

EATING DISORDERS: OBESITY

Obesity is defined as an excess accumulation of body fat at least 20% over average desired weight for age, sex, and height or a body mass index (kg/m²) of greater than 27.8 for men and greater than 27.3 for women. Obesity is a chronic condition considered by some to be a disability. The general prognosis for achieving and maintaining weight loss is poor; however, the desire for a healthier lifestyle and reduction of risk factors associated with life-threatening illnesses motivate many people toward diets and weight-loss programs.

CARE SETTING

Community level unless morbid obesity requires brief inpatient stay

RELATED CONCERNS

Cerebrovascular accident (CVA)/stroke

Cholecystitis with cholelithiasis

Cirrhosis of the liver

Diabetes mellitus/Diabetic ketoacidosis

Heart failure: chronic

Hypertension: severe

Myocardial infarction

Obesity: surgical interventions (gastric partitioning/gastroplasty, gastric bypass)

Psychosocial aspects of care

Thrombophlebitis: deep vein thrombosis

Patient Assessment Database

ACTIVITY/REST

- May report:** Fatigue, constant drowsiness
Inability/lack of desire to be active or engage in regular exercise; sedentary lifestyle
Dyspnea with exertion
- May exhibit:** Increased heart rate/respirations with activity

CIRCULATION

- May exhibit:** Hypertension, edema

EGO INTEGRITY

- May report:** History of cultural/lifestyle factors affecting food choices
Weight may/may not be perceived as a problem
Eating relieves unpleasant feelings, e.g., loneliness, frustration, boredom
Perception of body image as undesirable
SOs resistant to weight loss (may sabotage patient's efforts)

FOOD/FLUID

- May report:** Normal/excessive ingestion of food
Experimentation with numerous types of diets ("yo-yo" dieting) with varied/short-lived results
History of recurrent weight loss and gain
- May exhibit:** Weight disproportionate to height
Endomorphic body type (soft/round)
Failure to adjust food intake to diminishing requirements (e.g., change in lifestyle from active to sedentary, aging)

PAIN/DISCOMFORT

- May report:** Pain/discomfort on weight-bearing joints or spine

RESPIRATION

- May report:** Dyspnea
May exhibit: Cyanosis, respiratory distress (Pickwickian syndrome)

SEXUALITY

- May report:** Menstrual disturbances, amenorrhea

TEACHING/LEARNING

- May report:** Problem may be lifelong or related to life event
Family history of obesity
Concomitant health problems may include hypertension, diabetes, gallbladder and cardiovascular disease, hypothyroidism
- Discharge plan considerations:** **DRG projected mean length of inpatient stay: 5.1 days**
May require support with therapeutic regimen; home modifications, assistive devices/equipment.
Refer to section at end of plan for postdischarge considerations.

DIAGNOSTIC STUDIES

Metabolic/endocrine studies: May reveal abnormalities, e.g., hypothyroidism, hypopituitarism, hypogonadism, Cushing's syndrome (increased insulin levels), hyperglycemia, hyperlipidemia, hyperuricemia, hyperbilirubinemia. It is also suggested that the cause of these disorders may arise from neuroendocrine abnormalities within the hypothalamus, which result in various chemical disturbances.

Anthropometric measurements: Measures fat-to-muscle ratio.

NURSING PRIORITIES

1. Assist patient to identify a workable method of weight control incorporating healthful foods.
2. Promote improved self-concept, including body image, self esteem.
3. Encourage health practices to provide for weight control throughout life.

DISCHARGE GOALS

1. Healthy patterns for eating and weight control identified.
2. Weight loss toward desired goal established.
3. Positive perception of self verbalized.
4. Plans developed for future weight control.
5. Plan in place to meet needs after discharge.

NURSING DIAGNOSIS: Nutrition: imbalanced, more than body requirements

May be related to

Food intake that exceeds body needs
Psychosocial factors
Socioeconomic status

Possibly evidenced by

Weight of 20% or more over optimum body weight; excess body fat by skinfold/other measurements
Reported/observed dysfunctional eating patterns, intake more than body requirements

DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:

Knowledge: Diet (NOC)

Identify inappropriate behaviors and consequences associated with overeating or weight gain.
Demonstrate change in eating patterns and involvement in individual exercise program.

Nutritional Status (NOC)

Display weight loss with optimal maintenance of health.

