight member's involved in research in BHNNewsletter
4. Attend the FNCE Research Symposium, add research to your Professional Development Portfolio plan, and/or volunteer to help the Research Committee with the development of the Research Toolkit
5. Join the Dietetics Based Practice Research Network (DBPRN)
6. Fund an Outcomes Research Award/Grant or support ADAF Research
7. Provide research mentoring opportunities
8. Become a Research Coordinator/ Professional Development Coordinator for BHN or part of a BHN Research Sub-group or Committee
9. Support a Publications Award for Original Research in BHN
10. Support an Excellence in Research Award in BHN and nominate a BHN member for the ADA Excellence in Research Award

## How to Use Research to Your Advantage

There are a number of exciting and relatively easy ways for dietitians to become involved with research, ranging from learning more about dietetics-related research, to evaluating research in order to make practice-based decisions, and even participating in scientific research projects.

As a practicing dietitian, Becky has had the opportunity to do all three. Through her practice, she has conducted both formal and informal research studies on unintended weight loss, pressure ulcers and dysphagia. The study results were used to develop training programs for health care professionals including facility staff, to develop tools for practice and protocols to guide care. Through her volunteer work, most recently with the National Pressure Ulcer Advisory Panel, she had the opportunity to participate in a small working group to develop International Guidelines for the Nutrition Treatment of Pressure Ulcers. *"We followed very strict research criteria to formulate the guidelines and it was an incredible learning experience,"* Dorner said about the project. From small projects, to larger ones, to international involvement—does it get much more exciting than that? *"To think that we as dietitians, can impact care across the globe through our involvement in research—that's a pretty awesome—and humbling thought!"* said Dorner.

As a clinical and research dietitian, Linda has found that her clinical experience informs good research questions and that her research experience informs cutting edge clinical practice. *"It was when I incorporated research into my practice that I was viewed differently by my non-RD colleagues. Demonstrating the ability to discuss and conduct evidence based research led to more substantive salary increases, elevation of my position to Chief Dietitian and Director of Nutrition and Behavioral Research and many invitations to collaborate as a co-investigator on research projects and grants!"* said Delahanty.

### Applying Research to Practice: Advice for Getting Started

Take advantage of the tools available on ADA's website to learn how to incorporate research in your practice. The ADA Evidence Analysis Library® is a synthesis of the best, most relevant nutritional

research on important dietetic practice questions in an accessible, online, user-friendly library. The website offers a tutorial to assist you in navigating the site at [www.eatright.org/ealtutorial](http://www.eatright.org/ealtutorial) and also lists newly published evidence based questions and answers over the past 30 days and is updated daily!

- Get involved in ADA's DPBRN and join a team of professionals who are conducting ADA-sponsored research projects. By joining the DPBRN, you can participate in research that is meaningful to your practice and might potentially affect dietetic practice globally. As a DPBRN member you also have access to the top research experts in the field and can network with others who share your passion. Join your fellow colleagues and learn more about the research process, get involved in publishing research results, and contribute to dietetics outcomes and the greater good!
- Look for opportunities within your DPG to get involved in research. Some DPGs have mentoring programs or professional development coordinators, other DPGs have Research Committees or Research Coordinators and some DPGs offer small research grants.
- Express your interest in getting involved in research to colleagues conducting research in your work setting or practice area
- Attend the ADA Research Symposium to hear about cutting edge research and applications to practice.
- Watch for updates on the Research Toolkit being developed by ADA's Research Committee. This online interactive toolkit will be a valuable resource for practicing dietitians, students, dietetic interns, educators and junior faculty. An added benefit is that the online tutorials will be approved for continuing education credits.

### You Can Make it Happen

You can elevate your level of practice, increase your value, recognition and respect and be part of creating exciting evidence-based solutions for practice. You can do this by learning and getting involved with dietetics-related research. You can be part of the discovering the solutions you are searching for in your every day practice. Open your mind to the possibilities and think about your next step!

**Do you want to become part of a Research Committee or Research/Professional Development Coordinator for BHN?**

Contact Kathy Russell at [katerussrd@yahoo.com](mailto:katerussrd@yahoo.com) & Sharon Lemons at [slemons@prodigy.net](mailto:slemons@prodigy.net)

# STUDENT CORNER . . .

## Navigating Bloggerspace

By Meghan Lyle, Dietetic Student  
at the University of Washington

With Facebook, Twitter and the iPhone bringing us cyberspace access at a moment's notice, it may feel like we need to be perpetually wired to stay current. Some take advantage by finding their niche in the world of web. Blogs on everything from the daily life of a hamster to major corporate blogs by CEOs are out there for our perusing. Maybe you have a favorite blogger that you check out for gardening advice, new recipes, or do-it-yourself auto repair. The best blogs are usually strong in the following:

1. The author has clearly defined the scope of the blog. Blogs usually have an "About" section where you can find out more about the author and their credentials, and what the point of this blog is. An author that moves out of their defined scope will start to lose their audience.
2. Entries are short and sweet. A blog entry should not be a rambling, stream-of-consciousness verbal flood. Blog is short for 'web log', so a 'log' it should be. Bloggers who ramble in cyberspace soon ramble to themselves, or perhaps to a devoted following consisting of their own mother.
3. Current, current, current. A blog that is rarely updated or provides commentary on ancient history (i.e. last month) loses credibility with readers. We go to blogs for the latest. The latest on food or fashion, the latest on politics, the latest news. A rant or rave post about last week's news most likely will not be read. Except perhaps by one's mother, see point 2.

