FIRST, DO NO HARM: A PROFESSIONAL WEB SITE PROVIDING A NEW PARADIGM APPROACH FOR ASSISTING CLIENTS WITH WEIGHT-RELATED CONCERNS

By

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ABSTRACT

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PROVIDING A NEW PARADIGM APPROACH
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As a result of cultural beliefs, media influence, and health care professional education, Americans (especially women) have a preoccupation with body weight and feel enormous pressure to conform to an often-unrealistic thin ideal (Guillen & Barr, 1994; Nemeroff, Stein, Diehl, & Smilack, 1994; Rossi, 1988; Shaw & Kemeny, 1989). As a result, millions of Americans suffer from body dissatisfaction and are utilizing mostly ineffective and often harmful weight loss attempts that are widely supported by various health care providers (Gaesser, 1997; Garner & Wooley, 1991; NIH, 1992). "First, Do No Harm: A New Paradigm Approach for Assisting Clients with Weight-Related Concerns" (located on the World Wide Web at http://www.msu.edu/user/burkejoy/) provides a caring contrast to the traditional methods of "weight management". The web site is designed in a educational format based on Gagne, Briggs, and Wager's (1992) instructional design theory, and is meant to provide health professionals with the failures of the traditional approach and widespread, easy access to empowering, less harmful interventions based on the "new paradigm". Ultimately, it will foster self-acceptance, improved self-esteem, and improvements in overall health and well-being for clients through encouragement of self-acceptance, healthy, unrestrained eating, and regular, enjoyable physical activity.

This web site is dedicated to

all individuals who are in need

of caring, supportive health interventions to assist

them with weight-related issues.

PROFESSIONAL ACKNOWLEDGMENTS

This project would not be a reality if not for the encouragement and expertise of our scholarly project committee members, Joan Predko, R.N., Ph.D (chair), Jon Robison, M.S., Ph.D, and Nuala Kavanagh, R.N., C.S., M.S.N., Family Nurse Practitioner. It is because of their willingness to explore alternative approaches, review research literature with an open perspective, and venture into a new area with regard to a scholarly project that this web site is a reality. Importantly, our committee shares with us the desire to support clients in health and well-being through a caring, holistic, non-judgmental approach. We thank them for their encouragement, thoughtful suggestions, and confidence in us.

In addition, we would like to give special thanks to Joel Wiebenga, R.N., who has dedicated countless hours to the creation of this web site. We appreciate Joel's patience, creativity, and professionalism.

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I would like to express my deepest thanks to those people who have profoundly touched my life, and whose influence led to the eventual creation of this project. First, to my mother, Ruth Perkins, R.N., who exemplified the spirit of nursing and nurtured it within me. Second, to Linda, a very special friend, who helped me to grow both personally and professionally in a time when I felt that growth was impossible. Third, to my husband, Brian, whose enduring patience, support, and encouragement enabled me to invest the time and energy necessary to complete this web site. And finally, to my boys, Alex and Patrick, whose unconditional love and humor brought me through even the most difficult times.

Angela Berg

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http://www.msu.edu/user/burkejoy

INTRODUCTION

Most Americans are afraid of fat and insecure about eating (Fraser, 1997; Satter, 1987). Our culture places extraordinary value on thinness, believing it to be a requirement for beauty, success, healthy body image, and overall good health. The resultant preoccupation with body weight exerts enormous pressure on all individuals, but especially women, to conform to an often-unrealistic thin ideal (Guillen & Barr, 1994; Nemeroff, Stein, Diehl, & Smilack, 1994; Rossi, 1988; Shaw & Kemeny, 1989). A primary outcome of this cultural thin ideal is the development of the traditional old paradigm approach for assisting clients with weight-related concerns (the old paradigm) that is frequently utilized by health care providers (Appendix A).

The Background of the Problem

The cultural value on thinness has evolved over time. For most of the nineteenth century, a plump fleshy female figure was equated with success (evidenced by an ample food supply), health, and beauty. As the century drew to a close, food became more readily available, the wealthy began to feel a need to distinguish themselves from the stocky European immigrants, and fat was no longer equated with prestige (Fraser, 1997). As a result, there was a transition to thinner more athletic female frames. Women began to see themselves in more modern lifestyles that included roles other than those of wife and mother (Fraser, 1997; Rolls, 1991). By the end of World War I, women also began to value energy and vitality. Fat became a sign of self-indulgence and inefficiency (Segal-Isaacson, 1996). With each passing decade, thinness has gained increasing importance as a determinant of physical attractiveness (Rolls, Federoff, & Guthrie, 1991). The

importance of thinness has been promoted by the increasingly significant influence of the medical, fashion, and advertising industries (Fraser, 1997).

Media including television, movies, and magazines are among the most influential promoters of the thin standard, given their popularity and accessibility to the American people (Silverstein et al., 1986). Alarmingly, the media's influence can have significantly negative outcomes. For instance, exposure to media messages promoting extreme body image ideals has been shown to create body image dissatisfaction and lead to eating disorders (Anderson & DeDomenico, 1992; Stice, Neuberg, Shaw, Stein & Godofsky as cited in Nemeroff et al., 1994). Although a direct causal relationship between media portrayals and the attitudes and behaviors of individuals is difficult to prove, and other influences are likely to affect beliefs about physical appearance, there is undoubtedly an extremely strong influence of the media on the American public that is likely to continue. Importantly, this effect has the potential to increase given continuing advances in technology and the increasing popularity and accessibility of the Internet.

As noted by Fontaine (1991) and Robinson (1985), pressure from the media to emulate the culturally stereotyped thin ideal is a threat to women's body image and self-esteem. "Who am I and how do I make a difference in the world?" has been replaced with "What should I look like and what image should I project?" (Kearney-Cooke & Striegel-Moore, 1992, p. 99). Body image is the mind's representation of the body. It is mediated by multiple internal and external influences and affects one's thoughts, perceptions, and behaviors. The formation of negative body image frequently results from the concurrent influences of our cultural preoccupation with thinness and our society's subsequent

intense fear of fat. As a result, many individuals (especially women) frequently engage in weight loss activities that are neither safe nor effective.

In addition to its role in body image formation, the thin ideal has also profoundly influenced health beliefs. Many Americans and most health care providers believe that there is an ideal weight for optimal health and any weight above the ideal puts individuals at risk for increased morbidity/mortality. This belief originated with the development of the height/weight tables by Louis Dublin. A clear, statistically significant relationship between weight and health did not exist within the data utilized by Dublin, thus these tables were not evidence-based (Gaesser, 1997). Further, three decades of research have not supported a clear causal link between increased weight and adverse health consequences (Smith, 1995). Much of the research that does indicate such a relationship is fraught with contradictory findings, methodological flaws, and ethical limitations (Kassirer & Angell, 1998). Studies have shown that some health risk exists at both extremes of weight, but the exact nature of the relationship between weight and all-cause morbidity/mortality remains unknown. Still, most studies over emphasize the risks of increased weight while downplaying those associated with very low weights (Troiano, Frongillo, Sobal, & Levitsky, 1994). Because this skewed picture of the relationship between weight and health continues to be portrayed as an accurate representation of weight-related research, individuals continue to use improved health as a major rationale for pursuit of the thin ideal.

The need to lose weight is so strongly ingrained that Americans invest approximately 30 billion dollars annually in the weight loss industry (Fraser, 1997; Gaesser, 1997). In fact, "Dieting is so prevalent, and puritanical attitudes about eating are

so common, that people have gotten some very restrictive ideas about what is normal and natural in eating" (Satter, 1987, p. 69). Dieting has become a way of life for a majority of individuals and is most common among Caucasions, women, young adults, people with more than 12 years of education, and those with higher sociocenomic status (French & Jeffrey, 1994; Williamson, Serdula, Anda, Levy, & Byers, 1992). Counting and restricting calories by a multitude of different methods coupled with regimented exercise is the most popular weight loss strategy (Gaesser, 1997; Horm & Anderson, 1993).

Weight loss strategies have not proven to be effective or safe in producing weight loss and/or improved health. Despite initial short-term successes, 95 percent of all dieters studied regained all of their weight within five years and some actually became heavier than when they started (Gaesser, 1997; NIH, 1992). Further, while a majority of Americans have dieted to lose weight (French & Jeffrey, 1994), the mean weight of Americans aged 20 to 74 increased 3.6 kilograms between 1976 and 1991 (Kuczmarski, Flegal, Campbell, & Johnson, 1994; NIH, 1992). Attempting to lose weight can lead to adverse physical, psychological and social outcomes (Garner & Wooley, 1991). Alarmingly, most epidemiological studies suggest that weight loss is actually associated with increased mortality (Andres, Muller, & Sorkin, 1993; NIH, 1992; Pamuk, Williamson, Serdula, Madans, & Byers, 1993).

Old paradigm thinking is so entrenched within American society that health care providers' professional education continues in it's support, purporting that large weight is a serious health concern and weight loss through dieting and exercise is the appropriate solution (Bulechek & McCloskey, 1992; Herfindal & Gourley, 1996; Neinstein, 1996;

Pender, 1996; Porth, 1994; Stanhope & Lancaster, 1992). While contradictory evidence exists, the old paradigm is still widely accepted by most professors and students.

Health care providers have been shown to demonstrate discriminatory behaviors consistent with a culturally induced fear of and dislike for fat and fat people (Garner & Wooley, 1991; Maiman, Wang, Becker, Finlay, & Simonson, 1979; Young & Powell, 1985). As a result, health care providers frequently use old paradigm principles as the basis for interventions. Exercise is often related to potential weight loss and improved appearance. Unfortunately, teaching individuals how to increase physical activity and reap the health benefits of an active lifestyle is then lost. Studies have shown that approximately 25 percent of adults in the United States do not engage in any leisure-time physical activity (United States Department of Health and Human Services, 1996). In addition, despite overwhelming evidence of its inefficacy and even dangerous nature, dieting is also frequently supported by health care providers.

Statement of the Problem

Cultural beliefs, media influence, and professional education have contributed to health care provider attitudes that support utilization of the potentially harmful and often ineffective strategies of the old paradigm. An attitude shift in health care providers is needed to promote professional consideration of the new paradigm approach for assisting clients with weight-related concerns (the new paradigm), which is potentially more effective and less harmful (Appendix B).

Project Goals and Objectives

The goals of this scholarly project are to encourage clinician exploration of the new paradigm and foster attitude change among clinicians relative to weight-related issues. Goal achievement depends on successful completion of four objectives. The following two objectives provide the foundation for accurate exploration of the old and new paradigms: 1) synthesis of existing knowledge about the evolution and premises of the old and new paradigms and, 2) recognition/awareness of the inconclusive nature of existing weight-related research. The remaining objectives are: 3) utilization of instructional design theory (Gagne, Briggs, & Wager, 1992) to facilitate health practitioner knowledge and attitude change and, 4) use of the Internet to provide access to information pertinent to the new paradigm.

Conceptual Framework

Gagne, Briggs, and Wager's (1992) instructional design theory (IDT) serves as the foundation for instruction to be delivered using a professional web site. IDT identifies five potential learner capabilities/outcomes: verbal information, intellectual skills, cognitive strategies, attitudes, and motor skills. Verbal information consists of communicable facts that are learned via formal or informal means and are often essential data for the utilization of intellectual skills and cognitive strategies. Intellectual skills consist of procedural information leading to knowledge of how to do something. Cognitive strategies are approaches or modes for solving unique problems including the accurate selection, synthesis, and application of appropriate intellectual skills. Attitudes are persistent, situation specific mental sets impacting individual choices of action (behavior) and amplifying positive or negative responses to individuals, objects, or

situations. Motor skills are complex performances of bodily movement that lead to completion of a physical task.

Gagne, Briggs and Wager (1992) define effective instruction as a set of planned events designed in a systematic manner to activate and support the learner, thus facilitating learning of one or more identified capabilities/outcomes. IDT considers the external conditions that are necessary to create the internal process of learning, and is based on several assumptions. Appropriate instructional design: 1) is based on a systems approach and on knowledge of how human beings learn; 2) aids individual learning and impacts individual human development; and 3) has immediate and long range phases. A set of instructional events is systematically developed through the use of a multiple step process. The following describes the adapted multiple step process created to guide development of this scholarly project. The time line for completion of this scholarly project (web site) can be found in Appendix C.

Step One: Identification of Needs and Goals

A needs assessment is an extremely important initial phase in the development of designed instruction (Cox & Baker, 1981) that facilitates appropriate instructional design. Identification of needs includes assessment of learner characteristics and motivation. The targeted learners are health care providers, namely advanced practice nurses (APNs), physicians, physician assistants, nurses, and health educators practicing in primary care settings. In addition, medical specialists, nutritionists, and fitness professionals could benefit from viewing the web site. The identified learners are assumed to possess general agreement with the basic philosophical tenant first, do no harm, and professional knowledge based on the old paradigm with subsequent utilization of it's principles.

Motivational characteristics consistent with health professional status include the desire to: further knowledge base, stay abreast of current health related research, provide clients with optimum evidenced based care, and reduce frustration with the inefficacy of old paradigm-based recommendations.

In the process of setting goals, consideration must be given to available resources and potential constraints that may affect successful implementation of instruction (Gagne, Briggs, & Wager, 1992). Constraints include limited access to educational seminars due to location, time commitment, and cost. Also, consideration must be given to access and individual literacy in media options for delivery of instruction. Additionally, as members of a society placing high value on the thin ideal, many health care providers possess firmly entrenched attitudes which may pose a significant challenge to achieving acceptance of the new paradigm. Instructional resources include: proven methods for enhancing attitude change via appropriate instructional design, rapidly expanding access to computers and the Internet at home and in the workplace, increased weight-related research supporting new paradigm principles, and growing professional/public support for the new paradigm.

Goals for this project's learners are based on the above needs assessment as well as the review of constraints and resources. The resulting goals are: 1) consideration of a new cognitive strategy for dealing with weight-related issues and 2) facilitation of attitude change toward support of the new paradigm.

Step Two: Course Development

The most effective instructional design proceeds from general to specific or simple to complex concepts. Accordingly, a rationally organized course divides material

into single subject units that may be further divided into lessons (Gagne, Briggs, & Wager, 1992). Because this project addresses one major topic, it is classified as a course and is divided into five units of instruction, each with three to five lessons.

Step Three: Sequence of Instruction

The purpose of instruction sequencing is twofold. Sequencing should ensure appropriate acquisition of foundations for further learning (Gagne, Briggs, & Wager, 1992) and facilitate achievement of specific capabilities to be learned, such as attitudes. The stepwise sequence of instruction for this course is included as Appendix D.

Attitudes may be learned via direct and indirect methods. Direct methods include provisions of a reward(s) and learner feelings of success (Gagne, Briggs, & Wager, 1992). Participants will experience feelings of success as they progress through units and gain understanding of how failures serve as the rationale for the new paradigm. In addition, auditory and/or visual rewards may be provided for selection of "new paradigm" responses within one case presentation at a future date.

The indirect method for facilitating attitude change is human modeling (Gagne, Briggs, & Wager, 1992). Human models must first be respected. Further, they must be perceived as credible and powerful. Finally, learners must be able to identify with them. To meet these criteria, the first page of the web site will include a foreword by a published content expert, author biographies with photographs, and the project rationale. Gagne, Briggs & Wager state that the desired attitude should be directly observed through the models' behavior. However, due to our method of delivery, direct observation is impossible. The authors do provide two case presentations complete with

new paradigm interventions and rationale. This allows for the indirect observation of behaviors consistent with the authors' attitudes of new paradigm acceptance.

Step Four: Development of Objectives for Units and Lessons

Unit objectives lead to attainment of course goals. Lesson objectives assist with the logical division of units into easily understood segments and facilitate successful attainment of unit objectives. When written in terms of learner performance, lesson and unit objectives can also be used to measure learning outcomes (Gagne, Briggs, & Wager, 1992). The lesson and unit objectives within this course are worded to measure each learner's attainment of specific verbal information, intellectual skills, cognitive strategies, and/or attitudes (Appendix E).

