

# Nova Luna Center

## Eating Disorder Programs

### **The Physician's Role in the Prevention of Eating Disorders**

**Primary Prevention** - Reducing or eliminating the problem by understanding and addressing causes and risk factors. Physicians are doing primary prevention whether they know it or not when they:

- Educate patients about nutrition
- Play role of health educator
- Encourage healthy physical activity
- Promote positive body image
- Help families to communicate effectively, have healthy relationships, and build self esteem
- Guide parents and children through the challenges of growth and individuation

**Secondary Prevention** - Identifying the problem early, before it becomes severe. Physicians play an important role by:

- Noticing changes in physical parameters such as growth, weight, vital signs
- Sharing concerns and providing initial counseling
- Educating patients about the importance of adequate nutrition and health habits
- Consulting to schools, athletic organizations, and other influential groups

**Tertiary Prevention** - Developing strategies to keep the problem from getting worse. Again, physicians are unique in their ability to:

- Refer for appropriate therapy by knowing the resources in the area
- Break the denial by giving an historical perspective of their observations of the patient's condition and potential consequences of the eating disorders
- Educate patients about the positive benefits of treatment
- Monitor the medical status and keep patients stable while treatment proceeds
- Set a positive example of needing others by collaborating and communicating with mental health professionals
- Advocate for appropriate care when third party payers deny it

**Danger Zones** - Physicians, despite good intentions, often make the following mistakes. By developing an ongoing collaborative relationship, you may help them to avoid these:

- Setting or agreeing to an artificially low body weight
- Sharing own concerns with food, weight, body image
- Expressing negative feelings re: fat people
- Being over concerned about the increase in obesity so unable to identify pathogenic weight control
- Supportive restrictive dieting
- Not working collaboratively with other providers
- While attempting to support the patient or family, undermining treatment and reinforcing resistance

## WHAT'S UP DOC

**W**eight is more than a number on a scale; it represents self worth, self control, and status to people with disordered eating.

**H**eight is not the only factor to be considered when determining Ideal Body Weight. Need to know person's frame, musculature, family history, health status, and weight and nutritional history.

**A**norexia is the disorder physicians study more, but bulimia is more frequent, harder to diagnose, more secretive, and often coexists with anorexia.

**T**rauma is one of the precipitants for many with eating disorders. The eating disorder is a way to deal with the pain and other complicated emotions.

**S**ide effects of eating disorders intensify gradually. Laboratory values are not the whole story. Mood, concentration, thinking, energy, societal interactions, and quality of life are affected much sooner. Physicians should discuss both the psychological and physiological consequences.

**U**niversal - unfortunately, eating disorders are universal now affecting females of all ages, even prepubescent children, and males. They cut across socioeconomic, ethnic, and cultural groups in the U.S. and are now becoming a more global problem due to the impact of the media and internet.

**P**urging is not just vomiting. Laxatives, enemas, diuretics, excessive exercise, supplements; diet pills, medications, or alcohol to make one nauseous are other methods. Ask what the patient does to maintain or try to lose weight.

**D**ieting is always a precursor to eating disorders. Take this subject seriously and educate your patients about the dangers of restricted intake (such as bingeing / hypo-metabolism).

**O**ffice - your office may be full of Eating Disorder messages, magazines, dietary warnings, height and weight charts, comments about weight all can contribute to eating disorder attitudes.

**C**ompassion, consistency, and care are what a physician offers to patients with eating disorders. This role is very important, but alone, is not enough; refer to mental health specialists in eating disorders so the care can be comprehensive.

### Potential Risk Factors for Eating Disorders

<b>Personal Factors:</b>	Age (13-18), gender (female), weight (obesity) Early puberty / maturation Frequent restrained eating / dieting behaviors Unhealthy weight control behaviors (use diuretics, diet pills) Body Image dissatisfaction Difficulty expressing one's emotions and feelings History of depression Need for perfection Low self-esteem Stress / coping (lack of coping skills) Alcohol / Substance abuse History of sexual / physical abuse Early Dating (with questions / confusions as to appropriate behavior) Ill health / early pregnancy before feeling adequate to care for self
<b>Family Factors:</b>	Chronic criticism, high expectations Over involvement / under involvement Family function (disengaged, high conflict, or chaotic) Low parental affection SES/ ethnicity (white, middle - upper class for anorexia) Family history of eating disorders Family history of affective disorders (e.g. depression) Family history of substance abuse Family history of obesity / migraine
<b>Peer Factors:</b>	Attitudes about weight (thin is attractive, fat is ugly) Behaviors (others are purging, dieting) Teasing / bullying
<b>Cultural Factors:</b>	Media influence (Kate Moss is ideal size) Obesity stigmatization (Being fat is from lack of will power) Western society (Focus on body image as determining ones worth) Birth after 1960 (Earlier focus on thinness / second generation of dieting pressure)
<b>Factors Related to Activity:</b>	Judged by body appearance as well as performance or other attributes Gymnastics Professional Dance Modeling

