

OBESITY

DSM-IV

316.00 Psychological factors affecting medical condition—maladaptive health behaviors

Obesity is defined as an excess accumulation of body fat at least 20% over average weight for age, sex, and height. Although considered to be a type of eating disorder, obesity is a general medical condition coded on Axis III, with psychological factors that adversely affect the course and treatment of the medical condition, creating additional health risks for the individual.

ETIOLOGICAL THEORIES

Psychodynamics

Food is substituted by the parent for affection and love. The child harbors repressed feelings of hostility toward the parent, which may be expressed inward on the self. Because of a poor self-concept, the person has difficulty with other relationships. Eating is associated with a feeling of satisfaction and becomes the primary defense.

Biological

These disorders may arise from neuroendocrine abnormalities within the hypothalamus, which cause various chemical disturbances. Familial tendencies have been identified, but obesity is not clearly identified as being hereditary. People who are overweight have more fat cells than thin people and are known to be less active. Although overeating has long been believed to be the cause of obesity, research has not borne this out. Another popular theory has identified carbohydrates as the fattening substance. Currently, a high intake of fat in the diet is being identified as the reason for weight gain/inability to lose weight. The set-point theory proposes that people are programmed to maintain a certain level of weight to protect fat stores. Studies reveal that leptin regulates body weight by telling the body how much fat is being stored. Obese individuals often have higher leptin levels, suggesting a failure of the body to respond to leptin. This may represent a deficiency of receptor sites or inadequate amounts of glucagon-like peptide-1 (GPL-1), which may impair the leptin signaling pathway.

In recent research, genetics, metabolic changes placing some people at risk, and the way the body stores fat all play a part in the problems of obesity. Rather than a single, simple cause, obesity appears to be the result of a complex system reflecting all these factors.

Family Dynamics

Parents act as role models for the child. Maladaptive coping patterns (overeating) are learned within the family system and are supported through positive (or even negative) reinforcement. Family systems may sabotage efforts at changing any part of the system to maintain the status quo.

CLIENT ASSESSMENT DATA BASE

Activity/Rest

Fatigue, constant drowsiness

Inability/lack of desire to be active or engage in regular exercise

Increased heart rate/respirations with activity; dyspnea with exertion

Circulation

Hypertension, edema

Ego Integrity

Weight may/may not be perceived as a problem

Perception of body image as undesirable

Cultural/lifestyle factors affecting food choices; value for thinness/weight

Eating relieves unpleasant feelings (e.g., loneliness, frustration, boredom)

Reports of SO's resistance/demands regarding weight loss (may sabotage client's efforts)

Food/Fluid

Normal/excessive ingestion of food

History of recurrent weight loss and gain

Experimentation with numerous types of diets (yo-yo dieting) with varied/short-lived results

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

Pain/discomfort on weight-bearing joints or spine

Respiration

Dyspnea with exertion

Cyanosis, respiratory distress (sleep apnea, pickwickian syndrome)

Sexuality

Menstrual disturbances, amenorrhea

Social Interactions

Family/significant other(s) may be supportive or resistant to weight loss (sabotage client's efforts)

Teaching/Learning

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

DIAGNOSTIC STUDIES

Metabolic/Endocrine Studies: May reveal abnormalities (e.g., hypothyroidism, hypopituitarism, hypogonadism, Cushing's syndrome [increased cortisol or glucose levels], hyperglycemia, hyperlipidemia, hyperuricemia, hyperbilirubinemia). The cause of these disorders may arise out of neuroendocrine abnormalities within the hypothalamus, which result in various chemical disturbances.

Anthropometric measurements: Measures fat-to-muscle ratio.

NURSING PRIORITIES

1. Help client identify a workable method of weight control incorporating needed nutrients/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 pattern for eating and weight control identified.
2. Weight loss toward desired goal established.
3. Positive perception of self verbalized.
4. Plan in place to meet needs for future weight-control.

NURSING DIAGNOSIS

May Be Related to:

Possible Evidenced by:

Desired Outcomes/Evaluation Criteria— Client Will:

NUTRITION: altered, more than body requirements

Food intake that exceeds body needs

Psychosocial factors

Socioeconomic status

Weight of 20% or more over optimum body weight; excess body fat by anthropometric measurements

Reported/observed dysfunctional eating patterns; intake more than body requirements

Identify inappropriate behaviors and consequences associated with overeating or weight gain.