Step Five: Lesson Planning and Media Selection

The lesson format evolves from the designed objectives. Knowledge of learner characteristics is utilized as it determines the external and internal conditions that are involved in the learning. The identified conditions then determine the selection of media or combinations of media most likely to ensure favorable outcomes of instruction. Strategies for enhancing attainment of specific learning outcomes are also considered when lessons are planned. All lessons, according to Gagne, Briggs and Wager (1992), should: 1) get the learner's attention, 2) present the objectives, 3) stimulate what is already known about the subject, 4) present the new material, 5) provide guidance, 6) elicit performance, 7) provide feedback, 8) assess performance, and 9) enhance retention and transfer. Specific strategies for learning cognitive strategies and attitudes are also defined by Gagne, Briggs and Wager. Three main approaches to promote the learning of a new cognitive strategy are described and include rehearsal, elaboration, and

organization. Within this project, learners can utilize rehearsal by repeated web site visits, copying and printing selected text for continued review, and participating in case studies demonstrating desired behaviors. Elaboration includes paraphrasing, summarizing, and generating questions and answers. Participants can utilize elaboration when completing the case presentations. Guidelines for enhancing the learning of an attitude are also defined. A description of their relationship to this project can be found in Appendix F.

Further, highly effective continuing education offerings provide varied learning activities and supply learners with adequate identified resources (Cox & Baker, 1981). Accordingly, this web site utilizes various formats for material presentation including flowcharts, bulleted lists, and case presentations. As defined by Alspach (1995), the case presentation method of instruction is the historical and chronological depiction of a fictitious, but realistic client situation in which learners are expected to develop problem solving and critical thinking skills. Appropriately designed cases consist of complete, succinct data and are based on identification of desired instructional outcomes. Cases enhance learning by facilitating comprehension of how a theory is most accurately applied in practice. This property will help learners attain a new cognitive strategy related to the new paradigm. The case method is also appropriate for complex, novel, or unique situations requiring an outcome of instruction within the affective domain. Learners are allowed to consider examples in a risk-free environment and apply newly-learned concepts during situation analysis. Therefore, case presentations can promote attitude change within learners. One limitation of the case method is that participants need considerable time to process material and formulate answers. Because learners working

with material on the Internet can proceed at their own pace, the case method of instruction is highly appropriate for this medium.

An appropriate mode of delivery for this instructional material is via the World Wide Web. "The web offers the promise of media richness -- graphics, sound, video and interactivity. And it has the advantage of being situated right inside the world's largest virtual library -- the Internet" (C. Heeter, personal communication, January 27, 1998). Ubiquitous in nature, the Internet has the potential to reach enormous audiences worldwide. Currently, many learning institutions, including Michigan State University, utilize the Internet as a medium for instruction. Widespread availability of affordable, user friendly technology is advancing steadily and creating relatively easy and continued access to Internet-based instruction. As noted by Kiener and Hentschel (1989), learners need on-going access to information in order to deal with arising difficulties as they attempt incorporation of new ideas into practice. Presenting this course on the Internet will provide learners with continuous access as well as links to additional references. Therefore, use of the World Wide Web as the instructional delivery mode will enhance the assimilation of the new paradigm into health care practice. A copy of the web site can be found in Appendix G and is located at http://www.msu.edu/user/burkejoy on the World Wide Web.

Step Six: Learning Assessment

Assessment of learning is designed to measure attainment of unit objectives by using specific criteria identified within the objectives. Because this instruction is designed to assist with individual attitude change (an internal process), there will be opportunities for self-assessment of weight-related attitudes. Exploration of new

paradigm principles and their application will be accomplished through completion of case presentations. Therefore, participants may evaluate their understanding of the new paradigm.

Step Seven: Instructional Systems

An instructional system may be composed of either group or individual instruction, or some combination thereof. The most appropriate system of instruction is based on learner characteristics, external conditions, and comprehensive instructional goals (Gagne, Briggs, & Wager, 1992). Individual instruction delivered via the Internet is an appropriate system of instruction for this course as it meets the unique needs of the targeted learners and instructional goals.

Step Eight: Instructional Evaluation

Two main forms of instructional evaluation are used. The first, formative evaluation seeks to improve and refine the instruction itself. This can be accomplished in several different ways, including one-to-one testing, small-group testing, and field trials (Gagne, Briggs, & Wager, 1992). In one-to-one testing, a single learner progresses through the course materials under close observation. Any difficulties with the course design are then identified and recorded. Small-group testing involves completion of the instruction by a group of six to eight learners selected as representative of the target population. Pre and post-tests are utilized to determine the effect of the designed instruction. In a field trial, significant numbers of learners use the instruction and attitude surveys are collected to determine learner opinion related to the instruction. Any combination of these evaluative methods may be employed to provide sufficient data in deciding whether to keep, revise, or discard an instructional sequence.

One-to-one testing with a group of four nurse practitioner graduate students will occur prior to project completion. Immediate feedback will provide the authors with constructive criticism as well as the opportunity to clarify concepts through verbal explanation/discussion. Additionally, a practicing family nurse practitioner, education specialist, and content experts will review the web site and provide feedback that will be considered prior to completion of the site. Finally, as a form of a field trial, course participants will be offered the opportunity to provide feedback on course design via electronic mail, which can then be used to improve the course design.

The second form of instructional evaluation, summative evaluation, is used later to determine what has actually been learned as a result of the instruction. While summative evaluation is beyond the scope of this project, it is the hope of these authors that further research endeavors may be stimulated, including projects focusing on summative evaluation of this and/or similar instructional offerings related to the new paradigm.

Conclusion: Implications for Primary Care

For a majority of individuals, primary care settings serve as the principal point of entry into the health care system. As evidenced by the high prevalence of dieting in American society, many individuals possess weight-related concerns. Therefore, primary care providers are likely to be challenged with choosing an appropriate approach for assisting these clients. Exploration of the proposed web site by primary care practitioners will increase their awareness of the limitations inherent in the old paradigm, as well as their awareness of the physical, psychological, and social risks involved in old paradigm approaches. Further, it is expected that this web site will stimulate primary care

providers to incorporate new paradigm principles into practice, with subsequent positive effects for individual clients, and ultimately, improved quality of life for many members of society.

The American Nurses Association (1980) defines nursing as "the diagnosis and treatment of human responses to actual or potential health problems" (p. 9). As providers with extensive nursing knowledge, advanced practice nurses (APNs) are well prepared to assist clients who present with physical, psychological, and social responses to weight-related issues. When working with clients in primary care, the APN can utilize an ongoing relationship and appropriate roles such as client advocate, counselor, care manager, and clinician to provide quality, holistic care. Advanced practice nurses can optimize care by empowering clients with the knowledge, empathy, support, and resources necessary to prevent and/or resolve the complex responses to body weight issues. As professionals, APNs have the responsibility to continuously evaluate scientific research, accurately critique findings, and promote the clinical implementation of evidence-based interventions across health care professions.

The American public places its trust and confidence in health care providers. Justification of this trust will be enhanced as professionals assist with incorporation of an important new trend for primary care providers as described by Kassirer and Angell (1998):

> . . . doctors [primary care providers] should do their part to help end discrimination against overweight people in schools and workplaces. We should also speak out against the public's excessive infatuation with being thin and the extreme, expensive, and potentially dangerous measures taken to attain that goal.

Many Americans are sacrificing their appreciation of one of the great pleasures of life – eating – in an attempt to look like our semi-starved celebrities. Countless numbers of our daughters and increasingly many of our sons are suffering immeasurable torment in fruitless weigh-loss schemes and scams, and some are losing their lives. Doctors [primary care providers] can help the public regain a sense of proportion. p. 53-54.

APPENDICES

APPENDIX A

The Traditional Old Paradigm Approach for Assisting Clients with Weight-Related Concerns

- Old paradigm goals: To have all individuals conform to "ideal" body weights utilizing weight loss strategies.

- Old paradigm interventions: Recommend restricted caloric intake and increased exercise.

- Old paradigm assumptions (Robison, 1997):
  - Health and happiness only occur when ideal weight is obtained.
  - People only differ in size because they lack the will power to exercise regularly and restrict intake.
  - Everyone can be thin, happy, and healthy by dieting.

- Old paradigm outcomes (Gaesser, 1997):
  - Support for societal fear of and discrimination against fat and fat people.
  - Increased prevalence of disordered eating and eating disorders.
  - Increased prevalence of weight cycling.
  - Increased prevalence of higher BMIs in Americans.
  - No improvement in prevalence of sedentary lifestyle.
  - No decrease in prevalence of diseases once thought to be caused by obesity.

- Old paradigm rationale:
  - Obesity is a disease that causes significant morbidity and mortality.
  - Weight loss interventions are safe and effective for obesity treatment.

- Old paradigm scientific evidence:
  - Is fraught with contradictory findings, methodological flaws, and ethical limitations (Kassirer & Angell, 1998).
  - Does not support a clear, causal link between increased weight and increased morbidity and/or mortality (Smith, 1995).

APPENDIX B

The New Paradigm Approach
for Assisting Clients with Weight-Related Concerns

- New paradigm tenets: Feeling good about one's self, eating well in a natural, relaxed way, and being comfortably active (Berg, 1995, p. 110).

- New paradigm goals:
  - To instill individual confidence related to one's ability to make choices for better health resulting in improved self-esteem and increased energy.
  - To encourage all individuals to establish healthy body image as well as nourish healthy and positive eating and sensible physical activity.

- New paradigm interventions: Accomplish gradual changes leading to improved self-nurturing, increased fun physical activity, and relaxed unrestrained eating.

- New paradigm assumptions (Satter, 1996):
  1) body weight is primarily determined by genetic set point
  2) fatness is normal for some people
  3) fat people can be healthy and happy
  4) obesity is excessive weight gain for an individual
  5) the only appropriate intervention for obesity is to identify and resolve factors that disrupt the body's homeostasis.

- New paradigm outcome: Weight will reflect energy balance and lifestyle and will be no more morally important than hair color or height. All individuals, including children, will grow up to develop the weight that is genetically right for them (Satter, 1996).

- New paradigm rationale: There is no existing effective weight loss intervention. The focus must shift away from weight loss as a goal since there is evidence that improved physical and psychological health may be achieved by non-dieting interventions designed to increase physical activity, normalize eating and reduce weight fluctuation (Garner & Wooley, 1991).

- New paradigm scientific evidence: Although more research in needed to demonstrate the safety and efficacy of the new paradigm approach, at lease one work site study project has been completed. Carrier, K., Steinhardt, M., & Bowman, S. (1994) demonstrated that learning a non-restrained, internally driven eating style was associated with increased self-esteem and acceptance, increased physical activity and decreased dieting and weighing behaviors over a three-year period. As opposed to traditional weight loss programs that tend to lead to relapse over time, study

participants maintained and/or increased their mastery of internally driven eating over a three-year period.

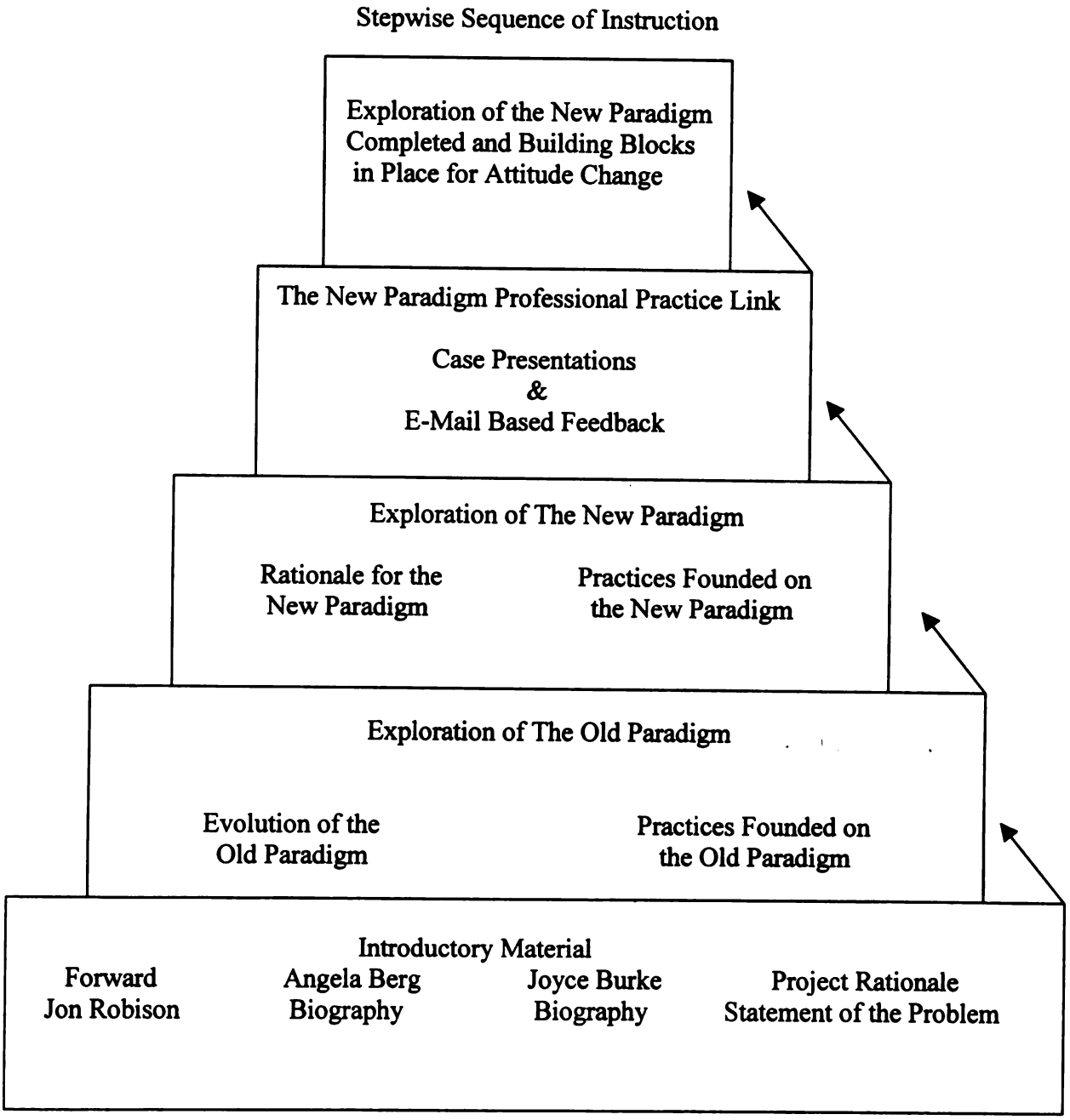
APPENDIX C

Time Line for Completion of Scholarly Project/Web Site

Tasks to be Completed:	Sept		Oct		Nov		Dec		Jan		Feb		Mar		Apr		May	
	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
Discuss weight-related health care with advisors	■																	
Consult with interested faculty about this topic & a potential committee chair	■	■																
Select committee chair			■															
Select committee				■														
Locate content expert				■														
Locate interested clinical expert				■														
Information Gathering	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■			
Literature review and critique			■	■	■	■	■	■	■	■	■	■	■	■	■			
Formulation of problem statement						■												
Selection of relevant theory						■	■											
Development of written proposal						■	■	■	■	■	■	■						
Defense of written proposal													■					
Identify server on which to locate web site												■						
Employ expert in web design													■	■	■	■	■	■
Design units/lessons based on content and theory													■	■	■			
Collaborate with web designer to create web site													■	■	■	■	■	■
Seek feedback from peers, committee, and other national experts															■	■		
Revise web site format and content as necessary															■	■		
Defend final project																	■	
Complete final revisions																	■	
Project to bindery with receipt to committee chair																	■	
Bound project distributed to College of Nursing and committee members																	■	■

1 = Days 1-15 of the designated month and 2 = Days 16-the month's end.