ACTIONS/INTERVENTIONS	RATIONALE
<p>Weight Reduction Assistance (NIC)</p> <p>Independent</p> <p>Review individual cause for obesity, e.g., organic or nonorganic.</p> <p>Implement/review daily food diary, e.g., caloric intake, types and amounts of food, eating habits.</p> <p>Discuss emotions/events associated with eating.</p> <p>Formulate an eating plan with the patient, using knowledge of individual's height, body build, age, gender, and individual patterns of eating, energy, and nutrient requirements. Determine which diets and strategies have been used, results, individual frustrations/factors interfering with success.</p> <p>Emphasize the importance of avoiding fad diets.</p> <p>Discuss need to give self permission to include desired/craved food items in dietary plan.</p> <p>Be alert to binge eating and develop strategies for dealing with these episodes, e.g., substituting other actions for eating.</p> <p>Identify realistic increment goals for weekly weight loss.</p> <p>Weigh periodically as individually indicated, and obtain appropriate body measurements.</p>	<p>Identifies/influences choice of some interventions.</p> <p>Provides the opportunity for the individual to focus on/internalize a realistic picture of the amount of food ingested and corresponding eating habits/feelings. Identifies patterns requiring change and/or a base on which to tailor the dietary program.</p> <p>Helps identify when patient is eating to satisfy an emotional need, rather than physiological hunger.</p> <p>Although there is no basis for recommending one diet over another, a good reducing diet should contain foods from all basic food groups with a focus on low-fat intake and adequate protein intake to prevent loss of lean muscle mass. It is helpful to keep the plan as similar to patient's usual eating pattern as possible. A plan developed with and agreed to by the patient is more likely to be successful.</p> <p>Elimination of needed components can lead to metabolic imbalances, e.g., excessive reduction of carbohydrates can lead to fatigue, headache, instability/weakness, and metabolic acidosis (ketosis), interfering with effectiveness of weight loss program.</p> <p>Denying self by excluding desired/favorite foods results in a sense of deprivation and feelings of guilt/failure when individual "succumbs to temptation." These feelings can sabotage weight loss.</p> <p>The patient who binges experiences guilt about it, which is also counterproductive because negative feelings may sabotage further weight loss efforts.</p> <p>Reasonable weight loss (1–2 lb/wk) results in more lasting effects. Excessive/rapid loss may result in fatigue and irritability and ultimately lead to failure in meeting goals for weight loss. Motivation is more easily sustained by meeting "stair-step" goals.</p> <p>Provides information about effectiveness of therapeutic regimen and visual evidence of success of patient's efforts. (During hospitalization for controlled fasting, daily weighing may be required. Weekly weighing is more appropriate after discharge.)</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Weight Reduction Assistance (NIC)</p> <p>Independent</p> <p>Determine current activity levels and plan progressive exercise program (e.g., walking) tailored to the individual's goals and choice.</p> <p>Develop an appetite reeducation plan with patient.</p> <p>Emphasize the importance of avoiding tension at mealtimes and not eating too quickly.</p> <p>Encourage patient to eat only at a table or designated eating place and to avoid standing while eating.</p> <p>Discuss restriction of salt intake and diuretic drugs if used.</p> <p>Reassess calorie requirements every 2–4 wk; provide additional support when plateaus occur.</p>	<p>Exercise furthers weight loss by reducing appetite; increasing energy; toning muscles; and enhancing cardiac fitness, sense of well-being, and accomplishment. Commitment on the part of the patient enables the setting of more realistic goals and adherence to the plan.</p> <p>Signals of hunger and fullness often are not recognized, have become distorted, or are ignored.</p> <p>Reducing tension provides a more relaxed eating atmosphere and encourages more leisurely eating patterns. This is important because a period of time is required for the appetat mechanism to know the stomach is full.</p> <p>Techniques that modify behavior may be helpful in avoiding diet failure.</p> <p>Water retention may be a problem because of increased fluid intake and fat metabolism.</p> <p>Changes in weight and exercise necessitate changes in plan. As weight is lost, changes in metabolism occur, resulting in plateaus when weight remains stable for periods of time. This can create distrust and lead to accusations of “cheating” on caloric intake, which are not helpful. Patient may need additional support at this time.</p>
<p>Collaborative</p> <p>Consult with dietitian to determine caloric/nutrient requirements for individuals weight loss.</p> <p>Provide medications as indicated: Appetite-suppressant drugs, e.g., diethylpropion (Tenuate), mazindol (Sanorex), Sibutramine (Meridia);</p> <p>Hormonal therapy, e.g., thyroid (Euthroid), levothyroxine (Synthroid);</p>	<p>Individual intake can be calculated by several different formulas, but weight reduction is based on the basal caloric requirement for 24 hr, depending on patient's sex, age, current/desired weight, and length of time estimated to achieve desired weight. <i>Note:</i> Standard tables are subject to error when applied to individual situations, and circadian rhythms/lifestyle patterns need to be considered.</p> <p>May be used with caution/supervision at the beginning of a weight loss program to support patient during stress of behavioral/lifestyle changes. They are only effective for a few weeks and may cause problems of addiction in some people.</p> <p>May be necessary when hypothyroidism is present. When no deficiency is present, replacement therapy is not helpful and may actually be harmful. <i>Note:</i> Other hormonal treatments, such as human chorionic gonadotropin (HCG), although widely publicized, have no documented evidence of value.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Weight Reduction Assistance (NIC)</p> <p>Collaborative</p> <p>Orlistat (Xenical);</p> <p>Vitamin, mineral supplements.</p> <p>Hospitalize for fasting regimen and/or stabilization of medical problems, when indicated.</p> <p>Prepare for surgical interventions, e.g., gastric partitioning/bypass, as indicated.</p>	<p>Lipase inhibitor blocks absorption of approximately 30% of dietary fat. Facilitates weight loss/maintenance when used in conjunction with a reduced-calorie diet. Also reduces risk of regain after weight loss.</p> <p>Obese individuals have large fuel reserves but are often deficient in vitamins and minerals. <i>Note:</i> Use of Xenical inhibits absorption of water-soluble vitamins and beta-carotene. Vitamin supplement should be given at least 2 hr before or after Xenical.</p> <p>Aggressive therapy/support may be necessary to initiate weight loss, although fasting is not generally a treatment of choice. Patient can be monitored more effectively in a controlled setting, to minimize complications such as postural hypotension, anemia, cardiac irregularities, and decreased uric acid excretion with hyperuricemia.</p> <p>These interventions may be necessary to help the patient lose weight when obesity is life-threatening. (Refer to CP: Obesity: Surgical Interventions.)</p>