Demonstrate change in eating patterns and involvement in individual exercise program.

Display weight loss with optimal maintenance of health.

ACTIONS/INTERVENTIONS

Independent

Review individual factors for obesity (e.g., organic or nonorganic).

Implement/review daily food diary (e.g., caloric intake, types of food, eating habits).

Discuss emotions/events associated with eating.

RATIONALE

Identifies/influences choice of interventions.

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 changes and/or a base on which to tailor the dietary program.

Helps to identify when client is eating to satisfy an emotional need rather than physiological hunger.

Formulate an eating plan with the client.

Although there is no basis for recommending one diet over another, a good reducing diet should contain foods from all food groups with a focus on low-fat intake. It is helpful to keep the plan as similar to client's usual eating pattern as possible. A plan developed with and agreed to by the client is more apt to be successful. **Note:** It is important to maintain adequate protein intake to prevent loss of lean muscle mass.

Develop nutritional plan using knowledge of individual's height, body build, age, gender, individual patterns of eating, and energy and nutrient requirements.

Standard tables are subject to error when applied to individual situations, and circadian rhythms/lifestyle patterns need to be considered.

Emphasize the importance of avoiding fad diets.

Elimination of needed components can lead to metabolic imbalances (e.g., excessive reduction of carbohydrates can lead to fatigue, headache, instability and weakness, and metabolic acidosis [ketosis] interfering with effectiveness of weight loss program).

Discuss need to give self permission to include desired/craved food items in dietary plan.

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. Knowing that it is important to include small portions of these foods can prevent negative feelings and promote cooperation with weight loss program.

Identify realistic increment goals for weekly weight loss.

Reasonable weight loss (1–2 pounds/wk) results in more lasting effects. Excessive/rapid loss may result in fatigue and irritability and ultimately lead to failure in meeting weight loss goals. Motivation is more easily sustained by meeting "stair-step" goals.

Weigh periodically as individually indicated, and obtain appropriate body measurements.

Provides information about effectiveness of therapeutic regimen and visual evidence of success of client's efforts. During hospitalization for controlled fasting, daily weight measurement may be required. Weekly weight measurement is more appropriate after discharge.

Determine current activity levels and plan progressive exercise program (e.g., walking) tailored to individual goals and choice.

Exercise furthers weight loss by burning calories and reducing appetite, increasing energy, toning muscles, and enhancing sense of well-being and accomplishment. Client's commitment enables the setting of more realistic goals and adherence to the plan.

Develop an appetite reeducation plan with the client.

In these clients, signals of hunger and fullness often are not recognized, have become distorted, or are ignored.

Emphasize the importance of avoiding tension at mealtimes and not eating too quickly.

Encourage client to eat only at a table or designated eating place and to avoid standing while eating.

Discuss restriction of salt intake and diuretic drugs if used.

Reassess caloric requirements every 2–4 weeks to determine need for adjustment. Be aware of plateaus when weight remains stable for periods of time.

Collaborative

Consult with dietitian to determine caloric/nutrient requirements for individual weight loss.

Provide medications as indicated:

Appetite-suppressant drugs, e.g., diethylpropion (Tenuate), mazindol (Sanorex);

Hormonal therapy, e.g., thyroid (Euthroid);

Vitamin, mineral supplementation.

Hospitalize for fasting regimen and/or stabilization of medical problems.

Refer for evaluation of surgical options (e.g., gastric partitioning, bypass), as indicated.

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 recognize that the stomach is full.

Techniques that modify behavior may be helpful in avoiding diet failure.

Water retention may be a problem because of increased sodium intake, as well as the result of fat metabolism.

Changes in weight and exercise will necessitate changes in diet. As weight is lost, changes in metabolism occur. Plateaus can create distrust and accusations of “cheating” on caloric intake, which are not helpful. Client may need additional support at this time.

Individual intake can be calculated by several different formulas, but weight reduction is based on the basal caloric requirement for 24 hours, depending on client’s sex, age, current/desired weight, and length of time estimated to achieve desired weight.

May be used with caution/supervision at the beginning of a weight loss program to support client during stress of behavioral/lifestyle changes. They are only effective for a few weeks and may cause problems of tolerance/dependence in some people.

