

# Weight Management Matters

## Weight Management

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### CPEU ARTICLE

## Development and Overview of the American Psychological Association Clinical Practice Guideline for the Treatment of Obesity and Overweight in Children and Adolescents

By: Hollie A. Raynor, PhD, RD, LDN



The field of nutrition and dietetics, similar to other healthcare fields, promotes the use of evidence-based practice (EBP).<sup>1</sup> In general, EBP is decision-making which includes the best available evidence from research combined with client characteristics, situations, and preferences.<sup>2</sup> Ideally, EBP uses shared decision-making, in which healthcare providers inform clients about available treatment options, including the graded strength and anticipated outcomes, from evidence-based guidelines. Clients then can use that information, along with important factors in their life, to make the best informed decision for treatment.<sup>3</sup>

In 2008, at the request of the U.S. Congress, the Institute of Medicine (IOM) established procedures for developing evidence-based guidelines to be used in practice.<sup>4</sup> These procedures are now widely used by many organizations, and are designed to assist practitioners with implementing high-quality recommendations. The development of evidence-based guidelines, which contain graded recommendations, reduced barriers many practitioners expressed regarding use of clinical research to assist with clinical decision-making.<sup>4</sup> These barriers include: practitioner access to

scientific literature; ability to critically evaluate the literature in terms of research quality; and time to review the scientific literature. Evidence-based guidelines developed using IOM procedures can be used by healthcare practitioners working in the area for which the guideline was developed to inform their practice. This includes guidelines developed by organizations from which the healthcare practitioner may not belong. Thus, the aim of this article is to describe the development and overview of the American Psychological Association Clinical Practice Guideline for the Treatment of Obesity and Overweight in Children and Adolescents.

### Developing the clinical practice guideline

In 2010, the American Psychological Association (APA) started development of clinical practice guidelines. As this process started, APA decided to follow the IOM process for developing guidelines published in 2011.<sup>4</sup> This process includes development of guideline panels which include professionals from multiple disciplines as well as community members with experience in the disorder or condition for which the guidelines will focus. For the guideline reviewed in this article, a

*(Continued on page 2)*

## IN THIS ISSUE

|  |    |
|--|----|
| <b>CPEU Article</b> .....  | 1  |
| Development and Overview of the American Psychological Association Clinical Practice Guideline for the Treatment of Obesity and Overweight In Children and Adolescents |    |
| <b>Member Services Update</b> .....  | 6  |
| <b>Research</b> .....  | 7  |
| Intermittent Fasting as a Tool for Weight Management   |    |
| <b>Bariatric Surgery</b> .....   | 9  |
| The Relationship Between Bariatric Surgery and Female Fertility  |    |
| <b>Pediatric Article</b>   |    |
| The Relationship between Traumatic Life Events and Pediatric Obesity.....  | 11 |
| <b>Student Article</b> .....   | 14 |
| The Inclusion of Mindfulness Training and Weight Loss and Management Programs  |    |
| <b>Obesity Action Center Message</b> .....   | 16 |
| <b>From the Editor</b> .....   | 17 |
| <b>From the Chair</b> .....  | 17 |

registered dietitian nutritionist was a member of the panel. The guideline panel developed recommendations based upon systematic reviews. The draft version of each guideline was made available for public comment for 60 days. The comments and the panel's responses to these comments were reviewed by APA prior to final approval, as occurs for all guidelines.

The process for guideline development the APA uses is slightly different from the process used for the Evidence Analysis Library (EAL). The EAL is a series of systematic reviews conducted by members of the Academy of Nutrition and Dietetics (the Academy) using a predefined approach. Following the systematic review, expert workgroup members grade the strength of the evidence to support conclusions which answer questions important to the Nutrition Care Process. As EAL panels only include Academy members, these panels are generally composed of individuals from the dietetics/nutrition profession and community members are not included. Review of each guideline occurs internally and externally, with external reviewers selected and representing an interdisciplinary group of individuals such as dietitians, doctors, psychologists, and nurses. The guideline is adjusted based upon these reviews.

At the time of the inception of the APA panel for the clinical practice guideline for the treatment of obesity, after a discussion of scoping in which key concepts and characteristics in the field were clarified and the existing guidelines in the area of obesity treatment were reviewed, the panel decided to focus on treatment of childhood and adolescent overweight and obesity  $\geq$  85th percentile body mass index [BMI].<sup>7</sup> This decision was primarily made because guidelines for the treatment of overweight and obesity in adults had been recently released and there was an identified gap in the area of childhood and adolescent obesity. The panel decided to focus on updating the widely recommended (e.g., U.S. Preventive Services Task Force, Academy of Nutrition and Dietetics, American Heart Association, National Institute for Health and Care Excellence) family-based multicomponent behavioral interventions for the treatment of child and adolescent overweight and obesity in individuals aged two to 18 years. However, the panel thought focusing

## Continuing Professional Education Section



**Shelly Summar, MSEd, RD, LD is the CPEU Section Editor**

This review examines: 1) the American Psychological Association's clinical practice guidelines for the treatment of obesity and overweight in children and adolescents; 2) evidence-based practice as it related to the treatment of overweight and obesity in children and adolescents; and 3) recommended interventions related to the treatment of obesity and overweight in children and adolescents.

on understanding mediators (processes that underlie the relationship between the intervention and the outcome) and moderators (factors that affect the strength of the intervention's ability to influence the outcome) of the intervention would be a helpful addition to guidelines. For outcomes, the panel decided to focus on body mass index (BMI), standardized BMI (zBMI), and serious adverse events (e.g., decreases in height velocity). For this guideline, family-based multicomponent behavioral interventions included behavioral interventions which involved caregivers and included three components: 1) a focus to increase in physical activity and/or decrease in sedentary behavior; 2) a focus on dietary change; and 3) a behavioral component to address 1 and/or 2. Any physical activity, sedentary behavior, or dietary change was included, thus the guideline was not focused on determining efficacy of any specific target/goal/strategy in these areas. The interventions could target caregivers alone or in combination with the child.

Delivery of the intervention needed to involve an interventionist, with the type of interventionist or the type of training for the interventionist not specifically defined to determine study eligibility, but the intervention could be delivered in various modes, such as individual, group, family, multidisciplinary teams, internet, telephone, mailings, social media.

### Development of key questions for the guideline

The guideline was developed from examination of investigations which showed two critical outcomes: a response to treatment as measured by BMI/zBMI at 12-month follow-up; and a response of  $\geq -0.25$  zBMI, as this is believed to improve cardiometabolic health in children.<sup>7</sup> Also, investigations were reviewed regarding how selected intervention characteristics and components, and child and family characteristics may influence outcomes to assist practitioners in understanding mediators and moderators of the intervention. The guideline was not designed to address other treatments for overweight or obesity, screening or assessment for overweight or obesity and related conditions, treatment follow-up, prevention of overweight or obesity, costs of treatments, pharmacological or surgical interventions, or availability of care.

The Key Questions for the guideline were:

1. In children and adolescents with overweight or obesity, do family-based multicomponent behavioral interventions reduce and maintain change in age/sex-standardized BMI?
2. What is the impact of selected characteristics of family-based multicomponent

*(Continued on page 3)*

behavioral interventions (dosage of contact, setting, interventionist qualifications, mode of delivery, use of multidisciplinary team, involvement of psychologist, cultural tailoring) in the management of age/sex-standardized BMI?