APPENDIX D


Stepwise Sequence of Instruction
Exploration of the New Paradigm Completed and Building Blocks in Place for Attitude Change
The New Paradigm Professional Practice Link
Case Presentations
&
E-Mail Based Feedback
Exploration of The New Paradigm
Rationale for the New Paradigm
Practices Founded on the New Paradigm
Exploration of The Old Paradigm
Evolution of the Old Paradigm
Practices Founded on the Old Paradigm
Introductory Material
Forward
Jon Robison
Angela Berg
Biography
Joyce Burke
Biography
Project Rationale
Statement of the Problem

APPENDIX E

Course Sequence with Objectives

Level of Instruction	Title	Objective (Human Capability Involved) The learner will:
Unit I	Evolution of the Traditional Old Paradigm Approach	Identify the major influences in the development of the old paradigm (Verbal Information [VI]).
Lesson A (Angie)	Historical Development of the Thin Ideal	Recount the events leading to formation of the thin ideal (VI).
Lesson B (Angie)	Media Influence, the Thin Ideal, and Body Image	Classify how the media has impacted enculturation of the thin ideal (VI). State that the thin ideal negatively impacts body image (VI).
Lesson C (Joyce)	The Relationship Between Weight and Health	Identify the limitations of scientific evidence supporting the old paradigm (VI).
Unit II	Practices Founded on the Old Paradigm	Delineate the incompatible nature of old paradigm practices with the selection of effective, safe interventions (Cognitive Strategy [CS]).
Lesson A (Joyce)	Weight Loss Prevalence and Methods	Describe the current rate of weight loss attempts in America (VI). State four methods used for weight Loss (VI).
Lesson B (Joyce)	Health Care Providers, Education, & Old Paradigm-Based Practice	Describe the concept that old paradigm interventions are a product of culturally-bound, inadequately supported scientific evidence (VI).
Lesson C (Joyce)	Prescribed Weight Loss: An Old Paradigm Intervention	Describe the traditional professional approach to weight loss (VI).

Lesson D (Angie)	Sedentary Lifestyle & the Goals of Healthy People 2,000	Outline physical activity goals of People 2,000 (VI). State that the current rate of sedentary lifestyle reflects low level participation in leisure-time physical activity(VI).
Unit III	Rationale for the New Paradigm	Link the concepts of the new paradigm with pre-existing, internalized intervention strategies (CS).
Lesson A (Joyce)	Failures of the Old Paradigm	List the harmful attempts of weight loss and/or attempts at weight loss (VI). Classify weight loss attempts as ineffective for reduced BMI/improved health (VI).
Lesson B (Joyce)	"Healthy Weight"	Describe how to apply the concepts of healthy weight to the new paradigm (Intellectual Skill [IS]).
Lesson C (Angie)	Benefits of Physical Activity	Delineate how regular physical activity positively affects health and well-being (IS).
Unit IV	Practices Founded on the New Paradigm	Consider interventions consistent with new paradigm principles as viable choices when confronted with weight related issues (Attitude [A]).
Lesson A (Both)	Size-Friendly Health Care Practice	Identify setting-specific characteristics that reflect size acceptance (VI). Describe the process of assessing clients for weight-related concerns and introducing them to the new paradigm (VI).
Lesson B (Angie)	Body Image/Size Acceptance	Define body image and the factors that influence body image (VI). Discriminate between interventions that promote and those that inhibit

		healthy body image and size acceptance (IS).
Lesson C (Joyce)	Healthy, Unrestrained Eating	Define the concept of healthy, unrestrained eating (VI). Generate interventions to promote healthy, unrestrained eating (IS).
Lesson D (Angie)	Promoting Physical Activity	Characterize an approach for physical activity assessment, intervention, and evaluation (VI). Compile strategies to empower clients to choose enjoyable, regular physical activity (IS). List a variety of forms of physical activity from differing levels of intensity and financial investment (VI).
Lesson E (Both)	New Paradigm-Based Client Information	To be completed in the future.
Unit V	Self-assessment activities	Given detailed case presentations, formulates responses consistent with new paradigm principles (A).

APPENDIX F

Strategies for Enhancing Attitude Learning

1. Provide learners with information about possible alternative choices
   - The project describes both the old and new paradigms in detail
   - Specific new paradigm interventions are provided
2. Provide learners with pros and cons of the desired behavior (the outcome of an attitude)
   - Potential difficulties with incorporating new paradigm interventions are provided throughout the web site
3. Provide relevant models for the desired behavior
   - Content expert, author biographies and photographs, and use of case presentations provide models
4. Ensure that the environment supports the desired behavior
   - The environment (web site) supports behavior indicative of a positive new paradigm attitude
   - Case presentations demonstrate the utility of the new paradigm in contrast to existing practice which may support old paradigm interventions
5. Fit the desired behavior into a larger framework of values
   - The new paradigm promotes acceptance and respect for all individuals
   - The new paradigm promotes health
6. Teach skills that make the desired behavior possible
   - Course lessons are designed to provide the rationale for and intervention strategies of the new paradigm
7. Recognize and reward the desired behavior
   - One case presentation will provide auditory/visual rewards when participants select new paradigm choices
8. Allow learners to set their own behavior-related goals
   - Because this is a web site, learners will set individual goals and proceed at their own pace
9. Use varied instructional strategies
   - Bulleted lists, a flow chart, case presentations, and limited prose will provide a variety of instructional methods
10. Avoid pairing the desired behavior with one that is unrelated
    - new paradigm interventions are not paired with other interventions which lead to unrelated lifestyle modification, such as smoking cessation and avoidance of alcohol consumption

APPENDIX G

First, Do No Harm: A Professional Web Site Providing a New Paradigm Approach for Assisting Clients with Weight-Related Concerns
http://www.msu.edu/user/burkejoy/

WELCOME

.....Welcome, health care professionals. Whether you are a counselor, dietitian, health educator, nurse, nurse practitioner, physician, physician assistant, or other health care provider, this web site has been designed to help you provide care for your clients with weight-related concerns. Millions of Americans struggle with weight issues on a daily basis, and most have experienced this struggle for many years. It is time for us, as professionals, to accept the challenge and employ appropriate measures to help our clients end this battle, thus improving their physical and mental health.

.....The information here is not a diet or weight loss plan. Instead, you will find alternatives to recommending diets and weight loss for clients. You may discover that the information presented is unlike what you have been taught. It is meant to provide you with a more balanced view of information available on weight-related issues and overall health. The facts and advice contained here may provoke intense emotions since they may contradict past learning and question the strong cultural ideals and judgements we have lived with for so long. Please review the information at your own pace with an open mind and allow time for the concepts to solidify in your mind as you discover their practicality.

This web site will provide you with the following:

- **The historical evolution of the thin, ideal body, how the media influences this ideal, and how this ideal is affecting the body image of millions of Americans, particularly women**
- **The relationship between body weight and health**
- **Current weight loss practices, their prevalence, and the effects of weight loss attempts**
- **Sedentary lifestyle prevalence and the physical activity goals of *Healthy People 2000***
- **Health care provider interventions based on what will be termed The Traditional Old Paradigm Approach and the problems inherent to this approach**
- **A definition of healthy weight**
- **The psychological and physical benefits of physical activity**
- **Suggestions for encouraging clients to have more positive thoughts about themselves and their bodies, reducing body hatred, and connecting the mind and the body**
- **Suggestions for encouraging healthy, unrestrained eating**
- **Methods to assist clients in adopting and/or maintaining a physically active lifestyle**
- **Suggestions for making your offices/clinics and practices size-friendly**
- **Opportunities for self-evaluation through participation in case presentations**
- **Opportunities to provide feedback to the authors of this site**

.....Whether you already utilize more gentle methods of counseling, educating, and intervening with clients who have weight-related concerns, or if you are interested in learning more about The New Paradigm Approach For Assisting Clients With Weight-Related Concerns, we believe there is something to be learned by all who participate in the lessons of this web site.

.....Your clients need you! They need your guidance, support, knowledge, and caring attitude to accomplish some of the most difficult changes--reconciliation of weight-related concerns and/or size acceptance. We believe we can help you. So, please involve yourself in this site. Bookmark this URL and come back to complete the lessons if your time is limited. Maintain the bookmark for easy access at the office or clinic where you see clients. We welcome your constructive feedback and have provided a means for E-mail contact with us.

.....Along the left margin you see the table of contents, which will remain on your screen no matter where you are in the site. We suggest that you start at the beginning in order to facilitate a more complete understanding of the interventions that are suggested at the end. The "client information" section will contain print-outs you may copy for your clients.

to Joyce ...or... to Angie ...or...to Both

Author biographies

Forward by Jon Robison, PhD

We would like to know about you as well.
Click here to tell us about yourself!

Sign Our Guestbook

View Our Guestbook

Our Webmaster

Ready to begin? Click NEXT

Forward by Jon Robison, PhD

FIRST ...DO NO HARM!

.....Despite overwhelming agreement on the failure of diets to promote lasting change and growing evidence of potentially dangerous physical and psychological consequences, weight-related research and intervention continue to focus on the promotion of weight loss through dietary restriction. And despite almost universal recidivism following weight-loss programs and an epidemic of dangerous eating disorders, people continue to spend billions of dollars yearly on weight-loss products and services.

.....As a scientist and practitioner who has been helping people with weight-related concerns for more than 10 years, I am deeply troubled by this continued investment in a clearly failed and potentially harmful approach. Our culture's unrelenting obsession with thinness has spawned a pervasive prejudice that causes tremendous suffering and social isolation for individuals of size. This is particularly damaging for young girls and women who are continually pressured to divert significant proportions of their energy and resources to the pursuit of ideals of body shape and size that are, for the vast majority, neither achievable nor healthy. Indeed, women of all sizes suffer from an intense fear of fat that plays havoc with their self-esteem and promotes disordered eating and exercise behavior. And men suffer as well, by participating in a culture that defines the worth of more than one half of its population in terms of physical appearance, rather than by the recognition of truly meaningful qualities such as honesty, compassion and love.

.....This tremendous pressure to be thin is driven by diet, fashion, cosmetic, fitness and pharmaceutical industries that reap tremendous financial rewards by promoting unattainable expectations, particularly for women. In addition, many obesity researchers have economic links to this so called "diet-pharmaceutical-industrial complex", creating powerful incentives for maintaining the status quo and contributing perhaps to questionable objectivity in the reporting of research findings.

.....Studies indicate that health professionals are often extremely prejudicial in their treatment of larger individuals. The "new paradigm" approach offers practitioners an alternative for compassionate, health-enhancing care. This approach encourages self-acceptance by honoring the natural diversity in body shape and size and by exposing societal prejudice and discrimination against larger individuals. It promotes the benefits of

physical activity by encouraging social, pleasure-driven movement. Ant it helps people to re-connect eating to internally driven hunger, appetite and satiety cues, leading to a more normal, peaceful, relationship with food.

.....This comprehensive web site, First Do No Harm, provides a much needed and long overdue resource to help health professionals move towards more compassionate and effective ways of helping people with weight-related concerns. Detailed explanation of the new paradigm will help practitioners understand the concepts and learn the skills necessary to incorporate this new approach into their practices.

.....By breaking the endless cycle of weight loss and regain, this approach can help to stop the waste of valuable resources that results from our cultural obsession with thinness. The goal is to help people make positive changes to improve the quality of their lives regardless of weight status. The end result will be a culture that is less judgmental and more truly diverse, and individuals who lead healthy fulfilled lives by honoring and caring for the bodies they already have.

Jon Robison, PhD, Health Education & Exercise Physiology, MS, Human Nutrition
Executive Co-Director, Michigan Center for Preventive Medicine, Lansing, Michigan
Adjunct Assistant Professor, Department of Kinesiology, Michigan State University

NEXT

Angie Berg, R.N.

Angie received her B.S.N. from Grand Valley State University in 1993 and anticipates graduation from Michigan State University with a master of science in nursing degree in May, 1998. Her clinical experience in acute care includes cardiac/neurology stepdown, surgical ICU, and cardiology services. Health behaviors have become an interest of hers not only through nursing experiences, but also as a result of nearly 10 years as an instructor in the fitness/aerobics industry.

She looks forward to beginning her new role as a family nurse practitioner and incorporating the principles found at this web site to help her clients achieve their individual best in health and well-being. She hopes that you will be able to use the information here to strengthen your holistic care as a practitioner and help your clients improve physical and emotional wellness.

Joyce Burke, R.N.

Joyce received her A.D.N. from Lake Superior State College in 1986, her B.S.N. from the University of Detroit Mercy in 1996, and anticipates her master of science in

nursing degree from Michigan State University in May, 1998. After graduation, she is looking forward to starting her career as a family nurse practitioner.

In the past 12 years, her nursing experience has included acute and primary care in Michigan, Florida, and Washington D.C.. During this time, she has gained experience in women's health, obstetrics, pediatrics, and professional education.

In both her personal and professional life, she has experienced the frustration of dealing with weight-related concerns. It is her hope that improved access to new paradigm principles will assist health care professionals to ease the suffering of disturbed body image and weight loss behaviors provoked by the thin ideal.

Thank you for your participation in this project. We appreciate your input for future updates.

Please fill in the information below, with your comments. All information will be kept confidential unless you give permission to use your comments (see permission box below). We will not use any comments without your name and address. If you prefer to email us, please click the Email button below. Information with a (*) is optional but appreciated. Thank You once again.

Name: *
Address: *
City/State/Country
Zip/ Postal Code:

E-mail Address here:

Please Specify Title/ Position

Age: 20 & Under

Gender

Have you utilized, or do you plan to utilize the new paradigm in your practice?

Choose one Please tell us breifly of your experience below, or send us an E-Mail.

Your comments here:

I Choose one give permission to use my comments on a feedback page.

Submit Reset

Send E-Mail

Return to "First Do No Harm"

Unit 1:

Evolution of the Traditional Old Paradigm Approach

Unit Objective: Upon completion, the learner will be able to identify the major influences in the development of the old paradigm.

Lesson Objectives:

Upon completion of Lessons 1A through 1C, the learner will be able to:

- **Recount the events leading to formation of the thin ideal**
- **Classify how the media has impacted enculturation of the thin ideal**
- **State that the thin ideal negatively impacts body image**
- **Identify the limitations of scientific evidence supporting the old paradigm**

NEXT

Unit 1A:

Historical Evolution of the Thin Ideal

The Thin Ideal and Women

.....Western society is intensely preoccupied with body size, exerting enormous pressure on individuals to conform to the thin ideal of body weight. This influence is imposed upon children, adolescents, and adults. Although the ideal for men has changed to encourage a more muscular, lean frame that is not too thin, the focus of the extreme messages and pressures has been on females. Negative consequences result from the imposition of these unrealistic appearance standards.

- **More body-oriented magazine articles in women's magazines than men's magazines from 1980 to 1991**
- **Female television characters are more likely to be thin than male characters in 20th century media**
- **Females receive more messages in ads and magazines to stay slim and in-shape than men do**
- **Many women directly relate physical appearance to self-esteem and are less satisfied with their body shape than men**
- **Women view their bodies more aesthetically while men view their bodies in light of function and activity**
- **Male ectomorphs have been rated intelligent but likely to be teased, while female ectomorphs have been considered to be more attractive and have more friends**

The History of Body Size/Shape

.....The focus on women's physical appearance and body weight is evident as far back as the 1800s.

- **During the Victorian era, the ideal body type for women was plump, fleshy, and full-figured**
- **The more slender Gibson Girl of the turn of the century portrayed the physical vigor and increasing interest of women in athletics. Physicians began to see body weight as a "science" of calorie counting, "ideal weights", and weigh-ins**
- **The Flapper Girl of the early 1900s had a thin frame with little curvature**
- **After World War I, active lifestyles added another dimension. Energy and vitality became central and body fat was perceived to contribute to inefficiency and was a sign of self-indulgence**
- **By the 1950s, a thin woman with a large bustline (though still heavy by today's standards) was considered most attractive**
- **By the 1960s, slenderness was judged by women to be one of the most important determinants of physical attractiveness**

References

E-Mail Angie

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Unit 1A:

References

Historical Evolution References

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Unit 1B:

Media Influence, the Thin Ideal, and Body Image

.....Media such as television, movies, and magazines are considered to be among the most influential promoters of the thin standard, given their popularity and accessibility to the American people. Importantly, this effect has the potential to increase given continuing advances in technology and the increasing popularity and accessibility of computers and the Internet.