<p>NURSING DIAGNOSIS: Body Image disturbances/Self-Esteem, chronic low</p> <p>May be related to</p> <p>Biophysical/psychosocial factors such as patient's view of self (slimness is valued in this society, and mixed messages are received when thinness is stressed)</p> <p>Family/subculture encouragement of overeating</p> <p>Control, sex, and love issues</p> <p>Possibly evidenced by</p> <p>Verbalization of negative feelings about body (mental image often does not match physical reality)</p> <p>Fear of rejection/reaction by others</p> <p>Feelings of hopelessness/powerlessness</p> <p>Preoccupation with change (attempts to lose weight)</p> <p>Lack of follow-through with diet plan</p> <p>Verbalization of powerlessness to change eating habits</p> <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Body Image (NOC)</p> <p>Verbalize a more realistic self-image.</p> <p>Demonstrate some acceptance of self as is, rather than an idealized image.</p> <p>Self-Esteem (NOC)</p> <p>Seek information and actively pursue appropriate weight loss.</p> <p>Acknowledge self as an individual who has responsibility for self.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Body Image Enhancement (NIC)</p> <p>Independent</p> <p>Determine patient’s view of being fat and what is does for the individual.</p> <p>Provide privacy during care activities.</p> <p>Promote open communication avoiding criticism/judgment about patient’s behavior.</p> <p>Outline and clearly state responsibilities of patient and nurse.</p> <p>Graph weight on a weekly basis.</p> <p>Encourage patient to use imagery to visualize self at desired weight and to practice handling of new behaviors.</p> <p>Provide information about the use of makeup, hairstyles, and ways of dressing to maximize figure assets.</p> <p>Encourage buying clothes instead of food treats as a reward for weight loss.</p> <p>Suggest the patient dispose of “fat clothes” as weight loss occurs.</p> <p>Have patient recall coping patterns related to food in family of origin and explore how these may affect current situation.</p> <p>Determine relationship history and possibility of sexual abuse.</p>	<p>Mental image includes our ideal and is usually not up-to-date. Fat and compulsive eating behaviors may have deep-rooted psychological implications, (e.g., compensation for lack of love and nurturing or a defense against intimacy).</p> <p>Individual usually is sensitive/self-conscious about body.</p> <p>Supports patient’s own responsibility for weight loss; enhances sense of control, and promotes willingness to discuss difficulties/setbacks and problem-solve. <i>Note:</i> Distrust and accusations of “cheating” on caloric intake are not helpful.</p> <p>It is helpful for each individual to understand area of own responsibility in the program so that misunderstandings do not arise.</p> <p>Provides ongoing visual evidence of weight changes (reality orientation).</p> <p>Mental rehearsal is very useful in helping the patient plan for and deal with anticipated change in self-image or occasions that may arise (family gatherings, special dinners) where constant decisions about eating many foods will occur.</p> <p>Enhances feelings of self-esteem; promotes improved body image.</p> <p>Properly fitting clothes enhance the body image as small losses are made and the individual feels more positive. Waiting until the desired weight loss is reached can become discouraging.</p> <p>Removes the “safety valve” of having clothes available “in case” the weight is regained. Retaining fat clothes can convey the message that the weight loss will not occur/be maintained.</p> <p>Parents act as role models for the child. Maladaptive coping patterns (overeating) are learned within the family system and are supported through positive reinforcement. Food may be substituted by the parent for affection and love, and eating is associated with a feeling of satisfaction, becoming the primary defense.</p> <p>May contribute to current issues of self-esteem/patterns of coping.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Body Image Enhancement (NIC)</p> <p>Independent</p> <p>Identify patient’s motivation for weight loss and assist with goal setting.</p> <p>Be alert to myths the patient/SO may have about weight and weight loss.</p> <p>Assist patient to identify feelings that lead to compulsive eating. Encourage journaling.</p> <p>Develop strategies for doing something besides eating for dealing with these feelings, e.g., talking with a friend.</p> <p>Help staff be aware of and deal with own feelings when caring for patient.</p> <p>Collaborative</p> <p>Refer to community support and/or therapy group.</p>	<p>The individual may harbor repressed feeling of hostility, which may be expressed inward on the self. Because of a poor self-concept the person often has difficulty with relationships. <i>Note:</i> When losing weight for someone else, the patient is less likely to be successful/maintain weight loss.</p> <p>Beliefs about what an ideal body looks like or unconscious motivations can sabotage efforts to lose weight. Some of these include the feminine thought of “If I become thin, men will pursue me or rape me”; the masculine counterpart, “I don’t trust myself to stay in control of my sexual feelings”; as well as issues of strength, power, or the “good cook” image.</p> <p>Awareness of emotions that lead to overeating can be the first step in behavior change (e.g., people often eat because of depression, anger, and guilt).</p> <p>Replacing eating with other activities helps retrain old patterns and establish new ways to deal with feelings.</p> <p>Judgmental attitudes, feelings of disgust, anger, and weariness can interfere with care/be transmitted to patient, reinforcing negative self-concept/image.</p> <p>Support groups can provide companionship, enhance motivation, decrease loneliness and social ostracism, and give practical solutions to common problems. Group therapy can be helpful in dealing with underlying psychological concerns.</p>