- A. Are these characteristics associated with the efficacy of the interventions?
  - B. What is the comparative effectiveness of these characteristics?
3. How do selected patient and family sociodemographic characteristics (child's age, severity of adiposity, parental obesity, race, socioeconomic status) affect family-based multicomponent behavioral interventions? Specifically, are different strategies used or needed for families with different sociodemographic characteristics?
  4. What is the impact of selected strategies of family-based behavioral interventions (goals and planning, comparison of outcomes, self-monitoring of behavior, self-monitoring of outcome, reward and threat, stimulus control, modeling of healthy lifestyle behaviors by parents, motivational interviewing, general parenting skills [e.g., positive parenting] or family conflict management) in the management of age/sex-standardized BMI?
    - A. Are these strategies associated with the efficacy of the interventions?
    - B. What is the comparative effectiveness of these strategies?
  5. What is the effect of patient adherence (e.g., percentage of homework completed, percentage of sessions attended), engagement, and retention on BMI outcomes?
    - A. What interventions or intervention characteristics and strategies are associated with these factors?
    - B. What levels of patient adherence, engagement, and retention are associated with improved efficacy of the interventions?

### Overview of the guideline

A summary of the recommendations is shown in Table 1, pg 4. Only one recommendation, based upon key question 1, "In children and adolescents with overweight or obesity, do family-based multicomponent behavioral interventions reduce and maintain change in age/sex-standardized BMI?" received a strong



rating from the panel's review of the literature, with all other recommendations receiving an insufficient rating. The recommendation with a strong rating indicates a family-based multicomponent intervention at a sufficient intensity of at least 26 hours is efficacious for reducing zBMI in children and adolescents, but this recommendation does not have specific guidelines regarding the dietary or physical activity intervention. To support this recommendation, from the review of articles which met inclusionary criteria, 12 efficacy trials with 26 or more contact hours showed an average reduction of -0.27 zBMI (95% CI: -0.38 to -0.16) relative to nonactive controls, while 13 efficacy trials with less than 26 contact hours showed an average reduction in zBMI of -0.04 (95% CI: -0.10 to 0.01). This recommendation closely matches that of the 2017 U.S. Preventive Services Task Force.<sup>8</sup> It is important to note no medical harms for the recommended treatment were reported in any study.

The recommended intervention has several key features.<sup>7</sup> The first is that the treatment focuses on development of healthy energy balance behaviors within the family. Also, the intervention is not just for the child or adolescent but for parents and potentially other family members as active participants. Both parents and children are making changes in physical activity, sedentary behavior, and/or eating. The level of parental involvement varies according to the developmental needs of the child. These interventions emphasize providing caregivers with tools, such as problem solving and providing contingent rewards which can be used to manage energy-balance behaviors, with these tools having relevance to many other childhood issues. This family-based approach supports modeling, consistent changes in the home environment, and the development of social support.

The evidence also suggested the recommended intervention may be more efficacious for younger children.<sup>7</sup> Out of 25 trials, there was

a significant association ( $p = .03$ ) between age and whether the trial met the clinically significant reduction in zBMI. In the 14 trials which showed a clinically significant reduction in zBMI, 10 (71%) targeted preschool- or elementary school-aged children and all trials focused on preschool-aged children showed a benefit. This finding is why treatment is recommended to start at the earliest age possible. Furthermore, there was no evidence other selected characteristics of the recommended treatment, such as setting, interventionist qualifications, mode of delivery, use of multidisciplinary team, or cultural tailoring had independent effects on zBMI.<sup>7</sup>

### Areas of insufficient evidence

The first question with insufficient evidence focused on potential moderators of the intervention such as severity of adiposity, parental obesity, race or ethnicity, and socioeconomic status.<sup>7</sup> Out of 36 trials, the following characteristics showed non-significant effects on zBMI in meta-regression: if a child had overweight vs. obesity; if one parent had overweight or obesity; or if the child was black or Hispanic. Evidence was insufficient to evaluate socioeconomic status as only two trials were identified in the review. This outcome indicated there was not enough evidence to recommend tailoring treatment on these individual characteristics.

There was also insufficient evidence to determine the comparative effectiveness of differing behavioral strategies, such as goals and planning, comparison of outcomes, self-monitoring of behavior, self-monitoring of outcome, contingent reward or threat, stimulus control, modeling of healthy lifestyle behaviors by parents, motivational interviewing, or parenting skills training of family-based multicomponent behavioral interventions.<sup>7</sup> This means the strategies with the biggest impact on outcomes could not be identified. For many of the efficacy trials, these strategies were delivered as a treatment package thus the effectiveness of any one

*(Continued on page 4)*

Table 1.

| Key Question                              | Summary  | Strength of Recommendation |
|---|--|----------------------------|
| Family-Based Multicomponent Interventions |  |                            |
| 1   | <p>For child and adolescent patients aged 2-18 with overweight or obesity, the panel strongly recommends that clinicians provide:</p> <ul style="list-style-type: none"> <li>• Family-based multicomponent behavioral interventions with <b>at least 26 contact hours</b> initiated at the earliest age possible.</li> </ul>   | Strong                     |
| Comparative Effectiveness of Components   |  |                            |
| 4   | <p>For child and adolescent patients with overweight or obesity, the panel concludes that there is insufficient evidence to recommend for or against clinicians offering any selected strategies of family-based multicomponent behavioral interventions over another, including:</p> <ul style="list-style-type: none"> <li>• Goals and planning</li> <li>• Comparison of outcomes</li> <li>• Self-monitoring of behavior</li> <li>• Self-monitoring of outcome</li> <li>• Contingent reward or threat</li> <li>• Stimulus control</li> <li>• Modeling of healthy lifestyle behaviors by parents</li> </ul> | Insufficient               |
| 2, 5                                      | <p>For child and adolescent patients with overweight or obesity, the panel concludes that there is insufficient evidence to determine if specific intervention characteristics or strategies are associated with adherence, engagement, or retention, or if adherence was associated with efficacy.</p>  | Insufficient               |
| 3   | <p>For child and adolescent patients with overweight or obesity, the panel concludes that there is insufficient evidence to determine whether specific intervention strategies were needed with patients or families having specific characteristics.</p>  | Insufficient               |
| 3   | <p>For child and adolescent patients with overweight or obesity, the panel concludes that there is either no association or insufficient evidence to determine whether other population characteristics other than age were associated with outcome.</p>   | Insufficient               |

(Continued on page 5)



component was difficult to ascertain. Therefore, the recommendation stated practitioners have flexibility in selecting what behavioral components to include in the intervention.

Finally, there was also insufficient evidence to determine if specific intervention characteristics or strategies were related to patient adherence to the intervention (other than attendance), engagement, or retention.<sup>7</sup> Part of the challenge in answering this question was adherence was not consistently defined or reported in studies thus making comparisons difficult.

### Needed areas of research

The inability to develop several recommendations indicates the need for more research in the area of childhood and adolescent obesity treatment. One research area identified is the need to ascertain the amount of reduction in adiposity (zBMI, BMI, percent overweight) needed to improve cardiometabolic health in children and adolescents.<sup>7</sup> Without knowing what degree of reduction in adiposity is needed to improve health in children and adolescents, evaluating the clinical effectiveness of a program becomes challenging. In adults, a reduction of 3-5% of body weight produces a reduction in triglycerides, blood glucose, and hemoglobin A1c with greater amounts of weight loss producing greater benefits particularly in regard to blood lipids (decreases in low-density lipoprotein cholesterol and increases in high-density lipoprotein cholesterol).<sup>9</sup> Thus, identifying this criterion for children and adolescents is important. Lack of detail in the methodology and/or results in many of the included investigations prevented

the ability to code the behavioral components of the intervention and determine adherence and engagement in these components.<sup>7</sup> Therefore, to understand the effect of these aspects of the intervention on outcomes, more detail in these areas needs to be included in published research. For example, articles should describe how behavioral components were implemented, such as when and to whom the behavioral component was introduced, length of implementation of the behavioral component during intervention, and participant adherence to the behavioral component should be reported, such as percent of time the participant reported using the behavioral component. Detail was also lacking in the samples regarding race, ethnicity, and socioeconomic status thus conclusions could also not be drawn regarding the moderating effect of these variables.