- **Exposure to various types of media promote an extreme ideal body image creating body dissatisfaction that can lead to eating disorder symptomatology**
- **Television commercials influence female self concept and achievement aspirations and television often depicts situations in which thin people prosper and larger people are ridiculed**
- **Between 1970 and 1990, there was an overall increased emphasis on weight loss and body shape in the content of a popular women's magazine, as well as a change in the portrayal of female models to a thinner and less curvaceous shape (every article stated that dieting would help improve appearance and attractiveness and exercise-related articles stated that the number one reason for exercise would be to improve attractiveness)**
- **High frequency exercisers (as compared with moderate frequency exercisers and non-exercisers) were more likely to exercise to burn fat/lose weight**
- **Though not socially desirable due to the detrimental consequences on the self-esteem and body image of consumers, the use of slim models is an effective method for motivating young women to exercise**
- **Despite an American public with increasing body weights, *Playboy* magazine increased the promotion of slimness over the period from 1959 to 1978; Miss America Pageant contestants were also found to be thinner over time, and winners of the pageant since 1970 consistently weighed less than the other contestants**
- **From the year 1959 to 1973 there was clearly an increase in the number of diet articles in 6 women's magazines**
- **Many young women are choosing smoking and its risks over the physical and emotional risks of dieting and other weight loss measures**
- **For many, the fear of not losing weight and the fear of gaining even a few pounds is far more important than the fear of poor health or preventable illnesses**

References

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Unit 1B:

References

Media Influence References

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Unit 1C:

The Relationship Between Weight & Health

.....This lesson explores the strength of the scientific evidence supporting/refuting the relationship between increased weight and adverse health risks. Health care providers receive a largely biased view of weight related research throughout their professional education. The material that follows is provided to give the professional reader a more balanced knowledge base from which to draw conclusions about the validity of claims stating that obesity is a disease entity and/or independent risk factor for increased morbidity/mortality.

.....Old paradigm belief: There is an ideal weight for optimal health and anything above that ideal increases one's risk for morbidity and mortality.

..... Does the available evidence support this belief?

Click on the links for a detailed discussion related to each of the statements below.

- **The Concept of Ideal Weight**
  The conceptual basis of ideal weight is the height/weight tables which are not representative of a statistically significant linear relationship between increased weight and increased morbidity and/or mortality.
- **The Challenges Facing Weight-Related Research**
  Weight-Related research is fraught with methodological flaws and ethical limitations.
- **The Evidence Related to Weight and Health**
  In over three decades of work, researchers have not clearly supported a direct, positive, and causal relationship between weight and morbidity/mortality.

New Paradigm alternatives:

1. The actual relationship between weight and health is unknown at present.

2. The available scientific evidence does not adequately support a causal relationship between large weights and adverse health risk.

References

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NEXT


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Unit 1C:

The Concept of Ideal Weight

Height/Weight Tables

..... Height/weight tables have influenced conceptualization of weight, overweight, and obesity since their development by Louis Dublin in the early 1940's, but one must ask if these tables are valid representations of the relationship between weight and health:[1]

- **Dublin reviewed insurance data and found that policy holders who weighed the least had the lowest mortality. Incidentally, a majority of these individuals were also in their twenties!**
- **For each height a 30-40 pound weight range was associated with low morbidity/mortality. This was explained by the *arbitrary* development of small, medium, and large frame sizes.**
- ***No research confirming a statistically significant linear relationship between weight and health among this population was ever conducted.***
- **The height/weight tables have been revised, but these revisions are not consistent with the 1979 Build Study upon which they are based.[2]**
- **Traditionally, overweight and obesity have been defined as steps along the weight continuum established by the height/weight tables:[3]**

Overweight & Obesity: An extension of Ideal Weight	
Overweight	10%-19% over ideal weight for height
Mild Obesity	20%-39% over ideal weight for height
Moderate Obesity	40%-99% over ideal weight for height
Severe Obesity	>100% over ideal weight for height

Body Mass Index (BMI)

- **BMI is a criterion for determining ideal weight and is defined as weight in pounds multiplied by 700, then divided by height in inches squared.[4]**
- **Even though there is no universally accepted definition of obesity, individuals with BMIs greater than 27.8 for a man or 27.3 for a woman are usually considered obese. [5,6,7]**
- **BMIs for adults ranging from 19 to 28 have been reported as desirable by various sources. This wide range depicts the ongoing debate as to the BMI level reflective of the lowest health risk as well as the rate of increasing risk associated with rising BMI.[5,6,7]**
- ***More accurate population studies are needed to better define the concepts of healthy and excess weight which may well vary according to age, gender, ethnicity, genetics, and lifestyle.[8,9]***

References

Back to Unit 1 C: The Relationship Between Weight and Health

Unit 1C:

The Challenges Facing Weight-Related Research

Two major Methodological challenges face weight-related research:

1. Body weight is determined by multiple factors including genetic, cultural, socioeconomic, behavioral, and situational mechanisms; therefore, determining the independent contribution of each variable may not be possible.[1]

2. Study findings are difficult to generalize since location of a bias free representative sample may not be possible.

- **The vast majority of individuals in America have dieted for weight loss at some point,[2,3] and dieting via caloric restriction leads to lasting effects on physiological and mental functioning.[4]**
- **To date, known populations of non-dieters have not been studied so it is difficult if not impossible to separate the influence of high BMI verses dieting within study results.[5]**

Ethical Concerns Associated with Weight-Related Research

1. Results of weight-related research funded primarily by commercial weight loss and pharmaceutical firms must be considered with great caution.

- **These businesses represent major constituents of the 30 billion dollar per year weight loss industry and the potential risk of conflicts in interest is clear.[6,7]**
- **The American Foundation Roundtable on Healthy Weight was convened to examine the rising incidence of overweight in America and base suggestions on a thorough review of the available scientific data.[8] This project was funded by Weight Watchers international. In one section, the anti-diet movement was called a communication challenge to be overcome[9] and many research studies refuting the existence of a relationship between adverse health consequences and obesity were not discussed.**

2. Throughout the history of research examining the relationship between weight and morbidity/mortality, there has been considerable over emphasis on the association between the risks of higher BMI with increasing morbidity/mortality.

- **Diminishing adverse findings related to low weight is common and usually occurs either by selective omission of discussion on underweight or selective emphasis on overweight.[10]**

- **Some reports actually downplay the risk associated with low body weight.**

References

Back to Unit 1 C: The Relationship Between Weight and Health

Unit 1C:

The Evidence Related to Weight and Health

.....Even though C. Everett Koop, the former Surgeon's General, has declared obesity a disease and cause of significant morbidity/mortality within the United States, three decades of research have not supported such a clear causal link.[1,2] It has been noted that fat distribution and BMI explain only about 9-13% of the variance in cardiovascular risk factors.[3] Further, research findings are diverse, revealing that the nature of the relationship between weight and morbidity/mortality remains unknown. While it does appear that some health risk exists at both extremes of BMI, concluding that increased weight is a major component of cardiovascular risk seems premature given the lack of valid scientific evidence appropriate for general application to the American public.

.....The following summarizes the contradictory nature of the available weight-related literature by specific disease entity. It is suggested that readers consider the following tables (just click on the topic headings below), then review the listed references and make an independent, but informed decision regarding the evidence upon which interventions for clients with weight-related concerns are currently based.

Conclusions

- **The scientific community is divided on the role of weight in the development of cardiovascular disease, hypertension, type 2 diabetes, breast, endometrial, and colon cancers, osteoarthritis, osteoporosis, and all-cause morbidity/mortality.**
- **Well designed studies utilizing true random samples are desperately needed to clarify the true nature of the relationship between weight and health, but it is unlikely that conclusive evidence will be available soon, given the failure of over**

30 years of research to end this debate.

- **Despite the lack of scientific agreement within the weight/health related research, a majority of scientists, the media, and medical professionals feel compelled to take a stand against increased weight. Therefore, there is a tendency to support the concept that high BMI (termed obesity) is a disease requiring treatment and the scientific evidence that supports this opinion is selectively overemphasized.**

References

Back to Unit 1 C: The Relationship Between Weight and Health

The Relationship between Weight & All-Cause Morbidity/Mortality	
Author	Dwyer (1996)[4]
Conclusions	*Comprehensive review of literature showed a linear relationship between weight & health risk. *States disease virtually guaranteed when BMI is 2-3 times "normal".
Concern	Any risks related to low or decreasing BMI were not addressed.
Authors	Manson, Willett, Stampfer, Colditz, Hunter, Hankinson, Hennekens, & Speizer (1995)[5]
Conclusions	*A positive linear relationship between weight/mortality exists. *Statistically significant health risks for women when BMI > 27. *Women should attempt to maintain BMI at or below 21.
Concerns	*Confounding variables including hypertension, diabetes mellitus, hypercholesterolemia, & weight cycling were not controlled in initial data analysis. *The sample did not represent the target population (American women). *Self-reported heights/weights were used. *Increased health risk was demonstrated for BMIs over 27, but BMIs at or below 21 were recommended.
Authors	Troiano, Frongillo, Sobal, & Levitsky (1994)[6]
Conclusions	Meta-analysis of research with over 30 years of follow up: *Many longitudinal studies do **not** support a positive linear relationship between weight & adverse health risk. *Some studies demonstrate a negative relationship. *Moderately increased BMIs are not associated with increased mortality. *Weights at or slightly below current recommendations are associated with increased health risks. *A "J" shaped relationship between weight and health exists.
Concerns	*Risk associated with weight loss may be explained by smoking and/or other comorbid conditions; however, studies that controlled for these variables have not demonstrated the removal of associated health risks

References

Next

Back to: The Evidence Related to Weight and Health

The Relationship Between Weight and Cardiovascular Disease	
Authors	Weinsier, Fuchs, Kay, Treibwasser, & Lancaster (1976)[7]
Conclusions	*Weak correlation between body fat, BP, cholesterol & triglycerides. *Mean levels of body fat not significantly different between patients with cardiovascular disease & controls *Weak correlation between body fat, BP, cholesterol & triglycerides. *Obesity is only a minor determinant of blood pressure and lipid levels. *Obesity's contribution to cardiovascular disease is extremely small or non-existent.
Concern	Although completed in 1976, represents the diversity of research results.
Authors	Wilcosky, Hyde, Anderson, Bangdiwala, & Duncan (1990)[8]
Conclusions	*Mortality rates are significantly higher among the very thin and very obese. *A "J" shaped relationship between weight & cardiovascular disease is supported. *No **significant** correlation between obesity and cardiovascular disease (or cancer) found.
Concern	Demonstrates the contradictory nature of research findings.
Author(s)	Meisler & St. Joer (1996)[9,10]
Conclusion	Studies relating obesity to cardiovascular disease show that BMIs equal to or < 22.6 (men) & 21.1 (women) would lead to less cardiovascular risk & 25% less cardiovascular disease.
Concerns	*Despite the fact that statistical procedures cannot prove causality[11], a causal relationship between specific BMIs & cardiovascular disease risk is proposed. *Recommended BMIs are far below the levels at which health risk is shown to be statistically significant.
Authors	Hubert, Feinleib, McNamara, & Castelli (1983)[12]
Conclusion	Obesity is an independent (causal) risk factor for cardiovascular disease.
Concerns	*Secondary analysis of Framingham heart study that used only 2 weights: The subjects' initial weight & weight after 25 years. *Unable to capture any effects associated with weight cycling. *Physical activity level, diet, & personality types not considered.
Authors	Willett, Manson, Stampfer, Colditz, Rosner, Speizer, & Hennekes (1995)[13]
Conclusions	*Obesity is an independent (causal) risk factor for cardiovascular disease. *Recommend that women maintain a BMI of <21 to minimize cardiovascular disease risk.
Concerns	*Assume hypertension, type 2 diabetes mellitus, & hypercholesterolemia to be intermediate steps in a causal relationship between obesity & CHD & don't control for their potential influence. *Support for the above assumptions are not included. *Recommendations for BMIs <21 justified by a very weak trend depicting

	increased risk for cardiovascular disease with rising BMI; however, significant risk was not demonstrated until BMIs were at least 29.

References

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Back to: The Evidence Related to Weight and Health

The Relationship between Weight and Hypertension	
Authors	Meisler & St Joer. (1996).[14,15]
Conclusions	*Literature review supports a positive relationship between increased BMI & hypertension. *40-50% of hypertension is attributable to obesity. *Reviewed data was insufficient to quantify weight targets to minimize the risk of hypertension.
Concerns	*There is a lack of evidence regarding the degree of weight loss needed to improve hypertension.
Authors	McCarron & Reusser. (1996).[16]
Conclusions	Weight reduction is only associated with blood pressure decrease while weight remains reduced.
Concerns	Since 95% of all dieters regain any lost weight within 1-5 years, weight loss and/or low weight may not be an appropriate goal for hypertension management.
Authors	U.S. Preventive Services Task Force. (1996).[17]
Conclusions	The relationship between BMI and hypertension is readily accepted by the medical community as evidenced by the use of weight loss as a primary intervention strategy for hypertensive individuals.
Concerns	Since 95% of all dieters regain any lost weight within 1-5 years, weight loss and/or low weight may not be an appropriate goal for hypertension management.
Authors	Weinsier, James, Darnell, Dustan, Birch, & Hunter. (1991).[18]
Conclusions	*Weight reduction may be used to treat hypertension. *Based on the hypothesis that volume expansion secondary to weight gain without a compensatory decrease in peripheral resistance leads to increased blood pressure in genetically sensitive individuals. *Weight loss decreases volume & therefore lowers blood pressure.
Concerns	*Weight loss and/or decreased blood pressure were not shown to be sustained over time. *Logically, volume expansion secondary to weight regain would likely reverse pressure lowering effects.

References

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The Relationship between Weight and Type 2 Diabetes	
Authors	Manson, Willett, Stampfer, Colditz, Hunter, Hankinson, Hennekens, & Speizer (1995)[19]
Conclusion	Literature review shows high BMI is associated with increased incidence of type 2 diabetes
Concern	Caution is needed when inferring causality from statistical studies demonstrating that two variables are associated.
Authors	Pi-Sunyer (1996)[20], Porth (1994)[21], & Reaven (1988)[22]
Conclusion	*Insulin resistance is the primary pathophysiology for type 2 diabetes. *Many studies have suggested a causal relationship between increased BMI and increased insulin resistance. *Research evidence supports a relationship between increased BMI, insulin resistance & type 2 diabetes. *The prevalence of concurrent high BMI, insulin resistance, & Type 2 diabetes in study populations seems confirmatory of a causal relationship.
Concern	Do other factors such as sedentary lifestyle play a significant role in the causal pathway described above?
Author	Gaesser (1997)[23]
Conclusion	*There may be a genetic predisposition for insulin resistance for some people. *Such a genetic predisposition may be aggravated by participation in sedentary lifestyle coupled with intake of a predominantly high fat diet. *The presence of such an environmental & genetic combination may lead to development of diseases such as Type 2 diabetes secondary to the presence of insulin resistance. *The regular intake of fat & lack of physical activity may alter the genetically susceptible body's sensitivity to insulin. *It may be that the association between increased BMI & insulin resistance is nothing more than innocent co-existence.
Concern	The mere presence of two or more variables in the same individual does not infer an inherent causal relationship.

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The Relationship between Weight and Cancer	
Authors	Ballard-Barbash & Swanson (1996)[24]
Conclusions	*Reviewed over 75 studies hypothesizing various relationships between body weight & endometrial and/or breast cancer, finding inconsistent results. *No study showed increased risk of endometrial cancer for women with BMIs <28. *Negative relationships between increasing BMI and pre-menopausal breast cancer were found. *Many studies demonstrated a weak positive association between BMI & postmenopausal breast cancer, but only 9-21% of the disease risk was explained by weight.
Concern	The literature reviewed does not support that high BMI is a major risk factor for the development of endometrial or breast cancer.
Authors	Shike (1996)[25]
Conclusions	*Literature review found insufficient research evidence to support hypotheses associating high BMI with increased risk for colon cancer. *Research has implicated increased dietary fat intake & sedentary lifestyle as probable independent factors in the development of colon cancer.
Concern	When variables often occur together (i.e. high fat diet, sedentary lifestyle, & obesity) it is tempting to assume that causal relationships are present. Such assumptions are often erroneous.