So maybe your friends would never call you "techie", but they rave about your creative cooking and health tips. Or maybe your patients love your counseling and want to refer their friends to you, but wish you had a website they could pass on. You would not be the first RD to turn to the web to get your name out there. Start by figuring out what the scope of your blog will be (see point 1). Then figure out how to start the design. If your blog will mostly be aimed at friends, family, and the random follower, a free blog "skin" or template may be reasonable. If you want to promote your business, you will probably want to invest in web design consultation and purchase a more specialized blog skin. For tips on templates and other advice for new bloggers, I found [www.startingablog.com](http://www.startingablog.com) to be a helpful site. Also make sure to familiarize yourself with blog etiquette. Find bloggers blogging on the golden rules of blog at [www.bloggingbasics101.com](http://www.bloggingbasics101.com) and [www.bloggingtips.com](http://www.bloggingtips.com).

Remember that what makes you love a blog is what will make readers love your blog: A slam-dunk first impression, current and pithy blog entries, and a defined scope. Ask yourself who you want your audience to be, and write with them in mind. Remember that even though only your mother may be tuning in at first, a blog-happy audience could soon be hanging on every typed word.

## BHN Blog Coming Soon!

BHN will soon have a presence on the Eatright.org Blog page. Four members of BHN, one from each of our practice areas will be posting at least once a week. Thanks to members Evelyn Tribole, MS, RD; Gale Maleskey, MS, RD; Jacqueline Larson, MS, RD; and Therese Shumaker, MS, RD, LD! We will let you know when the first Blog is to be posted.

## Behavioral Health Nutrition Executive Officers 2010-2011

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Texas  
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[slemons@prodigy.net](mailto:slemons@prodigy.net)

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Indiana  
574-647-2953  
[jlovisa@memorialsb.org](mailto:jlovisa@memorialsb.org)

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

### Manager, DPG/MIG Relations

*Anne Czeropski*  
American Dietetic Association  
Phone: 312-899-4852  
[aczeropski@eatright.org](mailto:aczeropski@eatright.org)

## RESOURCE PROFESSIONALS

### Addictions

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

### Eating Disorders

*Roberta Pearle Lamb, MPH, RD*  
Massachusetts  
781-405-4340  
[rpl@nwnutritioncoach.com](mailto:rpl@nwnutritioncoach.com)

### Intellectual and Developmental Disabilities

Open Position

### Mental Illness

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

## STUDENT LIAISON

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Committee Chair  
TBA

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

## Are You Seeking a Great Opportunity?

BHN is offering the opportunity to get involved in the future of Behavioral Health Nutrition. If you want to advance skills in the following areas, now is the time!

### Volunteers are needed for the following positions:

- Sponsorship Chair
- Publications Chair
- Student Liaison Committee Chair
- Student Newsletter Editor
- Student Committee Member
- IDD Resource Professional
- Standards of Practice Workgroup in Addictions

If you would like to volunteer yourself or suggest another BHN Member, please contact Sharon Lemons, MS, RD, Nominating Committee Chair at [slemons@prodigy.net](mailto:slemons@prodigy.net)

## BHNewsletter May Go Green

To continue offering the same quality of benefits with consideration of fiscal and environmental responsibility, BHN is asking for member input regarding BHN newsletters.

1. Are you amenable to receiving all four of the BHN newsletters electronically?
2. If BHN goes to all e-newsletters, will this impact your decision to remain a member?

Depending on your response, the Summer 2010 issue may be the last printed newsletter you will receive. Please offer your feedback through our member survey e-blast or notify the newsletter editor at [newsletter@bhndpg.org](mailto:newsletter@bhndpg.org) by Aug 30, 2010. Remember, all newsletters are available in the member section of the BHN website.

Don't miss the Fall 2010 electronic issue of BHNewsletter and other important announcements from BHN! Make sure ADA has your correct e-mail address on file at <http://www.eatright.org/MyADA/MyProfile.aspx>

Behavioral Health Nutrition  
c/o Diane M Spear, MS, RD, LD  
106 Craven Court  
Mannford, OK 74044

## Behavioral Health Nutrition

a dietetic practice group of the  
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