May be necessary when hypothyroidism is present. When no deficiency is present, replacement therapy is not helpful and may actually be harmful. **Note:** Other hormonal treatments, such as human chorionic gonadotropin (hCG), although widely publicized, have no documented evidence of value.

Obese individuals have large fuel reserves, but are often deficient in vitamins and minerals.

Aggressive therapy/support may be necessary to initiate weight loss, although fasting is not usually a treatment of choice. Client 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.

May be necessary to assist the client lose weight when obesity is life-threatening.

NURSING DIAGNOSIS**BODY IMAGE disturbance/SELF ESTEEM, chronic low****May Be Related to:**

Biophysical/psychosocial factors, such as client's view of self (slimness is valued in this society, and negative messages may be received when thinness is stressed)

Family/subculture encouragement of overeating

Control, sex, and love issues

Possibly Evidenced by:

Verbalization of negative feelings about body (mental image often does not match physical reality); expressions of shame/guilt

Rejection of positive feedback and exaggeration of negative feedback about self

Feelings of hopelessness/powerlessness; fear of rejection/reaction by others

Lack of follow-through with diet plan; verbalization of powerlessness to change eating habits; hesitancy to try new things

Preoccupation with change (attempts to lose weight)

Desired Outcomes/Evaluation Criteria—

Verbalize a more realistic self-image.

Client Will:

Demonstrate beginning acceptance of self as is, rather than an idealized image.

Acknowledge self as an individual who has responsibility for own self.

Seek information and actively pursue appropriate weight loss.

ACTIONS/INTERVENTIONS**RATIONALE****Independent**

Determine client's view of being fat and what it does for the individual.

Mental image includes our ideal and is usually not up to date. Fatness and compulsive eating behaviors may have deep-rooted psychological implications (e.g., compensating for lack of love and nurturing, or a defense against intimacy).

Provide privacy during care activities.

Individual usually is sensitive/self-conscious about body.

Have client recall coping patterns related to food in family of origin and explore how these may affect current situation.

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.

Determine relationship history and possibility of sexual abuse.

May contribute to current issues of self-esteem/patterns of coping.

Identify client's motivation for weight loss and set goals.

Be alert to myths the client/SO may have about weight and weight loss.

Have client keep a journal noting feelings that lead to compulsive eating.

Develop strategies for doing something besides eating for dealing with feelings (e.g., talking with a friend).

Graph weight on a weekly basis.

Promote open communication, avoiding criticism/judgment about client's behavior.

Outline/clearly state responsibilities of client and nurse.

Be alert to binge-eating, and develop strategies for dealing with these episodes (e.g., substituting other actions for eating).

Encourage client to use imagery to visualize self at desired weight and to practice handling new behaviors.

Provide information about the use of makeup, hairstyles, and ways of dressing to maximize figure assets.

Encourage buying clothes instead of food treats as a reward for weight loss.

May harbor repressed feelings of hostility, which may be expressed inward on the self. Because of a poor self-concept, client often has difficulty with relationships. **Note:** When losing weight for someone else, client is less likely to be successful/maintain weight loss.

Beliefs about what an ideal body looks like or unconscious motivations can sabotage efforts at weight loss. Some of these include the feminine thought of "If I become thin, men will pursue me or desire/rape me"; the masculine counterpart of "I don't trust myself to stay in control of my feelings"; as well as issues of strength, power, or the "good cook" image.

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).

Replacing eating with other activities helps to retain old patterns and establish new ways to deal with feelings.

Provides ongoing visual evidence of weight changes (reality orientation).

Supports client's own responsibility for weight loss; enhances sense of control, and promotes willingness to discuss difficulties/setbacks and problem-solve. **Note:** Distrust and accusations of "cheating" on caloric intake are not helpful.

It is helpful for each individual to understand area of own responsibility in the program to avoid misunderstandings.

The client who binges experiences guilt about it that is counterproductive because negative feelings may sabotage further weight loss.

Mental rehearsal is very useful to help client plan for and deal with anticipated change in self-image or deal with occasions that may arise (family gatherings, special dinners) in which confrontations with food will occur.

Enhances positive feelings of self-esteem, promotes improved body image.

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.

Suggest client dispose of “fat clothes.”

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.

Help staff be aware of and deal with own feelings when caring for client.