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The Relationship between Weight and Bone Disorders	
Author	Felson (1996)[16]
Conclusions	*Osteoarthritis results in more than 70% of total knee & hip replacements, leading to significant health care costs. *Literature review shows knee osteoarthritis to be four times more likely for individuals with a BMI of 30 or higher as compared with individuals with BMIs lower than 25. *Additional research in the area of bone health & any relationship to weight is needed.
Concern	*All cross-sectional studies reviewed did not demonstrate the same positive relationship between obesity and osteoarthritis.
Author	Wardlaw (1996)[17]
Conclusions	*Literature review showed that the risk of osteoporosis is decreased for women with BMIs of at least 26-28, & increased for women with BMIs of 22-24. *Additional research in the area of bone health & any relationship to weight is needed.
Concern	*Higher BMI is a potential risk factor for one bone disorder (osteoarthritis), but appears to be protective against another (osteoporosis). *The current evidence does not support citation of increased health risks to the skeletal system as justification for defining increased BMI as a risk to health.

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The Relationship between Weight and Gallbladder Disease	
Authors	Manson, Willett, Stampfer, Colditz, Hunter, Hankinson, Hennekens, & Speizer (1995)[28]
Conclusion	Individuals with higher BMIs have increased incidence of gallbladder disease and/or cholelithiasis.
Concern	The study did not control for weight cycling. Therefore, the effect of weight loss and/or regain cannot be excluded as a reason for the apparent increase in gallbladder disease evident among large individuals.

References

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Literature Supporting the Need to Treat High BMI	
Authors	Kannel, D'Agostino, & Cobb (1996)[22]
Conclusions	*Literature review supports weight reduction for BMIs >22. 6. *Review showed a positive relationship between obesity & hypertension, insulin resistance, & the ratio of total to HDL cholesterol.
Concerns	*Study limitations are not acknowledged & the disparity between "desirable" BMIs & findings showing no significant risk for BMIs <27-30 is troubling. *Selective overemphasis on the role of BMI in predicting health risk.
Authors	Kassirer & Angell (1998)[23], Wolf & Colditz (1996)[24] , NIH (1992)[25], & Borkan, Sparrow, Wisniewski, & Vokonas (1986)[26]
Conclusions	*BMIs >30 affect health & longevity because they are associated with elevated cholesterol, hypertension, & type 2 diabetes. *Excessive weight increases the risk for gallbladder disease, gout, CHD, & cancer & may lead to osteoarthritis of the weight-bearing joints. *Benefits of weight loss for otherwise healthy mildly/moderately heavy people is unknown, but, hyperglycemia, hyperlipidemia, & hypertension are improved by a loss of 10-15% of body weight. *A causal relationship between high BMI & increased morbidity/mortality is accepted with claims that obesity raised health care costs by 6.8% in 1990.
Concerns	*Many studies in the above reviews make no attempt to control the effects of cholesterol levels, diet, activity, or weight cycling. Without evidence refuting a statistically significant role for each of these potentially confounding variables, causal assumptions about the dangers of weight are impossible. *Summarizing the research in the above manner implies that large people are inherently unhealthy due to their weight, while weight loss is possible & leads to lasting improved health, but statistical support for these implications is not provided. *The logical conclusion that health benefits will be short term because most weight loss attempts fail is ignored & the available evidence on the adverse physical, emotional, & social effects of weight loss is not provided.
Literature Questioning the Need to Treat High BMI	
Authors	Kassirer & Angell (1998)[27], Fraser (1997)[28], Gaesser (1997)[29], Robison (1997)[30], Robison, Hoerr, Petersmarck, & Anderson (1995)[31], Troiano, Frongillo, Sobal, & Levitsky (1994)[32] & Garner & Wooley (1991)[33]
Conclusions	*Reevaluation of BMI recommendations is needed. *BMI defined as moderately overweight is not related to increased mortality. *BMI at or below that recommended is associated with increased mortality. *The possibility of long-term weight loss is unproven & evidence that weight loss may be harmful exists.
Concerns	*Additional studies are needed to determine the exact role of weight in health.

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Unit I C: References

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Back to The Relationship Between Weight and Health

Unit 2:

Practices Founded on the Old Paradigm

Unit Objective: Delineate the incompatible nature of old paradigm practices with the selection of effective, safe interventions.

Lesson Objectives:

Upon completion of Lessons 2A through 2D, the learner will be able to:

- **Describe the current rate of weight loss attempts in America.**
- **State four methods used for weight loss.**
- **Describe the concept that old paradigm interventions are a product of culturally-bound, inadequately supported scientific evidence.**
- **List the harmful effects of weight loss and/or attempts at weight loss.**
- **Describe the traditional professional approach to weight loss.**
- **Outline physical activity goals of *Healthy People 2,000*.**
- **State that the current rate of sedentary lifestyle reflects low level participation in leisure-time physical activity.**

NEXT

Unit 2A:

Weight Loss Prevalence & Methods

....."Dieting is so prevalent, and puritanical attitudes about eating are so common, that people have gotten some very restrictive ideas about what is normal and natural in eating" (Ellyn Satter, 1987, p. 69).[1] In fact, dieting has become a way of life for many individuals.

- **15-40% of all Americans are trying to lose weight at any given time.[2,3]**
- **Of adolescents, 44% of females & 15% of males are actively trying to lose weight.[4]**
- **In 1996, 46 million people were dieting.[5]**
- **Most Americans have dieted to lose weight & the most common dieters are:[6,7]**
  - **Caucasian**
  - **People with more than 12 years of education**
  - **Women**
  - **Those with higher socioeconomic status**
  - **Young adults**
- **In response to culturally induced pressure, girls as young as eight have been known to diet.[8]**
- **Alarmingly, many of the Americans who are currently trying to lose weight are not large or (at risk) by any standard.[9]**

What Methods Are Used To Attempt Weight Loss?

- **Counting and restricting calories persists as a primary weight loss approach. Common strategies employed to restrict intake include attempts at:[1,2,3]**
  - **Low calorie (1,000-1,500 Kcal/day) & very low calorie diets (600-800 Kcal/day)**
  - **Counting fat grams and/or calories ingested**
  - **Buying/eating only low-calorie/low-fat foods**
  - **Eating severely limited types of foods**
  - **Replacing foods with liquids/powders**
- **Attempts to enhance these strategies include the use of:**
  - **Regimented exercise plans**
  - **Individual counseling and/or informal or commercial support groups**
  - **Addition of macronutrient substances**
  - **Altered proportions of fat, protein, & carbohydrates in the diet**
  - **Intake of bizarre combinations of foods to enhance metabolism**
- **Attempting to succeed at weight loss may even involve the use of much riskier methods like:**
  - **Using diet pills**
  - **Fasting for more than 24 hours**

- **Surgical procedures i.e. liposuction or gastroplasty**
- **Vomiting after eating and/or ingesting laxatives (the only methods not sanctioned in any form by at least some health care providers)**

.....Lesson B presents why health care providers contribute to the prevalence of weight loss attempts through use of old paradigm interventions. Lesson C & Lesson D discuss how professionals use these interventions for weight loss/exercise. Unit III then explains the problems inherent in the old paradigm and Unit IV provides the rationale/methodology for the new paradigm (a potentially safer & more effective approach for clients with weight related concerns).

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Unit 2A: References

Who is Trying to Lose Weight in the United States?

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Back to: Who is Trying to Lose Weight In The United States?

Unit 2B:

Health Care Providers, Education & Old Paradigm-Based Practice

The Relationship Between Many Health Care Providers and Their Large Clients:

.....Unfortunately, health care professionals are not exempt from the impact of the culturally induced thin ideal in America. Obese individuals are stigmatized in this society and health care providers are often no exception.[1] Consider the following:

- **A review of studies shows that health care providers have negative attitudes toward large patients and are likely to discriminate in practice. [2]**
- **A survey of health professionals found that 84% felt obese people were self-indulgent, 88% assumed eating was to cover up other problems, and 70% assumed that excess weight was caused by underlying emotional disturbance.[3]**
- **Another study showed that health care providers stated that they didn't discriminate, but they did assign negative symptoms more often to obese clients and assumed they possessed poorer mental health than their average weight counterparts.[4]**
- **Additionally, the belief that obese individuals eat more, exercise less, are more emotionally unstable and are less disciplined than others is a widely held professional perception.[5]**

How Does This Relationship Develop?

- **Health care professionals' education promotes the old paradigm which consists primarily of telling clients with weight related concerns to attempt weight loss through restricted intake (dieting) and/or regimented physical activity (exercise).**
- **Such interventions rest primarily on the following three tenets:[1]**
  - **1. Health and happiness only occur when ideal weight is obtained**
    2. People only differ in size because they lack the will power to exercise regularly and restrict intake
    3. Everyone can be thin, happy, and healthy by dieting
- **Old Paradigm concepts that are often taught as indisputable fact despite the lack of sufficient scientific support (See Unit I Lesson C) include:**
  - **Obesity is an independent disease/risk factor in cardiovascular and other diseases**
  - **Dieting/regimented exercise are viable intervention strategies that can "cure" obesity**
- **To review examples of the old paradigm literature used to educate today's health care providers look up "obesity" in any of the following (or almost any other**

available) texts:

- **Bulecheck & McCloskey: Nursing interventions: Essential nursing treatments2**
- **Herfindal & Gourley: Textbook of therapeutics: Drug and disease management[3]**
- **Neinstein: Adolescent health care: A practical guide[4]**
- **Pender: Health promotion in nursing practice[5]**
- **Porth: Pathophysiology: Concepts of altered health states[6]**
- **Stanhope & Lancaster: Community health nursing: Process and practice for promoting health[7]**

..... While alternative views and awareness of contradictory evidence are beginning to appear in educational programs, the old paradigm is still widely accepted by a majority of professors and students alike.

References

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Unit 2B: References

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Back To: Health Care Providers and Old Paradigm-Based Practice

Unit 2C:

Prescribed Weight Loss: An Old Paradigm Intervention

..... Once in independent practice, health care professionals implement the principles that were learned throughout their educational experience. Consider the following:

- **Professional approaches to weight loss based upon the old paradigm usually consist of individual sessions of weight checks and physician encouragement coupled with:**
  - **Referral to a dietitian for nutritional education.**
  - **Consideration of referral to a counselor/ behavioral therapist for assistance in achieving weight loss.[1]**
  - **In addition, providers sometimes recommend specific weight loss methods that may be ineffective and even unsafe.**
- **Problems with the traditional approaches:**
  - **If weight loss is defined as a desired "behavior", then behavioral management may be inappropriate. Because weight loss is an outcome (not a behavior),[2] attempting to reinforce it may inadvertently strengthen unhealthy behaviors like vomiting, fasting, or drug abuse.**
  - **Traditional approaches have been shown to be disagreeable to many patients and largely ineffective as well.[3]**
  - **The ethical foundation and professional compatibility of old paradigm weight loss interventions has been questioned:[4]**

    "It is now widely agreed that obesity treatment is, in general, ineffective. It may be argued moreover, that it is more than ineffective: in many instances it is destructive. It may provide patients with failure experiences, expose them to professionals who hold them in low regard, cause them to see themselves as deviant and flawed, confuse their perceptions of hunger and satiety, and divert their attention away from other problems. Such negative consequences obviously do not occur all of the time or to all people; but they need to be given more serious consideration than they have in the past if we are to do no harm". (Garner & Wooley, 1991, p. 1251)[5]

In Unit III: Lesson A, the beliefs delineated by Garner and Wooley will be discussed in detail as the failures of the old paradigm are presented.

References

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NEXT

Unit 2C: References

Prescribed Weight Loss: An Old Paradigm Intervention

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Back To: Prescribed Weight Loss: An Old Paradigm Intervention

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Unit 2 D:

Sedentary Lifestyles and the Goals of *Healthy People 2000*

- **Approximately 25 percent of adults in the United States do not engage in any leisure-time physical activity (*Healthy People 2000* goal is no more than 15 percent of people age six and older)**
- **Approximately 22 percent of U. S. adults participate in regular, sustained physical activity during leisure-time (*Healthy People 2000* goal is 30 percent)**
- **The prevalence of regular, vigorous physical activity in the United States is 15 percent of those over age 18 (*Healthy People 2000* goal is 20 percent)**

.....Americans are not getting enough leisure-time activity. The reasons that people are not getting enough activity in their lives are complex and multifaceted, and may include the fact that many people are exercising for the wrong reason(s).

.....Of the individuals who believe that physical activity is important, many may believe the overwhelming reason to incorporate activity into one's lifestyle is to change the outward appearance of the body. This misconception is unfortunate, and those who provide health care services should accept the challenge to better educate the public about the many physical and psychological benefits physical activity affords. Health care professionals should take the opportunities presented to them to discuss physical activity with clients in a manner that accounts for the many physical and mental health advances proven to be associated with activity, with a de-emphasis on the changing of outward appearance and weight loss. When weight loss is a primary goal, clients may become discouraged when they fail to lose pounds or when they regain lost weight.

.....The benefits of physical activity and provider recommendations for use with clients will be provided in later lessons.

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Sedentary Lifestyles and the Goals of *Healthy People 2000*

Unit 3:

Rationale for The New Paradigm

Unit Objective: Link the concepts of the new paradigm with pre-existing, internalized intervention strategies.

Lesson Objectives:

Upon completion of Lessons 3A through 3C, the learner will be able to:

- **List the harmful effects of weight loss and/or attempts at weight loss.**
- **Classify weight loss attempts as ineffective for reduced BMI/improved health.**
- **Define the determinants of healthy weight.**
- **Delineate how regular physical activity affects health and well-being.**

NEXT

Unit 3A:

The Failures of The Old Paradigm

"All patients in the study had been treated in this fashion [a traditional old paradigm approach] and all had failed the regimen"[1]

Do patients fail weight loss regimens or do these regimens fail patients?

..... The widely variant definitions used for the concepts of diet, dieting, weight loss, and maintenance create difficulty in studying the efficacy of weight loss practices. Still, given the numbers of Americans trying to lose weight and their considerable financial investments, the lack of well-designed, long-term clinical trials evaluating various methods for voluntary weight loss is disturbing.[2] The available data is quite discouraging. The following links summarize the literature, showing that dieting, drugs, and surgery are not safe or effective weight loss practices. Further, it will be shown that when weight loss is rarely achieved, it is unlikely to improve, and may actually cause increased health risk either independently or secondary to weight cycling.

..... Before initiating or continuing use of old paradigm interventions, every health care provider must ask the following questions. Please review the following links/related references and use them as part of your foundation for evidenced based treatment decisions:

- Why is Weight Loss a Priority for So Many Clients?
- Are Weight Loss Attempts Effective?
- Is Attempting Weight Loss Safe?
- Does Weight Loss Actually Improve Health?
- What Are the Risks of Weight Cycling?
- Why is a New Paradigm necessary?

References

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Unit 3A:

Why Is Weight Loss a Priority for So Many Clients?

.....It is not surprising that so many individuals are trying to lose weight and that health care providers feel compelled to help them. Consider the following:

- **Americans have come to place extraordinary value on extreme thinness in response to the complex interaction of cultural beliefs, the media's coverage of weight related issues, and the medical, fashion, fitness, and diet industries' agendas.[1]**
  - **Many Americans characterize fat people as out of control, gluttonous, passive, failures.[2]**
  - **Large women in particular are seen as unattractive and responsible for their appearance.[3]**
  - **The need to lose weight is so strongly ingrained, that Americans are willing to invest approximately 30 billion dollars annually in the weight loss industry.[4,5]**
- **Assimilation of the thin ideal is the foundation for old paradigm thinking. It starts in childhood, leads to perpetuation of weightism (fear of fat and prejudice against large individuals), and progresses until a majority of individuals are acutely aware of the need to conform to socially defined weight related ideals.**
  - **In one survey, 25% of high school females & 20% of women thought they were the right weight but still reported trying to lose weight to avoid fatness.[6]**
- **The major reasons frequently cited in a national survey for dieting to lose weight included concerns about current/future health, fitness, and appearance,[7] but dieting rationales differed by gender, current BMI, and culturally generated beliefs.[8]**
  - **A majority of the men reported dieting to improve overall health/fitness**
  - **Most women reported trying to improve appearance and/or fitness**
  - **Individuals with BMIs <26 were likely to cite fitness/appearance as reasons for dieting.**
  - **Individuals with BMIs >35 were likely to cite health concerns as a primary reason for attempting weight loss.**

References

Back to Unit 3 A: The Failures of The Old Paradigm

Unit 3A:

Are Weight Loss Attempts Effective?