<p>NURSING DIAGNOSIS: Social Interaction, impaired</p> <p>May be related to</p> <p>Verbalized or observed discomfort in social situations</p> <p>Self-concept disturbance</p> <p>Possibly evidenced by</p> <p>Reluctance to participate in social gatherings</p> <p>Verbalization of a sense of discomfort with others</p> <p>DESIRED OUTCOMES/EVALUATIONS CRITERIA—PATIENT WILL:</p> <p>Social Involvement (NOC)</p> <p>Verbalize awareness of feelings that lead to poor social interactions.</p> <p>Become involved in achieving positive changes in social behaviors and interpersonal relationships.</p>
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ACTIONS/INTERVENTIONS	RATIONALE
<p>Socialization Enhancement (NIC)</p> <p>Independent</p> <p>Review family patterns of relating and social behaviors.</p> <p>Encourage patient to express feelings and perceptions of problems.</p> <p>Assess patient's use of coping skills and defense mechanisms.</p> <p>Have patient list behaviors that cause discomfort.</p> <p>Involve in role-playing new ways to deal with identified behaviors/situations.</p> <p>Discuss negative self-concepts and self-talk, e.g., "No one wants to be with a fat person," "Who would be interested in talking to me?"</p> <p>Encourage use of positive self-talk such as telling one-self "I am OK," or "I can enjoy social activities and do not need to be controlled by what others think or say."</p> <p>Collaborative</p> <p>Refer for ongoing family or individual therapy as indicated.</p>	<p>Social interaction is primarily learned within the family of origin. When inadequate patterns are identified, actions for change can be instituted.</p> <p>Helps identify and clarify reasons for difficulties in interacting with others, e.g., may feel unloved/unlovable or insecure about sexuality.</p> <p>May have coping skills that will be useful in the process of weight loss. Defense mechanisms used to protect the individual may contribute to feelings of aloneness/isolation.</p> <p>Identifies specific concerns and suggests actions that can be taken to effect change.</p> <p>Practicing these new behaviors enables the individual to become comfortable with them in a safe situation.</p> <p>May be impeding positive social interactions.</p> <p>Positive strategies enhance feelings of comfort and support efforts for change.</p> <p>Patient benefits from involvement of SO to provide support and encouragement.</p>