While not a focus the guideline did note that multicomponent interventions may have other benefits such as improvements in diet quality, physical activity, and psychosocial outcomes which were not part of the guideline review.<sup>7</sup> Therefore, it was recommended these benefits should be reported and systematically evaluated by researchers. Again while not a focus, it was stated the durability of outcomes over longer time periods (at 2 years or 5 years) from the multicomponent intervention needs to be examined.<sup>7</sup>

### Conclusion

The American Psychological Association Clinical Practice Guideline for the Treatment of Obesity and Overweight in Children and Adolescents provides a strong rating for the following recommendation: "For child and adolescent patients aged 2-18 with overweight or obesity, the panel strongly recommends the provision of family-based multicomponent behavioral interventions, with a minimum of 26 contact hours, initiated at the earliest age possible."<sup>7</sup> The clinical practice guideline is not intended to be interpreted as a standard of care but a general guide for best practices which can assist with shared decision-making between providers and families.

**Hollie Raynor, PhD, RD, LDN**, is a Professor in the Department of Nutrition and the Interim Assistant Dean of Research in the College of Education, Health, and Human Sciences at the University of Tennessee. She holds a MS in Public Health Nutrition and a PhD in Clinical Psychology. She is a registered dietitian and a licensed psychologist. She conducts research in lifestyle interventions for pediatric and adult weight management, has published over 125 peer-reviewed articles, and has received funding from the National Institutes of Health, American Diabetes Association, Academy of Nutrition and Dietetics Foundation, and WW International Inc. (formerly known as Weight Watchers International Inc.), for her research. She served as a member of the National Committee for Clinical Guidelines for Obesity for the American Psychological Association and as a member of the Prediabetes Evidence Analysis Library Committee for the Academy of Nutrition and Dietetics. Her research interests are on identifying best methods to implement dietary factors that enhance satiation (i.e., limiting variety, reducing energy density, shifting distribution of energy intake earlier in the day), and translating lifestyle intervention into practice-based settings (i.e., primary care).

### CPEU Process

Log in to [www.wmdpg.org](http://www.wmdpg.org) and then link to the CPEU quiz [here](#).

Take the quiz. Quiz results are reviewed at the end of each month. If you score

80% or higher, your CPEU documentation will be emailed to you.

(Continued on page 6)

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# Member Services Update

Mary Gray Hutchinson, MPH, RD, LDN



## Greetings from Member Services!

As I write this, we are preparing for an amazing spring but coping with a national pandemic. We never imagined we would

be quarantined, as a nation, due to Covid-19. I think at this point, we are all just dreaming of the day this passes and we can enjoy warmer weather and beautiful spring blooms.

## Survey

Our survey team has been working hard on analyzing your responses from the member survey. This survey went out in early March. Thank you to all who participated. With your input, we strive to make the Weight Management DPG increasingly valuable to wwmembers.

## Member Highlights

We would like to highlight some of our talented and inspiring members throughout

different platforms, including this newsletter. You all do wonderful work each day to improve the health of your clients and patients so don't be shy about nominating yourself. If you would like to highlight yourself or another Weight Management DPG member, please contact me at [mghutchison@gmail.com](mailto:mghutchison@gmail.com).

## Membership Renewal

It's that time of the year again to renew your Weight Management DPG membership. Thanks to your membership, we have been able to offer high quality resources, including FREE webinars, newsletters and teleforums on a variety of different topics in weight management, for which members have expressed interest. Please be aware most of these resources are recorded and available on our website to members, so you can access them at a time convenient to you. We would love to serve you for another year, so please don't forget to check the "Weight Management DPG" box when you renew your Academy membership and DPGs.

Also, don't forget to spread the news about all of the Weight Management DPG resources to your weight management colleagues. We now have a Member Referral program.

Talk to them and encourage them to join. You can submit your info and the name of the person you referred on the Weight Management DPG website ([wmdp.org](http://wmdp.org)). Quarterly, we'll do a random drawing and select one referrer and one new member to receive a \$25 gift card! It's super easy, and who couldn't use an Amazon gift card?! Encourage your peers and colleagues to be a WM member!

I look forward to another productive year as your Member Services Director. If you ever have any questions about your membership, please feel free to reach out to me by email at [mghutchison@gmail.com](mailto:mghutchison@gmail.com). I'll conclude by reminding you to please renew your Weight Management DPG membership by May 31st, and to share this valuable resource with your friends and colleagues by encouraging them to join as well!

# Intermittent Fasting as a Tool for Weight Management

By: Michael Fornaris, RD, CDE and Sarah T. Henes, PhD, RDN, LD



Michael Fornaris,  
RD, CDE

Conventional approaches to weight management involve some form of continuous calorie restriction (CCR) such as reducing daily energy intake by 500 to 750 kcals per day.<sup>1,2</sup> In contrast to this, intermittent fasting (IF) is adopted by those looking for an alternate dieting approach. Intermittent fasting is a general term which describes voluntary periods of fasting interlaid with normal eating. Various forms of fasts for religious or cultural reasons have been adopted throughout human history.<sup>3</sup> However, IF as a tool for weight management is growing in popularity. In fact, according to data by the International Food Information Council, intermittent fasting was the second most popular diet in 2019.<sup>4</sup> The most recent data from the Centers for Disease Control and Prevention (CDC) indicate nearly 40% of adults have obesity, thus highlighting the need for registered dietitian nutritionists (RDNs) to consider new evidenced-informed approaches to weight management.<sup>5</sup> This article reviews the current literature which discusses IF and how RDNs might use this evidence in a client's weight management program.

## Types of Intermittent Fasting (IF)

There is not a single "intermittent fasting diet", rather, there are several types of eating patterns described as intermittent fasting.<sup>3,6</sup> More common IF eating patterns include the 5:2 method, Alternate Day Fasting (ADF), and time-restricted feeding (Table 1).

Different combinations of IF also exist and range from eating nothing on fasting days to choosing shorter time-restricted feeding windows.

Table 1. Common types of Intermittent Fasting

| Method                      |  |
|-----------------------------|--|
| 5:2 modified fasting        | Restrict energy by 75% of needs or about 500-600 calories on two, non-consecutive days per week. Eat normally on non-fasting days. |
| Alternate Day Fasting (ADF) | Restrict energy by 75-100% of needs or about 0-600 calories every other day. Eat normally on non-fasting days.                     |
| Time-restricted feeding     | Restrict eating to a specified time window, usually 6-8 hours. Eat normally within this window.                                    |

## Research

Sarah Henes, PhD, RD, LD



Intermittent Fasting is currently a popular eating pattern used for weight loss. There is no single Intermittent Fasting "diet", rather there are several approaches which may include time restricted feedings or going a full day without eating. This article reviews the current body of research and the evidence for Intermittent Fasting as an approach for weight management.