95% percent of all weight loss attempts fail:

- **Successful weight loss practices would be evidenced by maintenance of a stable or reduced weight over time.[1]**
- **Weight loss efforts can lead to initial losses of more than 10% of initial body weight, but there is a strong tendency to regain the weight:[2,3,4]**
- **Up to two thirds of lost weight is usually regained within one year.**
- **Within five years, 95% of dieters will have regained all of their weight .**
- **Some will actually be heavier then when they started.**
- **The failure of weight loss practices is exemplified by steadily increasing weights within American society despite the prevalence of dieting. From 1976-1991, mean weights increased by 3.6 kilograms, while mean heights increased less than 1 centimeter for individuals 20-74 years of age.[5,6]**
- **Hypothesis: Human beings have evolved to maintain genetically determined weights by participation in a physically active lifestyle coupled with ingestion of a low fat diet. Relatively recent societal changes have led to increasing participation in sedentary lifestyles coupled with increased fat intake. These changes have caused genetically determined set-point weights to be over ridden.[7]**
- **Today's weight loss methods cannot alter thousands of years of evolution.**
- **The real issues surrounding weight are being missed: "The 'blame' for the obesity problem and for other 'diseases of civilization' must be placed squarely on the shoulders of a culture that promotes sedentary living, high-fat eating, and, at the same time (particularly for women), tremendous psychological and social pressure to be thin "(p. 423).[8]**

References

Back to Unit 3 A: The Failures of The Old Paradigm

Unit 3A:

Is Attempting Weight Loss Safe?

- **Further analysis of existing data sets and survival studies of persons losing weight voluntarily are urgently needed because it is difficult to distinguish intentional weight loss during healthy states from that associated with illness, psychosocial distress, or other reasons. Still, *most epidemiological studies suggest that weight loss is associated with increased mortality even though controversy as to the degree of risk is present.*[1,2,3]**
- **Weight loss attempts can lead to a variety of physical, psychological, and social risks.[4]**

The Physical Risks of Weight Loss

- **Weight loss may be especially dangerous for lean individuals as they are more likely to lose a greater proportion of lean body mass than larger persons.[5]**
- **Low Calorie Diets and Very Low Calorie Diets are particularly dangerous.[6,7]**
  - **Both diets may produce adverse side effects including:**

fatigue	electrolyte imbalance	acute gallbladder disease
hair loss	low serum albumin	gallstone formation
dizziness	altered metabolism	excessive loss of lean body mass
cardiac arrhythmias	death	

  - **The risks of these effects increase if unsafe practices such as fasting, intake of protein liquid supplements, self-induced vomiting, or laxatives are also employed.**

- **Surgical procedures, although rising in popularity, can also be very high risk.**
  - **These procedures are not supported by adequate clinical trials as appropriate treatment for obesity.[8]**
  - **Disruption of stomach function as a result of these procedures can adversely affect the following systems:[9]**

gastrointestinal	integumentary	skeletal
renal	hepatic	immune
endocrine	nervous	sensory

- **Various pharmacological agents have been employed as primary or adjunct treatment in weight loss regimens[10] and are not without risk.**
  - **The potential for irreversible pulmonary hypertension secondary to Dexfenfluramine use is well documented.**
  - **The FDA has recommended voluntary withdrawal of both Fenfluramine and**

Dexfenfluramine from the market due to the increased prevalence of valvular heart disease among individuals using a combination of Phentermine and Fenfluramine.

The Psychological Risks of Weight Loss

- **Caloric restriction may be a primary independent factor leading to significant psychological distress as evidenced by documented symptoms including:[11,12]**

irritability	**food/eating obsession**
distractibility	**compulsion to binge**
depression	**increased emotional responsiveness**

- **Repeated failures experienced secondary to unsuccessful weight loss attempts is also a clear psychological stressor and often results in guilt and self-hatred.**
  - **Large people are likely to share common prejudices about themselves including that they are lazy, undisciplined, and indulgent.[13]**
  - **Unsuccessful dieting may lead to more psychological distress than not dieting at all.[14]**
- **Eating disorders or disordered eating may develop in susceptible individuals engaging in weight loss practices.[15,16,17]**
  - **Dieting women may be at risk for binge-eating without vomiting and purging.[18]**
  - **Dieting leads to ignored internal cues for hunger and satiety, inability to identify fullness, and subsequent overeating/bingeing when voluntary dietary restriction is abandoned.[19]**
  - **Adults conflicted/troubled by eating pass along the tendency for disordered eating to their children.[20]**
  - **Each generation has witnessed the onset of body image disturbance and restrained eating at earlier ages.[21]**

The Social Risks of Weight Loss

- **While it is true that the mean BMI for Americans is rising, the standard by which individuals consider themselves too heavy is steadily decreasing.**
  - **45% of Americans considered themselves over weight in 1990.[22]**
  - **The percentage of individuals who considered themselves under weight, but were still trying to lose weight more than quadrupled between 1985-1990.**
  - **In educational institutions across America, average weight girls, and to a lesser extent boys, believe they are obese and disgusting[23] and spend considerable time worrying about and attempting to change their bodies that would be better spent on educational, familial, and social activities.**
- **In America, fat people are taught to feel guilty and blame themselves for the failures of weight loss programs, and to expect and accept rejection, mistreatment and discrimination regarding their weight.[24,25]**
- **Individuals suffering from the emotional and physical damage of restrained eating, weight cycling, and/or the stress of being larger than ideal within a fat phobic culture may experience decreased individual productivity.**

- **The financial commitment to weight loss is alarming.**
  - **30-50 billion dollars is invested in the weight loss industry annually diverting a huge portion of this country's gross national product.**
  - **Since 95% of all weight loss attempts fail, the diet industry appears to be a very shaky investment.**

References

Back to Unit 3 A: The Failures of The Old Paradigm

Unit 3A:

Does Weight Loss Actually Improve Health?

.....Short term health benefits secondary to weight loss have been reported. However, very few people have lost weight and kept it off. No research studies are available to show the true benefits of long-term weight loss.[1]

Short-term benefits of weight loss:

- **In one study patients with non-insulin dependent diabetes demonstrated lower risk for atherosclerosis through reduction of hypertension, hyperinsulinemia, and hyperlipidemia when placed on a 26 day program.[2]**
- **Studies have also shown that weight loss can prevent hypertension and possibly diabetes mellitus, improve serum glucose control in diabetic clients, decrease blood pressure for hypertensive patients, and improve lipoprotein levels.[3]**

Since 95% of all individuals regain any lost weight within five years, it remains to be determined whether short-term benefits have any lasting effect on health.[4]

References

Back to Unit 3 A: The Failures of The Old Paradigm

Unit 3A:

What Are The Risks Of Weight Cycling?

- **Pressure to diet and striving for unrealistic goal weights may lead women to use ineffective, potentially dangerous weight control methods and result in weight cycling as well. One study obtained the following results:[1]**
  - **Women who repeatedly regained weight reported consuming fewer calories, yet had higher BMIs and greater body dissatisfaction than did weight stable dieters or non-dieters.**
  - **The weight cycling women used more dieting methods, and more questionable methods including: Slim Fast, fasting/starving, smoking, vomiting, and taking diet pills, laxatives, or diuretics.**
  - **Most of these women perceived themselves as too big even though only 14% met the study's definition for over weight.**
- **Studies that sort out the role of independent variables within the complex weight cycling process and provide solid evidence of causal relationships may be impossible to complete.[2]**
- **Weight cycling is the center of considerable scientific debate and the related literature includes both positive and negative results.**
  - **Preliminary animal studies point to the evidence of health risk when weight is not stable.[3]**
  - **In some studies weight cycling was associated with increased cardiovascular risk and all-cause mortality.[4,5]**
- **There is evidence that dieting, if followed by return to initial weight levels, results in lower metabolic rates and inability to listen to internal satiety signals.**
  - **Subsequent weight loss may then be more difficult while weight gain becomes easier.**
  - **Therefore, dieting may lead to increasing weight for some individuals.[6,7,8,9]**
- **Weight cycling may adversely affect psychological health as well.**
  - **It has been shown that weight stability regardless of actual BMI is associated with greater psychological well-being than weight change.[10]**
  - **Weight cycling has also been associated with increased depression and lowered self-esteem.[11,12]**
  - **In one study, weight instability or cycling was positively associated with increased mood deterioration even though initial weight loss was significantly associated with increased self-confidence and elevated mood.[13]**

Weight cycling appears to affect energy metabolism, may result in faster regaining of weight, and may also have adverse psychological and physical effects. [14]

References

Back to Unit 3 A: The Failures of The Old Paradigm

Unit 3A:

Why Is a New Paradigm Necessary?

- **Inherited, environmental, cultural, socioeconomic, and psychological factors form the complex foundation for determination of weight.**
  Unit I Lesson A (Historical Evolution of the Thin Ideal)
- **There is insufficient evidence to claim that obesity is either a disease or a clear causal factor in other diseases that lead to increased morbidity/mortality for Americans.**
  Unit I Lesson C (Evidence Related To Weight and Health)
- **Because weight gain and/or loss is not a simple problem of will power, but a complex interaction between multiple factors, no effective method for achieving long term weight loss exists.**
  Unit III Lesson A (Efficacy)
- **The research based evidence shows that weight loss DOES NOT serve to improve long-term health.**
  Unit III Lesson A (Health Improvement)
- **There is considerable evidence to demonstrate that weight loss and its primary outcome, weight cycling, are dangerous from a variety of aspects.**
  Unit III Lesson A (Safety)

The preceding statements are a summary of conclusions based on the information provided in this web site. Please review the related pages for more detailed discussions complete with references.

References

Back to Unit 3 A: The Failures of The Old Paradigm

Unit 3A: References

The Failures of The Old Paradigm of Weight Management:

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Unit 3B:

Healthy Weight

..... **Lesson A demonstrated that traditional approaches to conceptualizing weight and treating weight-related concerns have not led to improved health or decreased the rate of weight gain within American society. The hypothesis that large people are inherently unhealthy while small people are inherently healthy is NOT supported. Current conceptualization of healthy or ideal weight as defined by the height/weight tables must be abandoned. However, delineating the failures of old paradigm thinking is not designed to suggest that a healthy weight does not exist. The foundation for a new weight paradigm rests on the following tenets of *healthy* weight:**

- **Each individual has a genetically determined "set-point" for weight that one's body vigorously defends in the presence of *healthy, unrestrained eating* and a *physically active lifestyle.***
- **Regardless of the actual weight maintained, the scientifically supported independent risk factors for increased morbidity and mortality (insulin resistance, serum glucose, blood pressure, and serum lipids) improve when one engages in a physically active lifestyle and healthy, unrestrained eating.**

..... **Therefore the focus for interventions designed to assist clients with weight-related concerns must shift from a focus on attainment of a specific weight to a primary focus on increasing physical activity and facilitating transition to healthier eating styles. Because some individuals' genetically determined weights fall into categories that are currently defined as "obese" by both medical and social standards, helping clients with Body Image/Size Acceptance concerns is of paramount importance as well. Unit IV provides specific information designed to facilitate implementation of new paradigm-based alternative approaches for caring for clients with weight-related concerns.**

**The preceding statements are a summary of a comprehensive review of weight-related research and literature. The primary influences include:

Fraser, L. (1997). Losing it: America's obsession with weight and the industry that feeds on it. New York: Dutton.

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NEXT

Unit 3C:

Benefits of Physical Activity: Psychological and Physical

..... Health care providers should be sure to educate clients about all of the benefits physical activity has to offer. Many clients view "exercise" as a means to weight loss, and have only incorporated physical activity at times when they were trying to lose weight. This could lead to an unfavorable opinion of activity if the client's goal was sustained weight loss and this did not occur, or if an association is made with stressful and uncomfortable dieting. Incorporating goals that focus on the overall health and well-being effects of physical activity can be helpful to clients. Physical activity can be looked upon as nourishment for the body, mind, and soul, just as food can be.

THE BENEFITS:

Subjective feelings of:

- **Better overall health**
- **More energy**
- **Improved endurance**
- **More flexibility**
- **Enhanced sleep**
- **Improved family relations**
- **A better sex life**
- **Less loneliness**
- **Better social life**
- **Improved mood**
- **More self-confidence**
- **Enhanced memory and concentration**
- **Greater overall life satisfaction**

Objective benefits:

- **Improved mood**
- **Positive influence on other health behaviors**
- **Improved sense of well-being (improvements in depression, anxiety states, sense of wellness)**
- **More vigor**
- **More energy to carry out activities**
- **Less chronic fatigue**
- **Improved health-related quality of life (dimensions of cognitive, social, physical, and emotional functioning; personal productivity, and intimacy)**
- **Improved fitness**

- **Increased lifespan**
- **Decreased risk for cardiovascular disease mortality (especially related to CHD)**
- **Delayed development of hypertension**
- **Reduces blood pressure in those with hypertension**
- **Increased HDL-C**
- **Decreased triglycerides, decreased LDL-C**
- **Increased lipoprotein lipase activity (an enzyme that removes cholesterol and fatty acids from the blood)**
- **Lowered risk and incidence of NIDDM; better control of blood sugar**
- **Lowered risk of osteoporosis**
- **Decreased risk for some cancers, especially colon cancer**
- **Reduction in arthritis-related pain and ADL limitation**

Studies show that many of the benefits of physical activity occur even when there is no change in body weight, such as:

- **Mental and emotional advantages**
- **Favorable lipid changes**
- **Helping to offset hypertension and diabetes**
- **Lower death rates (regardless of BMI or changes in BMI)**

References

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NEXT

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Back To: Benefits of Physical Activity

Unit 4:

Practices Founded on The New Paradigm

Unit Objective: Consider interventions consistent with new paradigm principles as viable choices when confronted with weight-related issues.

Lesson Objectives:

Upon completion of Lessons 4A through 4D, the learner will be able to:

- **Identify setting-specific characteristics that reflect size acceptance.**
- **Define body image and the factors that influence body image.**
- **Discriminate between interventions that promote and those that inhibit healthy body image and size acceptance.**
- **Identify affirmations that can be used by clients to improve body image.**
- **Define the concept of healthy, unrestrained eating.**
- **Generate interventions to promote healthy, unrestrained eating.**
- **Compile strategies to empower clients in choosing enjoyable, regular physical activity.**

References

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Unit 4A:

Size-Friendly Health Care Practice

Caring for clients of all sizes in an open and accepting manner is of paramount importance in the provision of effective primary health care. However, implementing specific New Paradigm strategies requires that health care providers:

1. Understand and accept that traditional old paradigm based approaches are often ineffective and unsafe as discussed in Unit I and Unit II.

2. Accept that new paradigm principles provide an alternative approach that may be safer, logical, and more effective (future research is needed) as discussed in Unit III.

3. Establish a size-accepting environment in which to provide health care.

4. Know when and how to implement the New Paradigm Approach for Assisting Clients with Weight-Related Concerns.

5. Adopt interventions which help individuals:

A. With improved body image/size acceptance (Lesson B).

B. Establish/restore healthy, unrestrained eating (Lesson C).

C. Increase physical activity (Lesson D).

Implementing the New Paradigm Approach for Assisting Clients with Weight-Related Concerns

Establishing a Size-Friendly Health Care Environment

Unit 4A:

Implementing the New Paradigm Approach for Assisting Clients with Weight-Related Concerns

Not all clients or providers are ready for a new approach when dealing with weight-related concerns. Therefore, utilization of appropriate assessment, diagnosis, and referral are critical to new paradigm implementation:

- **Clients suffering from a diagnosed eating disorder or entrenched "disordered eating" need assistance from mental health professionals and nutritionists (preferably those currently utilizing new paradigm principles).**
- **Primary health care providers MUST be aware of new paradigm resources within their community and utilize them when ever necessary (look to this site in the future for a list of size-friendly providers in the mid-Michigan area).**
- **Providers must empower clients by instructing them to access customer service representatives for third party payors and ask direct questions about covered services. Further, clients can be encourage to appeal through appropriate channels when size-friendly services are denied.**
- **An appropriately implemented new paradigm approach is interwoven throughout the client encounter. Specific suggestions for implementation during each phase of a client encounter include the following:**

Assessment

- **Make no size-related assumptions about client needs (remember: small clients may have weight-related concerns, while large clients may not).**
- **Address the subjects of body image, eating, and physical activity in the context of health promotion screening. Avoid linking this assessment to body weight.**
- **Use open-ended questions/statements such as:**
  - **"How do you feel about your physical appearance?"**
  - **"How physically active are you?"**
  - **"Tell me about your eating patterns."**
  - **"Describe what the terms hunger, appetite, and satiety mean to you."**
  - **"What, if anything, concerns you about your eating patterns, physical activity, and/or appearance?"**
  - **"Would you like assistance with any of these concerns?"**

Diagnosis

- **Avoid the use of "obesity" as a medical diagnosis because it provides clients with a socially negative label and does not represent one clearly accepted set of criteria.**
- **Consider alternative diagnoses addressing actual (& correctable) pathology such**

as:

- Alteration in nutrition: chronic restrained eating
- Sedentary lifestyle
- Body image disturbance

Goals

- Ask the client to prioritize weight-related concerns.
- Actively involve the client in the identification of mutually desired goals.