<b>Beliefs / Assumptions that led to current practices</b>	<b>What new evidence challenges those assumptions?</b>
<p><b>ASSUMPTION:</b> Obesity is a health risk for everyone. The goal is to attain an “ideal” or “desirable” body weight as defined by tables.</p> <p><b>PRACTICES:</b> Routinely weigh all patients at all visits. Initiate weight discussion with all large patients at all visits. “Lose weight” is the standard advice for patients over ideal weight.</p>	<p><b>NEW EVIDENCE:</b></p> <ul style="list-style-type: none"> <li>•Whether obesity is a health risk and to what extent varies between individuals. A “healthy weight” can be within a large range that is defined by an individual’s health status. Periodic weighing every one to three years is recommended at clinical discretion.</li> <li>•Overall health is the goal, not reaching an ideal weight. Small weight losses, even 10-20 pounds lost with moderate behavior changes maintained over time can improve hypertension and diabetes.</li> <li>•Central body obesity may be a greater health risk than peripheral obesity or overall body weight. Though most seekers of weight loss services are women with peripheral obesity, younger men with central obesity may be at highest health risk.</li> </ul>
<p><b>ASSUMPTION:</b> Overeating and lack of activity are the main reasons why people are obese. Patients can reach their ideal weight if they follow low calorie or low fat diets and exercise.</p> <p><b>PRACTICES:</b> Advise patients to eat less and exercise more to lose weight. Give a calorie restricted diet sheet.</p>	<p><b>NEW EVIDENCE:</b></p> <ul style="list-style-type: none"> <li>•Obesity is a heterogeneous condition with a complex etiology. Genetic and environmental factors interact to influence weight. Treatment (if any) must be tailored to an individual’s needs to be effective.</li> <li>•No one method of safe, effective treatment has been developed for losing and maintaining the loss of significant amounts of weight for those who are already obese. Health risks have been associated with weight loss. Negative physical and psychological consequences have been associated with weight cycling.</li> <li>•There is little evidence that restrictive diets lead to long-term weight loss maintenance. Restrictive dieting leads to feelings of deprivation, low self esteem, depression, anger and guilt followed by weight regain when usual eating patterns resume.</li> <li>•Educate patients on ways to eat healthy low-fat foods that can be sustained for a lifetime. Reduced fat and increased vegetable, fruit, and grain consumption is the focus for nutrition advice, not calorie counting.</li> <li>•Moderate physical activity throughout the day can improve health status. Most significant benefit is moving from being totally sedentary to somewhat active. Patients need help getting started with activity. Most don’t get started and stop soon after starting.</li> </ul>
<p><b>ASSUMPTION:</b> Patients should be able to lose the weight if they are strongly motivated.</p> <p><b>PRACTICES:</b> Tell patients they have to lose the weight before surgery, or other necessary procedures. Expect the patient to do it.</p>	<p><b>NEW EVIDENCE:</b></p> <ul style="list-style-type: none"> <li>•Change is a process that varies in individuals and can take a long time. Identification of lifestyle changes that can be maintained must be the focus, not rapid weight loss or practices that cannot be maintained. Unless individuals can exercise, it is unlikely that they will be able to lose and then maintain weight loss. Large people face significant barriers to exercise.</li> <li>•Stigmatization and negative attitudes toward the obese among health professionals can be a barrier to quality care</li> </ul>

Abstracted from “Health and Weight at Kaiser Permanente: A Discussion paper” (1995) that includes a more complete discussion of the research (including citations) and rationale for changes. See RESOURCES listing on page 7 for information on how to receive the full report.

*From Margo Maine, PhD., Institute of Living*