## The Latest Research on IF

The scientific literature on IF is still new, and several recent studies and reviews have shed light on the safety and efficacy of IF. The most recent systematic review searched IF studies conducted between 2000 and 2019.<sup>6</sup> Eighteen randomized control trials and nine trials with no control group were identified and included in the review. Weight loss was achieved with IF in most trials less than 12 weeks in duration and with fewer than 60 participants.<sup>6</sup> A variety of fasting protocols were used with the most common being a form of the Alternate Day Fasting. Twelve of the trials reviewed used CCR as a comparison group with IF and all demonstrated similar weight loss results. The longest randomized trial to compare IF with CCR was published by Headland and associates in 2019 which demonstrated similar weight loss results after one year ( $-6.6 \pm 6.1$  kg,  $n = 53$  for CCR and  $-5.0 \pm 4.9$  kg,  $n = 49$ ,  $p=0.2$ ).<sup>7</sup> An interesting observation in this study is the drop-out rate was higher in the IF group at 58% vs. the CCR group at 49%. This was not considered a significant difference. Another randomized control trial (the HELENA trial) of shorter duration

conducted by Schubel and colleagues found both the IF and the CCR group achieved similar results in weight loss, body composition, and several metabolic biomarkers including serum lipids, insulin concentration, HOMA-IR (Homeostatic Model Assessment of Insulin Resistance) levels, and adipokines after 12 weeks, and similar weight loss maintenance results after 26 weeks.<sup>8</sup>

More research is needed to fully understand the efficacy and long-term effects of IF.<sup>3,6</sup> Many studies are of limited sample size and duration. The research so far seems to highlight intermittent fasting is at least as effective as conventional weight-loss interventions in timeframes generally ranging from a few months to one year.

## How does IF work?

There are several proposed mechanisms underlying the beneficial effects of IF. From a weight-loss perspective, IF provides a framework for a consistent calorie deficit.<sup>3</sup> Although it may be argued fasting can lead to an overconsumption of calories during non-fasting periods, the evidence generally suggests this does not occur.<sup>3</sup> Other mechanisms such as the influence of the circadian rhythm and gut microbiome are also thought to play a role in metabolic health.<sup>3,9</sup> Humans are known to have an internal biological clock regulated in the hypothalamus which works to coordinate body processes such as feeding signals, sleep, metabolism, and hormone secretion.<sup>3,9</sup> This natural circadian rhythm is synced to day and

(Continued on page 8)

night cycles to optimize metabolic pathways. Behaviors misaligned with the circadian rhythm, such as eating late at night, are thought to contribute to metabolic issues such as impaired glucose tolerance.<sup>3,9,10</sup> Although much of this research used animal models, research in shift workers consistently demonstrates an increased risk of cardiometabolic disease.<sup>3,9,10</sup> In addition, since the gastrointestinal tract is closely linked to circadian rhythm, some evidence suggests IF can favorably impact the gut microbiome which can improve metabolic health. Data on how IF may affect energy expenditure are not yet clear in humans.<sup>3</sup>

### Considerations for certain populations

To date, IF is found to be generally safe for adults.<sup>3,6</sup> However, caution should be used for certain medical conditions especially in diabetes. Limited evidence suggests IF can help persons with type 2 diabetes achieve significant weight loss and manage blood glucose.<sup>11</sup> However, caution should be exercised in those at risk for hypoglycemia, especially if taking insulin or sulfonylureas.<sup>11,12</sup> In a 2018 randomized control trial, Corley and associates found the rate of hypoglycemia increased after participants with diabetes underwent an IF intervention.<sup>12</sup> This study also found education and adjusting hypoglycemic medications such as sulfonylureas and metformin can decrease hypoglycemic events. While Grajower and associates conclude in their 2019 review that with proper medical guidance IF may be a safe approach for weight loss in some patients with diabetes, others still recommend patients with diabetes avoid IF eating patterns until there is more conclusive long-term research in this population.<sup>13,14</sup>

IF may not be suitable for those who require small, frequent feedings as part of their nutrition therapy.<sup>15</sup> This may also include those who have undergone bariatric surgery.<sup>15</sup> Other studies suggest participants who underwent complete alternate day fasting (no energy intake on fasting days) experience intense feelings of hunger.<sup>3</sup> This suggests more extreme versions of IF may be more difficult to follow.<sup>3</sup> Finally, IF would not be recommended for those with eating disorders as the focus on restriction may exacerbate disordered eating behaviors.<sup>14</sup>

### Conclusion

Complex physiological, behavioral, and environmental factors make losing weight and weight management difficult.<sup>16</sup> Thus, it is important for RDNs to continually stay abreast of new

research related to effective weight management approaches. Currently available data from research using humans suggest IF appears comparable to CCR in weight loss outcomes. However, IF appears to have its own set of adherence challenges.<sup>2-3,6</sup> More research and longer studies in humans are needed to fully understand how IF compares to conventional approaches in the long term.<sup>2-3,6,17</sup> Also, due to the variability in IF protocols not much is known about its sustainability and long-term health effects.<sup>3,6</sup> Much of the current literature seems to indicate IF is a safe method of weight loss for most adults, and more research is needed in special populations such as in geriatrics and those with chronic diseases such as COPD, kidney failure, or heart disease. There are populations for which IF is not recommended such as pregnant or breastfeeding women, adolescents, patients with eating disorders, and person who require food with medications.<sup>14</sup> It is important for RDNs to individualize care as it is known any eating plan which consistently creates a caloric deficit will result in weight loss. IF may offer another tool in the toolbox.

*Michael Fornaris, RD, CDE is currently working as a clinical dietitian at the Hines VA Hospital in the Chicagoland area. In this role, Michael works closely with military veterans to help them meet their weight management, diabetes, and wellness goals. Michael also precepts dietetic interns, works on department process improvement projects, and occasionally covers the nutrition care for the inpatient areas of the hospital.*

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# The Relationship Between Bariatric Surgery and Female Fertility

By: Victoria R. Delgado RDN, CSOWM, LD



The American College of Obstetricians and Gynecologists (ACOG) defines infertility as the failure to become pregnant after 12 months in women less than 35 years

old and after six months in women 35 years of age or older. The ACOG reports up to 15% of couples experience infertility.<sup>1</sup> Weight, whether underweight or overweight, can impact a woman's fertility. Women with obesity attempting to get pregnant experience a two-fold longer time to pregnancy compared to women of a normal weight, and women who are underweight experience a four-fold longer time to pregnancy.<sup>2</sup> Data from the 2015-2016 National Health and Nutrition Examination Survey reports the prevalence of obesity to be 39.8% among American adults and 36.5% among women of childbearing age (aged 20-39).<sup>3</sup> While bariatric surgery rates are increasing, only 1% of eligible Americans have bariatric surgery.<sup>4</sup> This article will examine infertility, causes, and relationship with bariatric surgery.