Judgmental attitudes, feelings of disgust, anger, and weariness can interfere with care/be transmitted to client, reinforcing negative self-concept/image.

Help client identify positive self-attributes. Focus on strengths/past accomplishments (unrelated to physical appearance).

It is important that self-esteem not be tied solely to size of the body. Client needs to recognize that obesity need not interfere with positive feelings regarding self-concept and self-worth.

Collaborative

Refer to community support and/or therapy group.

Support groups can provide companionship, increase motivation, decrease loneliness and social ostracism, and give practical solutions to common problems. Group therapy can be helpful in dealing with underlying psychological concerns.

NURSING DIAGNOSIS

SOCIAL INTERACTION, impaired

May Be Related to:

Verbalized or observed discomfort in social situations

Possibly Evidenced by:

Self-concept disturbance

Reluctance to participate in social gatherings

**Desired Outcomes/Evaluation Criteria—
Client Will:**

Verbalization of a sense of discomfort with others

Verbalize awareness of feelings that lead to poor social interactions.

Be involved in achieving positive changes in social behaviors and interpersonal relationships.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Review family patterns of relating and social behaviors. Assess weight issues among family of origin, especially mother/father.

Social interaction is primarily learned within the family of origin. When inadequate patterns are identified, actions for change can be instituted.

Encourage client to express feelings and perception of problems.

Helps client identify and clarify reasons for difficulties in interacting with others (e.g., client may feel unloved/unlovable or insecure about sexuality).

Assess client's use of coping skills and defense mechanisms.

Have client list behaviors that cause discomfort.

Involve in role-playing new ways to deal with identified behaviors/situations.

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?").

Encourage use of positive self-talk such as telling oneself "I am OK" or "I can enjoy social activities and do not need to be controlled by what others think or say."

Collaborative

Refer for ongoing family or individual therapy as indicated.

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, or resistance to change.

Identifies specific concerns and suggests actions that can be taken to effect change.

Practicing these new behaviors lets client become comfortable with them in a safe environment.

May be impeding positive social interactions.

Positive strategies enhance feelings of comfort and support efforts for change.

Client benefits from involvement of family/SO to provide support and encouragement.

NURSING DIAGNOSIS

May Be Related to:

Possibly Evidenced by:

Desired Outcomes/Evaluation Criteria—

Client Will:

KNOWLEDGE deficit [LEARNING NEED] regarding condition, prognosis, self care and treatment needs

Lack of/misinterpretation of information

Lack of interest in learning, lack of recall

Inaccurate/incomplete information presented

Questions/request for information about obesity and nutritional requirements

Verbalization of problem with weight reduction

Inadequate follow-through with previous diet and exercise instruction

Assume responsibility for own learning.

Begin to look for information about nutrition and ways to control weight.

Verbalize understanding of need for lifestyle changes to maintain/control weight.

Establish individual goal and plan for attaining goal.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Determine level of nutritional knowledge and what client believes is most urgent need.

Necessary to know what additional information to provide. When client's views are listened to, trust is enhanced.

Identify individual holistic long-term goals for health (e.g., lowering blood pressure, controlling serum lipid and glucose levels).

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.

Provide information about ways to maintain satisfactory food intake in settings away from home.

"Smart" eating when dining out or when traveling helps client maintain weight and desired level while still enjoying social outlets.

Identify other sources of information (e.g., books, tapes, community classes, groups).

Using different avenues of accessing information will further client's learning. Involvement with others who are also losing weight can provide support.

Emphasize necessity to continue follow-up care/counseling, especially when "plateaus" occur.

As weight is lost, metabolism changes, 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 help client continue weight loss.

Identify alternatives to chosen activity program to accommodate weather, travel, and so on. Discuss use of mechanical devices/equipment for reducing weight.

Promotes continuation of program. **Note:** 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.

Discuss necessity of good skin care, especially during summer months.

Prevents skin breakdown/yeast infections in moist skinfolds.

Identify alternative ways to "reward" self/family for accomplishments or to provide solace.

Reduces likelihood of relying on food to deal with feelings.

Encourage involvement in social activities that are not centered on food (e.g., bike ride/nature hike, attending musical event, group sporting activities, window shopping).

Provides opportunity for pleasure and relaxation without "temptation." Activities/exercise may also use calories to help maintain desired weight.