<p>NURSING DIAGNOSIS: Knowledge Deficient [Learning Need] regarding condition, prognosis, treatment, self care, and discharge needs</p> <p>May be related to</p> <p>Lack of/misinterpretation of information Lack of interest in learning, lack of recall Inaccurate/incomplete information presented</p> <p>Possibly evidenced by</p> <p>Statements of lack of/request for information about obesity and nutritional requirements Verbalization of problem with weight reduction Inadequate follow-through with previous diet and exercise instructions</p> <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Knowledge: Diet (NOC)</p> <p>Verbalize understanding of need for lifestyle changes to maintain/control weight. Establish individual goal and plan for attaining that goal. Begin to look for information about nutrition and ways to control weight.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Teaching: Prescribed Diet (NIC)</p>	
<p>Independent</p>	
<p>Determine level of nutritional knowledge and what patient believes is most urgent need.</p>	<p>Necessary to know what additional information to provide. When patient's views are listened to, trust is enhanced.</p>
<p>Identify individual holistic long-term goals for health (e.g., lowering blood pressure, controlling serum lipid and glucose levels).</p>	<p>A high relapse rate at 5-year follow-up suggests obesity cannot be reliably reversed/cured. Shifting the focus from initial weight loss/percentage of body fat to overall wellness may enhance rehabilitation.</p>
<p>Provide information about ways to maintain satisfactory food intake in settings away from home.</p>	<p>"Smart" eating when dining out or when traveling helps individual manage weight while still enjoying social outlets.</p>
<p>Identify other sources of information, e.g., books, tapes, community classes, groups.</p>	<p>Using different avenues of accessing information furthers patient's learning. Involvement with others who are also losing weight can provide support.</p>
<p>Emphasize necessity of continued follow-up care/counseling, especially when plateaus occur.</p>	<p>As weight is lost, changes in metabolism occur, interfering with further loss by creating a plateau as the body activates a survival mechanism, attempting to prevent "starvation." This requires new strategies and aggressive support to continue weight loss.</p>
<p>Identify alternatives to chosen activity program to accommodate weather, travel, and so on. Discuss use of mechanical devices/equipment for reducing.</p>	<p>Promotes continuation of program. <i>Note:</i> Fat loss occurs on a generalized overall basis, and there is no evidence that spot reducing or mechanical devices aid in weight loss in specific areas; however, specific types of exercise or equipment may be useful in toning specific body parts.</p>
<p>Determine optimal exercise heart rate. Demonstrate proper technique to monitor pulse.</p>	<p>Promotes safety as patient exercises to tolerance, not peer pressure.</p>
<p>Discuss necessity of good skin care, especially during summer months/following exercise.</p>	<p>Prevents skin breakdown in moist skinfolds.</p>
<p>Identify alternative ways to "reward" self/family for accomplishments or to provide solace.</p>	<p>Reduces likelihood of relying on food to deal with feelings.</p>
<p>Encourage involvement in social activities that are not centered around food, e.g., bike ride/nature hike, attending musical event, group sporting activities.</p>	<p>Provides opportunity for pleasure and relaxation without "temptation." Activities/exercise may also use calories to help maintain desired weight.</p>

POTENTIAL CONSIDERATIONS following acute hospitalization (dependent on patient's age, physical condition/presence of complications, personal resources, and life responsibilities)

Therapeutic Regimen: Ineffective management—complexity of therapeutic regimen, perceived seriousness/benefits, mistrust of regimen and/or health care personnel, excessive demands made on individual, family conflict.