## Causes of Infertility

There are several suspected causes of infertility in women with obesity. Research suggests women with obesity have a delay in pregnancy compared to women of normal weight when all women had normal menstruation and similar intercourse frequency.<sup>2</sup> This is thought to be related to the quality of the oocyte (immature egg cell). Oocytes in women with BMI >25 have been shown to be smaller and less likely to complete development after fertilization.<sup>5</sup> Polycystic Ovarian Syndrome (PCOS) and insulin resistance are other suspected causes of infertility in women with obesity.<sup>1</sup> PCOS is diagnosed using the Rotterdam criteria when two of three criteria are met: hyperandrogenism; irregular menstruation; or polycystic ovaries.<sup>6</sup> PCOS affects 5-10% of women of childbearing age.<sup>6</sup> An estimated 30% of women with obesity also have PCOS.<sup>6</sup> Irregular menstruation is a primary cause of infertility in women with PCOS and obesity is known to exacerbate these symptoms.<sup>2</sup> Insulin resistance also impacts fertility. Obesity and PCOS have been shown to

## Bariatric Surgery

Annette Langan, MS, RD, CSOWM, LDN

Many women of childbearing age have obesity, which can affect fertility and the ability to carry out a healthy pregnancy. Here, Victoria R. Delgado RDN, CSOWM, LD explains the ways in which bariatric surgery appears to reduce infertility rates in women with obesity. Though there are some special considerations to keep in mind, bariatric surgery is a viable option for RDNs to educate patients with obesity about if the patient is hoping to become pregnant.



independently contribute to insulin resistance. High levels of insulin can increase production of androgen hormones and cause no egg to be released during a menstrual cycle which contributes to infertility.<sup>6</sup>

## Lifestyle Modifications & Infertility

Lifestyle changes and a 5% weight loss have been shown to have significant improvements in symptoms of PCOS.<sup>6</sup> Increased physical activity independent of weight loss may also improve fertility.<sup>7</sup> Studies have also examined the relationship between dietary intake and fertility. These studies observed diets lower in saturated fats and the Mediterranean-style eating pattern lowered instances of infertility.<sup>7</sup> With this said, the opinion developed by the ACOG Committee on Gynecologic Practice and American Society of Reproductive Medicine recommends patients attempt to attain a normal body mass index (BMI 18-25) before conceiving due to the association of high BMI with infertility, and maternal and fetal pregnancy complications.<sup>8</sup> However, for an individual with obesity, achieving a normal BMI can be very challenging.

## Bariatric Surgery & Infertility

Individuals with obesity may seek to lower BMI by non-surgical treatment or surgical modalities. Non-surgical weight management treatment has been shown to decrease weight by 5-10% and improve associated co-morbidities.

Surgical management of obesity with bariatric surgery has been shown to produce higher amounts of weight loss than non-surgical treatment.<sup>4</sup> According to the American Society of Metabolic and Bariatric Surgery between 2015-2018 more than 76% of bariatric surgeries performed were the sleeve gastrectomy (VSG) or Roux-en-Y gastric bypass (RYGB).<sup>9</sup> On average, the sleeve gastrectomy produces about 50% excess weight loss while the RYGB produces 60-80% excess weight loss.<sup>10</sup> Excess weight is defined by subtracting an individual's weight before surgery by the weight at a BMI of 25. Percent excess weight loss is then defined as the amount of weight loss divided by the excess weight multiplied by one hundred. Literature on the impact of bariatric surgery on fertility is limited, however available research indicates positive impact. One systematic review and meta-analysis concluded the incidence of PCOS drops from 45.6% to 6.8% following bariatric surgery and infertility rates decrease from 18.2% to 4.3%.<sup>2</sup>

## The Role of RDNs Relating to Infertility and Bariatric Surgery

Based on the findings reported in this brief article, it can be assumed the bariatric registered dietitian nutritionist (RDN) may often encounter women of childbearing age pursuing bariatric surgery for weight loss as a means to improve fertility. It is vital bariatric

(Continued on page 10)

RDNs work closely with medical bariatricians, bariatric surgeons, or other physicians involved in the patient care to ensure patients are receiving consistent, evidence-informed advice on pursuing pregnancy following bariatric surgery. The ACCE/TOS/ASMBS Guidelines recommend avoiding pregnancy for 12-18 months following bariatric surgery or until the rapid weight loss phase has ended and weight has plateaued or remained stable for several months.<sup>4</sup> The ACOG Committee Opinion notes pregnancy during the rapid weight loss phase can impact fetal growth.<sup>8</sup> Bariatric surgery candidates of childbearing age should be counseled on the appropriate form of contraception both before and following bariatric surgery.<sup>4</sup> Individuals who desire to become pregnant following bariatric surgery should discuss timing with their bariatric physician and obstetrician. While post-bariatric surgery patients can achieve pregnancy, these pregnancies may come with a higher risk of complications and lower fetal birth weight.<sup>11</sup> Dorothy McFadden wrote Nutritional Needs in Pregnancy after Weight Loss Surgery in the Winter 2019 *Weight Management Matters* Newsletter. This article summarizes nutrition care in pregnant post-bariatric surgery women and how the RDN can assist patients in meeting their increased nutritional needs.<sup>11</sup>

**Victoria R. Delgado RDN, CSOWM, LD** is passionate about the field of bariatric surgery and weight management and has been working as a bariatric dietitian for over 8 years. She attained the Certified Specialist in Obesity and Weight Management credential in 2018. Victoria received her Bachelors in Science from University of Georgia and has been a RDN in Atlanta, GA for the past 10 years, working the most recent 6 years with Emory Healthcare.

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# The Relationship between Traumatic Life Events and Pediatric Obesity: Enhancing Trauma Informed Care

By: Brenda Manzanarez, MS, RD, Mari Radzikk, PhD, Brittany Kabakoff, LCSW



Brenda Manzanarez MS, RD



Mari Radzikk, PhD



Brittany Kabakoff LCSW

In understanding the patient's role in health and wellness care, it is imperative to understand key life events, especially traumatic life events, to successfully address weight issues in children and youth with obesity. Complex interactions between biological, genetic, social, and environmental factors are known to play a role in weight management with the prevalence of obesity in children and adolescents at 18.5%.<sup>1</sup> This article will review the relationship between pediatric obesity and childhood trauma and offer interventions clinicians may want to consider in enhancing assessments and help guide the course of care.

## Overview of Trauma

It has become abundantly clear traumatic life events color the lens through which one sees the world and this is observed in the way patients manage their health. Adverse Childhood Experiences (ACEs) describe major childhood life events which are negative in nature including abuse, neglect and household challenges (e.g., violence, mental health, substance misuse).<sup>2-4</sup> Merrick reported 62% of adults have experienced one ACE during childhood and nearly one-quarter experienced three or more ACEs. More types of ACEs experienced in childhood are found to have incremental lasting lifetime effects in mental (e.g., mental illness, victim of violence, social issues) and physical health (e.g., heart disease, diabetes, obesity), because the vulnerabilities the child experiences are often manifested in poor coping and higher risk-taking in adulthood.<sup>5</sup> In other words, ACEs affect the protective factors which help a child navigate childhood and build resiliency to manage the travails of adulthood in a more positive fashion.

## Pediatric Article

### Katie Arlinghaus

A substantial body of research indicates a negative association between adverse childhood events and an individual's health and wellbeing. In this edition, we provide an overview of how adverse childhood events may interfere with pediatric weight management and discuss strategies for dietitians to provide effective care to individuals with traumatic histories.