Plan

- Based directly on the mutually determined goals
- Client empowerment is the primary strategy with the client deciding on the plan's direction:
  - Contemplation of change may be the client's only initial action.
  - Working on body image, eating patterns, physical activity, or any combination thereof may be selected as the initial course of action.
  - The goal-driven plan should include specific interventions for:
    - Improved body image/size acceptance (Unit IV Lesson B).
    - Healthy, unrestrained eating (Unit IV Lesson C).
    - Promoting physical activity (Unit IV Lesson D).
  - · Written client information can be used to reinforce learning (In the future look to Unit IV Lesson E : "New Paradigm-based Client Information" for handouts you may copy and give to clients).

Evaluation

- Re-assessment is necessary at each visit to determine readiness to accept/continue the new paradigm approach.

Ongoing evaluation of progress toward goal attainment with revision of the plan as needed is critical.

Back to Unit 4 A: Size-Friendly Health Care Practice

Unit 4A:

Establishing a Size-Friendly Health Care Environment

Creating a size-friendly environment means considering each client's total experience within your setting.

Arrival:

- **All staff should greet clients in an approving, helpful, and courteous manner.**
- **Comments/humor promoting size discrimination must be strictly prohibited.**

Waiting:

- **Décor (pictures, statues, etc) should NOT emulate the thin ideal.**
- **Reading materials should appeal to a wide variety of interests.**
- **Avoid choosing a preponderance of materials that promote the thin ideal.**
- **Include materials that offer an alternative view of desirable images such as Radiance or BBW.**
- **Many of the chairs should be sturdy, armless, and big enough to support large clients.**

The Examination Room:

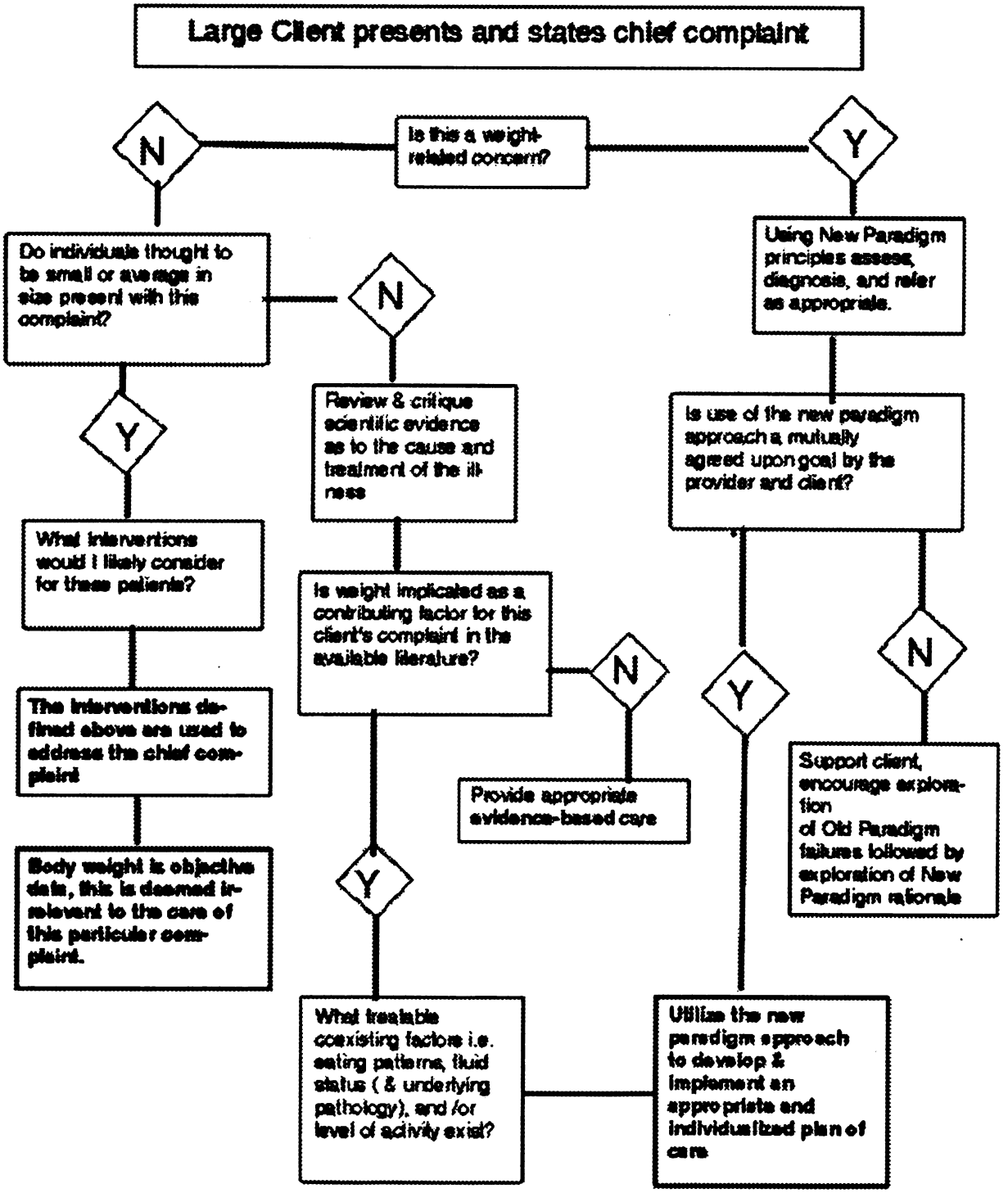
- **Chairs within exam rooms should also be big, armless, and sturdy.**
- **The exam table should be secured to prevent tipping and big enough to position large clients comfortably throughout their exam.**
- **Gowns and drapes should be large enough to provide both comfort and privacy.**
- **Accurately sized medical equipment including blood pressure cuffs, needles, and tourniquets must be available in order to obtain accurate readings and specimens.**

The Encounter:

- **Providers must remember to consider body weight as only one piece of information within the vast data base that exists for each client.**
- **One's body weight in and of itself implies little-if anything about health status .**
- **When large clients seek health care providers might consider using this size-friendly algorithm.**

Next

Algorithm to Assist with Establishment of a Size-Friendly Health Care Environment



Back to: Establishing a Size-Friendly Health Care Environment

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Unit 4B:

Body Image

..... The extreme message that people are to emulate the culturally stereotyped thin ideal is a threat to women's body image and self-esteem. "Who am I and how do I make a difference in the world?" has been replaced with "What should I look like and what image should I project?" (Kearney-Cooke & Striegel-Moore, 1992, p. 99).

..... Body image is one component of self-esteem that is the mind's representation of the body, mediated by multiple internal and external influences, with the ability to influence thoughts, perceptions, and behaviors. A negative body image is understood to reflect a perception of the body that may or may not be consistent with reality, but more importantly, has negative emotional implications (and probable negative physical implications) for an individual.

..... The development of negative body image is related to America's thin ideal body type, the attempts to emulate this ideal, and society's intense fear of fat. Unfortunately, for many Americans the result is refusal to accept one's size and countless attempts to change the appearance of the body through usually ineffective and often harmful methods.

- **Beginning in adolescence, body dissatisfaction in females is related to perceived weight and body measurements.**
- **Body satisfaction declines through adolescence, and continues through adulthood - particularly for women.**
- **Pressure to conform to the thin ideal is exerted via the media, health care professionals, and critical family members (particularly parents who fear their children will become fat adults).**
- **Negative body image is associated with behaviors that are potentially harmful to health such as dieting and exercise addiction.**
- **Health care professionals can help clients with weight-related issues understand the history of the thin ideal and the extreme pressures that society places on individuals to conform to this body type. Importantly, practitioners can also avoid contributing to these pressures by employing a caring, non-judgmental attitude and by focusing interventions on overall physical, emotional, and spiritual health instead of body size. Helping clients learn to make healthy choices and develop a sense of acceptance, love, and respect for themselves is extremely important.**

..... In the process of helping parents to become more accepting of a variety of body sizes and shapes, you may also be helping their children. Many of the pressures placed on children and adolescents come from family members who think they also have to emulate the thin ideal.

..... Employing measures to help clients become more accepting of themselves is the beginning to the utilization of New Paradigm principles. Size Acceptance is addressed next page.(Click Here)

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Unit 4B:

Size Acceptance

..... A client with weight-related concerns must develop personal size acceptance to properly begin to utilize the principles of the new paradigm, namely healthy, unrestrained eating and physical activity with goals other than weight loss. If a client still wants to lose weight, he/she will have a difficult time abandoning dieting and the goal of weight loss through physical activity. Importantly, feelings of failure are probable given the poor success of sustained weight loss. Practitioners can best help their clients by supporting them in efforts to improve overall health and sense of well-being, and by avoiding judgment based on body size.

..... Kratina, King, and Hayes (1996) discuss the importance of self-acceptance in their book *Moving Away from Diets: New Ways to Heal Eating Problems and Eating Resistance.* Trusting internal signals and feeling good about one's body is important for four main reasons:

1. **With self-acceptance the mind and body can really connect, which is a critical component of overall health.**
2. **It is difficult for clients with body dissatisfaction/body hatred to take good care of themselves.**
3. **Clients need to care about themselves to want what is best for their health, and self-care is necessary for optimal health and well-being.**
4. **Without a sense of peace, for example when clients are busy degrading themselves for their size/habits, making healthy choices is more difficult.**

..... Kratina, King, and Hayes suggest four steps (from B.A. Bruno) for individuals to work through in a process of empowerment. (The authors give details for each step on pages 22 through 26 of their handbook. In addition, some handouts that may be reproduced are included.)

1. **Recognize the myths about fat and the realities about diets.**
2. **Claim responsibility for health and begin to listen to internal messages.**
3. **Redefine personal goals.**
4. **Get involved.**

References

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NEXT

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Size Acceptance

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Unit 4C:

Healthy Unrestrained Eating

Healthy unrestrained eating is NOT synonymous with "I can eat what ever I want whenever I want and still be healthy".

Consider the following definitions of each concept within this term:

- **Healthy: refers to the regular choice of a wide variety of foods with an emphasis on a well-balanced nutritious diet such as the one portrayed by The Food Guide Pyramid.**
- **Unrestrained: refers to the legalization of all foods. No food is "good" or "bad". All foods contain various combinations of calories and nutrients and may be consumed in moderation as part of a healthy diet.**
- **Eating: As consistent with Webster's dictionary, means "to place (food) in the mouth, chew, and swallow.**

..... Many Americans have restrained their intake in an attempt to conform to society's unrealistic thin ideal. In response, they have lost awareness of their own physical, emotional, and spiritual cues related to hunger/satiety. When it comes to food, the needs of the body, mind, and spirit have become distrusted enemies that need to be quelled at all costs. The goal for health care providers is to maintain their clients' internal ability to appropriately regulate food intake and/or to restore this ability when it has been destroyed by chronic dietary restraint (dieting).

Interventions for Establishing/Restoring Healthy, Unrestrained Eating:

- **Increasing professional knowledge base is essential. In addition to this web site, two particularly useful references are:**
  - **Satter, E. M. (1987). *How to get your kid to eat . . . but not too much.* Palo Alto, CA: Bull Publishing.**
  - **Kratina, K., King, N., & Hayes, D. (1996). *Moving away from diets: New ways to heal eating problems & exercise resistance.* Lake Dallas, TX: Helm Seminars, Publishing.**
- **Primary care interventions may include but are not limited to:**
  - **Educating clients about The Food Guide Pyramid and what constitutes nutritious intake.**
    - **Encourage gradual changes with additions implemented before subtractions. i.e. increase intake of fruits/vegetables by 1 serving per day each week until the recommended number of servings is achieved, then decrease the servings of fat/sugars by 1 serving per day each week.**
    - **Discuss the concept that one likes what one eats not eats what one likes. i.e. most people chose whole milk until they become accustomed to skim, then dislike whole if it is reintroduced. Suggest that the same thing could happen with the transition to a lower fat menu.**

    - **Empower the client with knowledge and accept that they must chose their own path when it comes to eating.**
- **Helping clients understand normal eating (synonymous with healthy unrestrained eating) as defined by Ellyn Satter in her book: *How To Get Your Kid To Eat...But Not Too Much.***
    - **Assist clients to reestablish their ability to recognize internal cues for hunger/satiety through self-awareness and record keeping.**
    - **Legalize all foods, thus helping clients to enjoy eating without the intrusion of guilt, fear, or other negative emotions that the client relates to the eating experience.**
    - **Ensure that healthy eating is only one part of health promotion that encompasses the whole of human existence including the triad of body, mind, and spirit.**
- **Avoidance of condemning weight gain (directly or indirectly) and/or praising weight loss.**
    - **Do not weigh clients unless it is clearly clinically indicated i.e. to assist with determination of hydration status or for calculation of an accurate drug dosage.**
    - **Focus on other health parameters including feelings of well-being, energy level, blood pressure, serum lipids, insulin resistance, and serum glucose.**
- **Discussing the dangers of dieting .**
- **Providing concrete reasons NOT to diet while offering the alternative of healthy, unrestrained eating (Kratina, King, & Hayes provide a list that can be duplicated for clients).**
- **Assisting parents to maintain healthy, unrestrained eating within their children beginning at birth and to restore healthy, unrestrained eating in children of any age as soon as possible (Satter is an excellent resource for parents when coupled with appropriate referrals when feeding problems are suspected to be symptoms of family dysfunction).**
- **Helping clients avoid perpetuation of American Society's fear of fat by encouraging:**
    - **Avoidance of media (like popular magazines) that constantly portrays excessive thinness as the desired norm.**
    - **Increased awareness of personal feelings/perceptions related to body size acceptance.**
    - **Avoidance of personal promotion of fat discrimination.**

****The preceding is based primarily on the works of Satter and Kratina, King, and Hayes (listed above) and from content presented in "Non Dieting Management of Weight" a graduate level course at Michigan State University taught by Esther Park and Jon Robison summer semester, 1997.**

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Unit 4C:

Normal Eating
(Healthy, Unrestrained Eating)

As defined by Ellyn Satter (1987) in *How To Get Your Kid To Eat...But Not Too Much* *p. 69:*

"Normal eating is being able to eat when you are hungry and continue eating until you are satisfied. It is being able to choose food you like and eat it and truly get enough of it-not just stop eating because you think you should. Normal eating is being able to use some moderate constraint in your food selection to get the right food, but not being so restrictive that you miss out on pleasurable foods. Normal eating is giving yourself permission to eat sometimes because you are happy, sad or bored, or just because it feels good. Normal eating is three meals a day, most of the time, but it can also be choosing to munch along. It is leaving some cookies on the plate because you know you can have some again tomorrow, or it is eating more now because they taste so wonderful when they are fresh. Normal eating is overeating at times: feeling stuffed and uncomfortable. It is also undereating at times and wishing you had more. Normal eating is trusting your body to make up for your mistakes in eating. Normal eating takes up some of your time and attention, but keeps its place as only one important area of your life.

In short, normal eating is flexible. It varies in response to your emotions, your schedule, your hunger, and your proximity to food."

Back to Lesson C

Unit 4D:

Promoting Physical Activity

..... The following will explore suggestions for client assessment, strategies for promotion of enjoyable activity, and potential forms of physical activity (including many different kinds of moderate-intensity, enjoyable body movement that may have previously been excluded from suggestions for beneficial activity).