### Early Effects

The childhood and adolescent years are a period of growth and development which help shape healthy coping, problem solving, relationship building, and health.<sup>6</sup> A growing body of literature has found chronic toxic stress and traumas during childhood can alter the brain and have detrimental effects to the nervous, endocrine, and immune systems, and even DNA.<sup>7,8</sup> Disruption from high levels of stress to the developing brain areas (hippocampus, prefrontal cortex, and amygdala) responsible for decision-making, impulse behaviors, emotions and memories may lead to increased risk for learning disabilities, self-regulation, anxiety, hyperactivity, and cognitive impairments.<sup>9</sup> The constant "on" activation results in weight-related issues such as increased body mass index, increased visceral fat mass, changes to eating behaviors, inflammation, and higher release of stress response cortisol hormone levels.<sup>8-12</sup>

### Relationship with Food

Food has different meanings to people based on cultural traditions, preferences, accessibility, and past experiences with food. Negative social and familial stressors are associated with unhealthy eating patterns including eating stimulation, reduced food intake, binge-purge and addictive behaviors.<sup>13-17</sup> These behaviors are thought to be coping mechanisms for feelings of anxiety, sadness, guilt, and anger.<sup>18</sup> Unfortunately foods eaten are most often

energy dense and lack nutrition which may additionally make a person go through a cycle of feeling ashamed, guilty, and frustrated with themselves.<sup>19</sup>

### Social & Environmental Impact

Lack of personal safety and difficulty navigating systems for needed services are areas which may indirectly impact children with obesity in trying to mitigate negative experiences. Overweight youth experience higher rates of bullying from their peers, siblings, and even parents and extended family members.<sup>10</sup> Some families decide to home-school their children to avoid further trauma.<sup>20</sup> Albeit, the shift of routine from a structured school-schedule to one with minimal structure disrupts eating and sleeping patterns. One case example is a 12-year old female with severe obesity and history of suicide attempts attributed to bullying at school and social anxiety confides she often eats alone in her room when feeling down. Another is a 16-year-old female living in a foster care setting attributing her obesity to "stress eating" to deal with difficult emotions (like anger or guilt) due to familial and social stressors. In both cases, a mental health provider would be appropriate to work along with the RDN to best guide the patient on behaviors and cognitive restructuring so food doesn't continue to be the coping mechanism.

(Continued on page 12)

## The Medical Provider Role and the Patient Role

If providers are not aware of patients' adverse events or understand their impact, then effective weight management may be further hindered by the patient or parent's social-emotional reactions to the interventions laid out. The Location of Self is a process that has been used as a model by psychotherapists to: 1) bring awareness of differences and similarities between the patient and clinician which can hinder or aid in counseling; and, 2) acknowledge there are areas which might make people feel nervous (e.g. race, class, religion, sexual orientation, and roles associated power and vulnerability).<sup>21</sup> Identifying these may help providers understand their role, unconscious biases, and how personal experiences may not always align with patients' lives and past and current situations, and avoid giving unrealistic recommendations. Topics RDNs should consider in their assessment include current or history of maltreatment, victimization such as bullying or ostracization, food and financial insecurity, family conflicts, social support, and friendships. For a full list of items to assess, see the Family Health History and Health Appraisal Questionnaires at the end of this article.

## Using Motivational Interviewing as a Tool

Patient and family ambivalence to change through provider interventions is one reason why people leave counseling. It is important to try to determine the patient's desire for change as motivation is an important tool when working on any health behavior change and ability to follow up with recommendations.<sup>22,23</sup> Children who have experienced trauma may not be aware of personal dietary behaviors, thoughts, and emotions linked to their trauma so identifying the need for change is not always overt and will take time to connect. Motivational Interviewing (MI) takes into consideration the impact of life experiences like trauma and helps the provider tailor the intervention at a more manageable and effective pace.<sup>24</sup> MI focuses on building rapport with the individual and eliciting motivation for behavioral change rather than solely identifying areas for dietary interventions.<sup>25,26</sup> MI meets the patient and family "where they are at" in terms of wanting to make a change. By understanding individual goals and desires, change is more likely to be client-centered and followed up.

## Working within a Team Approach

Without a doubt, pediatric patients with a history of obesity and trauma require a team approach to help patients and families understand their condition and course of medical care.<sup>16,27</sup> Consulting and co-managing a patient's care with other mental health professionals can enrich the follow-up to dietary recommendations provided by the RDN. If the patient hasn't received services related to trauma, a social worker can aid in making referrals to appropriate agencies and follow-up with families to assure they are successfully navigating the often confusing medical and health insurance world. Through ongoing therapy a psychologist may offer the patient ways to navigate food thoughts, emotions, and dietary behaviors which affect health goals, while the RDN can jointly provide tangible dietary approaches.

## Summary

Knowledge of past or present trauma aids the clinician in considering how a patient's weight or trajectory is related to certain coping behaviors and in identifying areas of needed support.<sup>28</sup> The RDN can support the patient in creating positive food relationships by developing an awareness of the patient's trauma history and utilizing a team approach to mediate stressors which may include obesity-related co-morbidities and trauma-related mental health concerns. Awareness and patience with thoughtful dietary interventions, solid rapport with the patient, and mindful awareness of one's own reactions can benefit in the long-term in the successful achievement of the patient's treatment goals.

### Helpful tools

Centers for Disease Control and Prevention – Adverse Childhood Experiences (ACEs)

<https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/index.html>

Family Health History and Health Appraisal Questionnaires

<https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/about.html>

**Brenda Manzanarez, MS, RD** is a clinical dietitian who specializes in pediatric nutrition at Children's Hospital Los Angeles in the Division of Clinical Nutrition and Lactation Services. For the past 10 years, she has led community family-centered programs, research and program development for children, adolescents, and young adults. [bmanzanarez@chla.usc.edu](mailto:bmanzanarez@chla.usc.edu)

**Mari Radzik, PhD**, clinical psychologist and Assistant Professor of Clinical Pediatrics at Keck School of Medicine of USC in the Division of Adolescent and Young Adults at Children's Hospital Los Angeles. She specializes in adolescent and young adult mental health. [mradzik@chla.usc.edu](mailto:mradzik@chla.usc.edu)

**Brittany Kabakoff, MSW, LCSW** is a clinical social worker who provides assessment, support and resources for patients and families at the Center for Endocrinology, Diabetes and Metabolism at Children's Hospital Los Angeles. [bkabakoff@chla.usc.edu](mailto:bkabakoff@chla.usc.edu)

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(Continued on page 13)

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# The Inclusion of Mindfulness Training in Weight Loss and Management Programs

By: Sara Alamdari and Dr. Cary Kreutzer, EdM, MPH, RDN, FAND

## Introduction



Sara Alamdari

Effective weight management programs are critically needed as more than two-thirds of American adults over the age 20 are considered to be overweight or obese.<sup>1</sup> Obesity is one of the leading causes of death worldwide and associated with an increased risk for several chronic diseases, including heart disease, type 2 diabetes, cancer, and metabolic syndrome.<sup>1,2</sup> Standard weight loss recommendations include a combination of

reduced caloric intake, increased physical activity, and modified behavior.<sup>2</sup> Mindful eating is a form of behavior modification that could have a significant impact on weight management, as it reduces emotional eating and promotes the awareness of internal, rather than external, cues to eat.<sup>3</sup>

Mindfulness focuses on the present moment. It directs attention to current experiences to increase self-control and prevent mind-wandering.<sup>4</sup> Mindful eating results in a positive shift in food habits, controlled portion sizes, and prevents weight gain by increasing awareness of physical hunger and stomach fullness, and appropriately responding to those cues.<sup>3</sup> Promoting mindfulness could potentially resolve problematic eating behaviors and assist with managing and controlling food intake.<sup>3</sup> This paper will review the effectiveness of mindfulness-based interventions among overweight and obese adults in weight management programs and aims to inform Registered Dietitian Nutritionists how to apply mindfulness in practice.

## Mindfulness and Weight Loss

While weight loss can reduce the risk for chronic diseases related to obesity, sustaining weight loss is challenging, especially in individuals for whom overeating is a way to

## Student Article

Mary Gray Hutchison MPH, RD, LDN

Thank you Sara for your desire to contribute to the WM DPG newsletter by writing an informative student article about the impact of Mindfulness Training with Weight loss and management programs. We know this is an important topic for RDs to be knowledgeable about since we can help promote mindfulness in our practices.



cope with psychological stress.<sup>5</sup> However, managing stress with meditation and mindfulness techniques can be effective in reducing stress-induced binge eating.<sup>5</sup> To determine whether managing stress and incorporating mindfulness improves weight loss, 194 adults with obesity were randomized to a 5.5-month program with or without mindfulness training and identical diet and exercise guidelines.<sup>5</sup> The intervention included mindfulness training for stress management, exercise, and eating. The goal of the mindfulness-based intervention was to enhance awareness and promote self-regulation of emotions, food cravings, taste satisfaction, physical hunger, and stomach fullness.<sup>5</sup> Participants were encouraged to continue mindful eating at home with meditations for a minimum of 30-minutes a day, 6-days a week to reduce stress.<sup>5</sup>

The overall effect of adding mindfulness components to promote weight loss was not significant, however, evidence supports the mindfulness intervention could promote long-term maintenance of fasting glucose and lipid levels.<sup>5</sup> Most behavioral interventions have maximal weight loss at six months and gradually weight regain thereafter.<sup>5</sup> While this effect was seen in the control group, the mindfulness group maintained weight loss and regained an average of only 0.3 kg from six months to 18 months.<sup>5</sup> The mindfulness group had a mean weight loss of 4.2 to 5.0 kg (4.3–5.1%) in 18 months.<sup>5</sup> According to recent obesity guide-

lines, sustained weight loss of 3 to 5% likely results in clinically significant reductions of type 2 diabetes, fasting glucose and triglyceride levels, as found in this study.<sup>5</sup>

## Barriers to Weight Loss Interventions

Psychological stress and reward-driven eating are two major barriers to long-term weight loss. Reward-driven eating can disregard hunger and satiety cues leading to overeating and weight gain. Reducing reward-driven eating is a key component to mindfulness which can result in sustained weight loss.<sup>6</sup> An individual's overconsumption of highly palatable foods is similar to addiction, as it can increase dopamine-related activity in the brain and alter pleasure pathways.<sup>6</sup> In this case, an individual might consume increasingly more highly palatable foods to achieve the same level of pleasure or "reward" they previously experienced with a specific food, only to never reach the same level of satisfaction.<sup>6</sup> Additionally, those who have poor psychological resources for coping with stress may also experience difficulty losing and sustaining weight loss, whether it be from the effects of stress on the body or using food as a coping mechanism.<sup>6</sup>

The mediating effects of psychological stress and reward-driven eating on sustained weight loss when using mindfulness interventions were examined based on data collected through the Supporting Health by Integrating

(Continued on page 15)

Nutrition and Exercise (SHINE) randomized clinical trial.<sup>6</sup> Results suggested among 194 adults with obesity (BMI 30 to 45), the mindfulness intervention had significant reductions in reward-driven eating at six months post-intervention when compared to the active control group.<sup>6</sup> Weight loss at 12 months was similar between the two groups, illustrating no significant difference. However, the inclusion of basic psycho-education and some psychological interventions within the active control group may have contributed to the difference observed at the 12-month mark.<sup>6</sup> This study concluded weight loss was effectively achieved and maintained by reducing reward-driven eating through mindfulness training rather than traditional weight loss interventions, supporting the use of mindfulness interventions in weight loss programs.<sup>6</sup>

### Mindfulness and Impulsive Food Choices

While mindfulness training has been used to address eating behaviors, it also has an impact on impulsive food choices.<sup>7</sup> A randomized control study with 172 adolescents (medium age = 13.13 years) and 176 adults (medium age = 23.33 years) randomly assigned to complete a brief mindful eating training, watch a video about nutrition, or serve as a control.<sup>8</sup> Participants with a higher body fat percentage were seen to make more impulsive food choices, while participants in the mindfulness group had the most positive changes in their impulsive food choices.<sup>8</sup> Mindfulness training was significantly effective in changing food behaviors among participants who made more impulsive food choices and those with the highest body fat percentage, which may prevent weight gain in these populations.

### Mindfulness and Binge Eating

Mindfulness-based intervention was effective in reducing stress-related overeating among 47 overweight and obese women (mean BMI 31.2), which may reduce abdominal fat in the long term.<sup>9</sup> The intervention consisted of nine weekly classes of 2.5 hours and one 7-hour

silent day of guided meditation after the sixth class.<sup>9</sup> Guided meditations introduced mindful eating practices and promoted awareness of physical sensations of hunger or fullness, taste satisfaction, food cravings, and identified emotional eating triggers.<sup>9</sup> Supplemental meditations which focused on awareness of negative emotions, and kindness and forgiveness towards others were also included.<sup>9</sup>

Each weekly session incorporated mindfulness through yoga or meditation, a group discussion of progress or challenges since the last session, followed by an introduction to a new eating or emotional awareness practice.<sup>9</sup> Participants were encouraged to continue practicing meditations and mindfulness practices before and during meals at home.<sup>9</sup> The intervention successfully increased mindfulness and responsiveness to hunger and fullness sensations, reduced anxiety and eating in response to external food cues, and tended to reduce emotional eating.<sup>9</sup>

### Conclusion

Mindfulness reduces reward-driven eating and impulsive food choices related to emotional eating, thus improving self-regulation of physical hunger and awareness of satiety cues to reduce caloric intake.<sup>6,7,8</sup> There are various mindfulness-based interventions, however there are four overall principles consistent across all aspects of mindful eating:<sup>10</sup>

- 1. Check-in with yourself.** Ask yourself: Am I hungry, full, bored or stressed? Is what I'm about to eat going to nourish my body and how will I feel after?
- 2. Take it slow.** Sit down, start with a small portion, chew your food thoroughly, and put down your utensil between bites. Appreciate the taste, texture, and aroma.
- 3. Eliminate distractions.** Put away your phone, turn off the TV, and do not eat in your car. Focus on eating mindfully as your only activity during meals or snacks.

### 4. Practice self-forgiveness and patience.

Bad habits develop over time, so don't expect eating behaviors to improve overnight. Be patient, practice daily meditations, and stay present in the moment.

Mindfulness training reduces stress and enhances psychological well-being for a variety of health conditions, including reducing binge eating among individuals with eating disorders and promoting weight loss among obese and nonobese adults.<sup>6,8,9</sup> Studies suggest mindful eating techniques assist in weight management as these focus on food awareness and preventing stress-induced overeating.<sup>5,9</sup> Overall, the incorporation of mindfulness training was effective in weight regulation and reducing emotional eating among overweight and obese adults.<sup>1,3-6,9</sup>

*Sara Alamdari is a graduate student in the coordinated dietetic/master's program for Nutrition, Healthspan, and Longevity '20 at the University of Southern California. Sara applies her passion and knowledge in mindful eating and incorporates mindfulness in her clients' lives to promote overall emotional, mental, and physical wellness.*

### Supervising Professor bio:

**Dr. Cary Kreutzer, EdD, MPH, RDN, FAND,** Clinical Associate Professor, USC Leonard Davis School of Gerontology & Keck School of Medicine, has been a practicing RDN since 1982, primarily serving at-risk and underserved populations. She continues to provide limited services at Children's Hospital Los Angeles in the Alta Med Pediatric Clinic FQHC running a healthy eating group for parents and children who are overweight or obese. She teaches full-time at the USC Leonard Davis School of Gerontology and serves as director of the ACEND-Accredited Master of Science Degree Coordinated Program in Nutrition, Healthspan and Longevity. Her areas of expertise include health promotion and disease prevention through nutrition, obesity prevention and intervention, developmental disabilities and chronic illness, health systems and health care access and nutrigenomics.

*(Continued on page 16)*

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# Obesity Action Center Message

## Opportunity to Connect with more Patients through the OAC's Obesity Care Provider Locator

We are excited to share a new opportunity for you through our relationship with the Obesity Action Coalition (OAC) and their healthcare provider locator, Obesity Care Providers. The OAC has created this free public resource as an option for individuals to search for a healthcare provider in their area.

The OAC would like to extend the invitation to all WMDPG members to be listed in their provider locator at [www.obesitycareproviders.com](http://www.obesitycareproviders.com).

Here are some key points we would like to share with you regarding this relationship:

- **Submitting Your Listing** - In order to submit your listing to the locator, you will need to visit this link <https://www.obesityaction.org/ocp-complete-listing> and complete the form. You must submit your email to be listed.
- **Multiple Practices** - If you have multiple practice locations, you are able to have each of them listed, however, you will need to provide a unique email address for each listing. Essentially, you will complete the form multiple times with a different email each time for each practice location.
- **Use of Your Email Address** - By completing the OAC's form, you are opting in to their locator database and you will receive an

email each quarter to update your listing information, if any information has changed. Your email address will not be used for any other OAC-related communications unless you are an OAC member and are currently receiving communication from them. In addition, email addresses will not be sold or provided to any other entity for any use.

- **Opting Out** - If you do not wish to be listed in the database, please do not complete the form.

This is an excellent marketing opportunity for you, and we are proud to partner with the OAC on this effort. If you have any questions, please do not hesitate to contact Nina Crowley at [crowleyn@musc.edu](mailto:crowleyn@musc.edu). If you have specific questions regarding the locator itself, please direct them to the OAC at [info@obesityaction.org](mailto:info@obesityaction.org).

### Add-on Premium Access Membership at NO CHARGE:

In the fight against COVID-19, the Obesity Action Coalition (OAC) has made the wellbeing of their Community a priority. The OAC recognizes that now more than ever, patients with obesity need access to valuable tools and resources to help them in their journey. In response to this need, the OAC is proud to

open-up their Premium Access Membership for free through July 1 so that patients and providers can get access to quality, science-based resources and valuable tools to help them through this time.

The OAC is offering Premium Access Membership at no charge through July 1, 2020. Premium Access Membership includes many great benefits, including OAC's educational archives, and provides you the opportunity to stay connected to patient issues, learnings and concerns. [CLICK HERE](#) (or type this URL into your search box: <https://www.obesityaction.org/free-pam-form>) to take advantage of this great resource, and all that the OAC has to offer to healthcare providers like you, who care for individuals affected by obesity.

If you decide to use this offer, FIRST join the OAC as a member. You will receive a confirmation email. If you don't, check your junk or spam box, or your company's firewall could prevent access. Once you have your OAC membership, use the link above to upgrade to Premium Access.



# From the Outgoing Chair

By: Tracy Oliver, PhD, RDN, LDN



It is indeed a different world since our last WM DPG newsletter was delivered to you. Who would have imagined we would be navigating a national pandemic due to COVID-19?

I hope you and your families remain healthy and safe during these unprecedented times. I know we are all looking forward to the day when our world returns to our new normal, and in the meantime, I hope you can enjoy our newsletter to keep you abreast of current and trending topics.

As I write this Chair's Column, it is hard to believe that my time as chair has come to an end! It has been an absolute honor to serve the Weight Management Dietetic Practice Group (WM DPG) and to work with our exceptional Executive Committee (EC). Ten years ago, I took the step to become actively involved with the WM DPG, and it is a decision I never regretted. Over my tenure, I have served as a Research Briefs Coordinator, CPEU Newsletter Editor, Chair-Elect, and now Chair. I have had fantastic opportunities which enhanced my leadership skills, increased networking connections with colleagues, and created lifelong friendships. I encourage you to take that step forward and become a member

leader as it has great personal benefits but also moves forward the dietetics profession.

It is exciting to reflect on this year and see all that WM has accomplished. WM has rolled out a new 2018-2023 Strategic Plan and updated our Guiding Principles to coincide with the new plan. WM has launched a new website to ensure resources and materials were easy to navigate and find. The WM DPG was represented on the DPG Advisory Council with Academy leadership to ensure we have a voice in upcoming matters that pertain to DPG management. We shared our expertise within the House of Delegates and many hot topics focused on evidence-based practice within the Academy. Our Public Policy team remains tirelessly involved in Public Policy and Advocacy initiatives. Lastly, we have recently developed an informal partnership with the Obesity Action Coalition (OAC) and believe the additional opportunities will serve the members of both organizations in a mutually beneficial manner.

We hope you find this newsletter CPEU article informative as we learn from experts such as Hollie Raynor PhD, RD, LDN on the Development and Overview of the APA Clinical Practice Guideline for the Treatment of Obesity and Overweight in Children and Adolescents. Additionally, topics

include intermittent fasting as a tool for WM, the role of adverse childhood events (ACEs), and pediatric obesity and the inclusion of mindfulness strategies for weight loss in WM programs. We hope these articles, as well as many more, will be a resource for you and your WM practice.

While this year has come to a close, we still have much to do. The EC and the Academy have approved our Program of Work/Budget for 2020 – 2021. The WM DPG continues to work with the Academy Publications Department to update the Pocket Guide to Bariatric Surgery with a target of release for 2021. We are underway navigating FNCE® 2020 planning for Indianapolis, IN. Additionally, we are providing timely resources to equip our members during a national pandemic. Please keep an eye out for our upcoming webinar on June 24, 2020, entitled Obesity and COVID-19 featuring experts Bob Kushner, MD, who will discuss the medical implications and Michael Vallis, PhD, RPsych who will consider the psychological consequences of this pandemic.

We hope you enjoy this newsletter and all that it has to offer, and we look forward to your on-going membership in the WM DPG. Working together, we will persevere, and our nation and the profession will be stronger.

# From the Editor

By: Laura Bartee, MS, RD, LD



I have to start this column by acknowledging the difficulty the COVID-19 pandemic has brought to our world and specifically the WM DPG community. I would venture a guess that we all know

someone who has contracted COVID-19, and we certainly all have been impacted in numerous ways. I am sending healing thoughts and energy to all of our members and your families and friends. As Tracy mentioned in her column, I hope this issue of our newsletter can provide each of our members help in some way, whether it serve as a distraction from current events or to provide ideas for future practice.

This Editor's column is a difficult one for me to write, not only because I cannot seem to convey across text my care and concern for everyone during the pandemic. This column marks the end of an

era for me, as it signifies the end of my tenure with the newsletter team. I started volunteering with this team around six to seven years ago as a column writer. Graduating from writing a column, I moved into our Editor's ladder as I have fondly been calling it recently. I served as Associate Editor and then for the last two years, as the Editor. With our next issue, Lisa Paige will take over as Editor and she will continue her hard and diligent work for this team.

The experience of volunteering with the DPG and especially with the newsletter team, working my way through the positions and seeing how much our team's work benefits DPG members has been incredible. I've written in a past column how enriching volunteering has been to my life and I've always been vocal and encouraging to others regarding volunteering in whatever capacity suits them best. Whether you choose to volunteer with our DPG, your local associations or in another area outside of

nutrition, I hope your experience is enriching and positive as well.

If you are looking for more ways to volunteer with our DPG, I highly recommend considering volunteering for the newsletter team. We are always in search of potential authors, subject matter reviewers for our sections and volunteer editors.

Thank you everyone for your readership during my Editor tenure. I am very excited to see how much the newsletter benefits under Lisa's leadership. I'll be enjoying my extra time by finally cleaning out and organizing my wreck of an email inbox until my next volunteering adventure finds me. I'll also be conveying the information from this issue's research column on intermittent fasting to all of my patients, as it's a popular conversation topic in my office as of late!

Stay safe and healthy my friends - Laura