CLIENT ASSESSMENT

..... Evaluation of physical activity is a priority component of a total health assessment in the primary care setting. The topic may best be introduced in the context of lifestyle and what a client does "to take care of" him/herself. Avoidance of relating a patient's body weight directly to activity patterns can help set the stage for promotion of joyful activity outside of the context of weight/weight change. Taken in the context of total health and well-being, the discussion can be used to explore the many different benefits of regular physical activity (Unit III Lesson C) and set more meaningful and realistic goals without a body weight focus.

..... Will, Demko & George (1996, p. 580) suggest the following guidelines to assess a client's readiness for physical activity:

1. Does the patient have knowledge of the benefits of physical activity? (More Information)
2. Does the client believe that changing his/her activity level is needed? (More Information)
3. Has the client ever tried to incorporate or increase activity level in the past? How do past experiences with this affect current thoughts about increasing activity? (More Information)
4. Does the client believe he/she can increase physical activity now? (More Information)
5. What are the client's perceived problems/barriers with making such a change? (More Information)

..... In addition, it may be beneficial to find out what the client believes your role is as a practitioner, and how he/she believes you will best work together. The client could benefit from knowing how you perceive your role and that you plan to share information that can help the client make his/her own choices for better health (empowerment approach).

..... Rather than giving the same information and recommendations to all clients regardless of where they are in a process of changing activity patterns, each client should be treated as an individual. This includes consideration of the whole assessment (as above) and giving people the information they need to become better decision-makers for their own health.

..... If a client is ready to increase physical activity, proper risk assessment with

appropriate screening is recommended before the client begins.

ACTIVITY PROMOTION (based on assessment)

..... Abandoning the more traditional approach to promoting health may be necessary. This means leaving behind a disease focus that concentrates on risk factors, client fear, and principles of behavior modification to motivate patients to exercise. The key to health promotion (and thus, increased physical activity) may lie in an empowerment approach.

In reference to empowerment:

"In a helping relationship it is a process of enabling people to choose to take control over and make decisions about their lives. It is also a process which values all those involved." (Rodwell, 1996; p. 309)

..... The health professional's role is that of a facilitator and resource person. Through improved self-awareness, self-growth, and utilization of resources, the client will become more able to assert control over factors that affect his/her health. As both a process and an outcome, empowerment has the ability to result in greater energy and sense of well-being.

SUGGESTIONS FOR PHYSICAL ACTIVITY

..... Having knowledge of the community in which you practice can be very helpful in working with clients. Just as you are familiar with referral sources for other health professionals you can utilize, try to be familiar with what your community has to offer to help people increase physical activity.

..... The intensity level of the physical activities you suggest to a client will depend on the client's physical abilities, fitness level, goals, and preference. Following are some suggestions across a variety of intensity levels.

INDOOR ACTIVITIES

Relatively inexpensive:

- **Stair climbing (at home and at work)**
- **Walking (schools, malls, during lunch breaks; alone or with partner/child)**
- **Bowling**
- **Housework**
- **Exercise videos (rent or buy)**
- **Resistance training (light hand weights, resistance bands)**
- **Playing with children/caring for children**
- **Organized classes through community education/clubs that do not require membership (exercise classes, dance classes alone or with partner, martial arts)**
- **Team sports (basketball, volleyball, racquetball, etc.)**

More expensive:

- **In-home exercise equipment (bike, stair climber, cross-country ski, riders; buying second-hand can save money)**
- **Organized activities at club where membership is obtained (racquetball, basketball, volleyball, aerobic dance, swimming/aqua classes, resistance training, etc...)**

OUTDOOR ACTIVITIES

Relatively inexpensive:

- **Walking (sidewalks, trails, beach; walk with kids, dog)**
- **jogging**
- **Skating (ice, in-line, roller)**
- **Gardening/yard work**
- **Shoveling snow**
- **Team sports (tennis, softball, soccer, basketball)**
- **Playing with/sledding with kids, pulling the kids in a sled**
- **Parking farther away from destination at work, shopping**
- **Playing on the beach, swimming, beach sports**

More expensive:

- **Golf (on a course, using driving range)**
- **Biking (could rent a bike to try it out, or rent one occasionally for a change without the expense of purchasing a bike)**
- **Cross country skiing (purchase used equipment or rent)**
- **Canoeing**

If you have any other suggestions, please feel free to send e-mail to the address on the "Welcome" page of this site.

References

E-Mail Angie

NEXT

Unit 4D:

Promoting Physical Activity: Assessing Client Knowledge Of Physical Activity Benefits

Knowledge of the potential benefits of physical activity may affect a client's understanding of the need for changing this aspect of lifestyle. For example, if a person perceives that the main reason to be active is to lose weight (and it has not worked for this individual), they may benefit from knowing the many different advantages outside of changing one's appearance.

Suggested assessment questions:

- **"Are you familiar with the good things physical activity can do for you?"**

  "Yes" - discuss/validate with client. If necessary, ask the client if he/she would like to know of more.

  "No" - ask the client if he/she would like to know more.

  (Client information handouts will be available at a future date.)

- **"I have a printed list of the benefits of physical activity that I can give you. Would you like to see it?" (Available at a future date.)**

  Discuss and answer questions appropriately.

Review Unit III Lesson C Benefits of Physical Activity

Back to:Unit 4 D: Promoting Physical Activity

Unit 4D:

Promoting Physical Activity: Does the Client Believe There is a Need for Change?

As discussed previously, knowledge of the many benefits of physical activity may contribute to a client's understanding of the need for change. Again, a belief that change (increased activity) means weight loss can contribute to feelings of failure and an overall negative outlook on regular physical activity.

In addition to understanding the potential benefits of physical activity, does the client have knowledge of the risks of a sedentary lifestyle? Without using fear as a motivator for a client, gently relate how increasing activity can improve the individual patient's clinical picture/health risks.

Despite giving good information to someone, he/she may not be willing to say "okay, I'm ready". Unfortunately, as with many other health behaviors, change is unlikely to occur in a client who does not believe there is a need or is not ready to make major changes yet. Providers must be patient, functioning as a resource and support person no matter where a client is in being ready to change.

Back to:Unit 4 D: Promoting Physical Activity

Unit 4D:

Promoting Physical Activity: Past Experience With Physical Activity

Knowledge of one's past experience with physical activity can help lead to understanding of current patterns.

- **If past attempts to increase physical activity were associated with dieting, a client may have memories of a regimented exercise program undertaken at a time when energy levels were low from a restricted calorie diet. In addition, if the goal was to lose weight and maintain a loss, physical activity may be considered a failure if weight loss goals were not achieved (which is likely for many dieters).**
- **Individuals who were injured during physical activity, or have fear of this for other reasons, may be reluctant to become more active. Some may have done "too much too soon" with resultant soreness or excessive fatigue.**
- **Evaluation of a client's objectives for physical activity in the past may reveal inappropriate goals (such as a frequency, intensity, or duration that were not compatible with ability/fitness level) which could have set the client up for failure. (See "Does the client believe he/she can increase physical activity now?" for tips on setting goals.)**
- **Large clients may have been ridiculed or may have the perception that others are watching them when they are active. Some clients have memories of being teased as children in gym class, or of being chosen last to be on a team.**

Discussion with a client may reveal yet other experiences they may not have realized were affecting their feelings today. Some of these concerns may be particularly distressing for clients and may require more formal counseling.

Back to:Unit 4 D: Promoting Physical Activity

Unit 4D:

Promoting Physical Activity: Does The Client Believe He/She Can Increase Physical Activity Now?

This may be related to perceived barriers or the client's perception of what is involved in increasing physical activity for better health. Perceived barriers are addressed in assessment item #5.

If exercise was recommended to a patient in the past, it may have been in a more complex manner than what could work for many individuals. For example, recommending a particular exercise 3 to 5 times a week, for a specific length of time, at such and such a heart rate may prove to be too overwhelming.

Making sure clients know that many enjoyable forms of physical activity exist and that several short bouts of activity can be beneficial (see the last section of Unit IV Lesson D) may help them believe they can increase their activity level.

SETTING REALISTIC GOALS

Remember, the client knows best what is realistic for him/herself. For someone who is inactive in leisure time, adoption of a new form of physical activity once a week for one month is progress. A client who has been active intermittently may need to strive for some regularity in activity patterns. Some clients may wish to improve endurance. Take a few moments to discuss goals with your clients.

Utilize assessment items 1-5 to help with setting goals.

1. What is the client's current activity level? What does the client believe is realistic as a beginning goal?

2. Use the list provided in Unit IV Lesson D to suggest alternate forms of activity your client may not have thought of. The client should have the opportunity to choose the form(s) of activity that are enjoyable and carry the most likelihood of adherence.

3. Start slow - make sure your client knows that any level of activity that is an increase from where they are now is progress.

4. Let your client have the power to determine the rate of increasing the activity level. Small successes in increased activity could lead to more confidence, and over time your client may find it easier to believe he/she can do more.

5. Stay in touch with your client either through follow up visits or by

contact that is not face to face to provide support, validate progress, give resources, and update goals.

Back to:Unit 4 D: Promoting Physical Activity

Unit 4D:

Promoting Physical Activity: Potential Bariers to Physical Activity

Barriers to physical activity may include:

- **Perceived time limitations**
- **Feelings of intimidation, especially in group settings**
- **Financial cost**
- **Lack of interest**
- **Limited access to facilities**
- **Lack of discipline**
- **Boredom**
- **Being tired**
- **Availability of resources, location, safety issues**
- **Attainment of appropriate/comfortable clothing**
- **Inappropriate goals**
- **Lack of support**
- **Activity that is not perceived as enjoyable**
- **Past experience with physical activity**

Suggestions to help overcome common barriers:

Time limitations:

- **Have the client write down what he/she does in a typical week, including the time schedule. He/she may realize why they have trouble finding time, or they may discover some time slots that are available. As discussed in assessment item #4, several short bouts of activity are beneficial and may be easier to fit into busy schedules.**
- **If physical activity seems to interfere with family time, suggest activities that can be done together such as walking, playing, or swimming. If health club membership is an option, suggest an organization in your area that offers family and children's activities.**

Lack of interest/boredom:

- **Consider the client's past experience with activity. Did they attempt something they don't enjoy because someone said it was "good for them"? Did they do "too much too soon"? Have they been doing the same activity for a long time? Suggest variety in activities, alone and with others, and make sure the client chooses from options that they know they enjoy or think they might be able to**

learn to enjoy.

- **Some may discover (or rediscover) team sports as stimulating.**

Feeling tired:

- **Explore past activities with your client. Again, did they do "too much too soon"? Do they feel too tired to incorporate activity? In addition to ruling out other causes of fatigue, gently remind clients that regular physical activity can help combat fatigue by increasing feelings of wellness and improving sleep.**

Lack of discipline:

- **This may be related to the question in assessment item #2, "Does the client believe the increasing activity is necessary?" Making increased activity level a priority is important, and clients need you to provide them with information and resources to help them make this decision.**

Back to:Unit 4 D: Promoting Physical Activity

Unit 4D:

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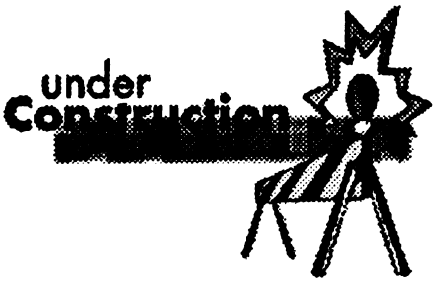

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Please choose the next lesson

Unit 5:

Self-Assessment Activities

Unit Objective: Given detailed case presentations, provides responses consistent with new paradigm principles.

E-Mail Joyce and Angie

Next

Unit 5: Case Presentation #1:

A New Paradigm Application

.....The following case is designed to help you visualize how the new paradigm might be implemented when assisting a client with potential hypertension. Consider the following client data, then answer the questions provided. When you are ready, compare your plan of care with that of the authors'.

S/.....

- **Alex L. 38 y/o white male. Presents to your primary care office for a pre-employment physical.**
- **Health maintenance: non-smoker, 1-2 beers twice a month, plays in a racquetball league 2 nights a week, wears seat belt. Last physical 2 years ago. No history of restricted dieting, weight-cycling, or recent weight loss/gain.**
- **Eating pattern (a typical 24 hour period):**
  - **7 AM: Cheese Danish, 2 cups coffee**
  - **Noon: Big Mac, large order fries, large Coke**
  - **3PM: Large apple**
  - **6 PM: Grilled BBQ chicken, baked potato with butter, asparagus, water**
  - **9PM: Apple pie ala mode, milk**
- **Social history: married x14 years, 2 school-age children, +family and social support, +stress related to recent unemployment secondary to corporate merger.**
- **Past medial history: appendectomy @ age 18 without complications, last Td @ 36 y/o**
- **Family history: father deceased age 48 with MI, mother L&W age 60 with Type 2 diabetes**
- **Medications: Tylenol 3-4 times/mo for HA**
- **NKDA**
- **ROS: unremarkable**

O/....

- **Ht: 70"**
- **Wt: 189 lbs**
- **BMI: 27**
- **BP: 158/92 recheck 154/90**
- **P: 86**
- **R: 14**
- **HEENT: WNL**
- **Lungs: CTAB**
- **Heart: RRR without murmur**
- **Peripheral vascular: WNL**
- **Abdomen: WNL**
- **Neuro: WNL**

- **MS: WNL**

  As a provider, what are you concerned about?

  What are you reassured by?

  What other information would be necessary?

A/....

What are your primary diagnoses?

P/.....

What is your plan of care?

To view how the authors would use the new paradigm approach to assist this client, click "next" below.

NEXT

Case Presentation #1:
(Authors' Plan of Care)

A New Paradigm Application

.....The following case is designed to help you visualize how the new paradigm might be implemented when assisting a client with potential hypertension. Consider the following client data, then answer the questions provided. When you are ready, compare your plan of care with that of the authors'.

S/.....

- **Alex L. 38 y/o white male. Presents to your primary care office for a pre-employment physical.**
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- **Neuro: WNL**
- **MS: WNL**

As a provider, what are you concerned about?

- **Diet high in fat and low in fruits and vegetables**
- **High stress r/t unemployment**
- **First-degree relatives with history of MI before age 55, and Type 2 diabetes**
- **Elevated blood pressure at this visit**

What are you reassured by?

- **Plays racquetball 2x/wk**
- **No tobacco**
- **ETOH in moderation**
- **+Family/social support**
- **Unrestrained eating pattern (no history of dieting/weight cycling)**
- **Physical exam WNL**

What other information would be necessary?

- **More details of physical activity patterns**
- **What is/are this client's primary concern(s)?**
  - **What does the client believe your role is?**
  - **What does he expect of you?**

A/....

What are your primary diagnoses?

- **R/O hypertension**
- **Alteration in nutrition: high fat intake and low fruit/veggie intake**
- **Potential for increased physical activity**

Considering this client's potential diagnosis of hypertension (to be confirmed) and the presence of 2 risk factors for cardiovascular disease (male, +family history), interventions should focus on lifestyle. This is especially important given the additional diagnoses related to nutrition and activity patterns. *Notice how the plan of care is not dependent on weight loss.*

P/.....

What is your plan of care?

- **Appropriate assessment and follow-up to R/O hypertension**
- **Empower the patient to establish goals, and develop an individualized plan according to his personal priorities (Unit IV Lesson A)**
  - **Focus on the development of healthy, unrestrained eating (Unit IV Lesson**

C)

and/or

- Promote increased physical activity (Unit IV Lesson D)

- Consider on-going collaborative relationship with plan evaluation & revision at each visit

E-Mail Joyce and Angie

NEXT

Case Presentation #2:

A New Paradigm Application

..... The following case is also designed to help you visualize how the new paradigm might be implemented when assisting a client with weight-related concerns. Consider the following client data, then answer the questions provided. When you are ready, compare your plan of care with that of the authors'.

S/

- **Wanda T. is a 42 y/o female. Presents to your primary care office requesting Meridia to "help stop her yo-yo dieting". States she would like to reach goal weight of 120 lbs to "look great and feel better".**
- **Health maintenance: non-smoker, non-drinker, has intermittently participated in aerobic dance classes for weight loss throughout adult life (currently sedentary), wears seat belt. Last physical 6 months ago. States weight 115 lbs with first diet at age 18 (wanted to lose 5 lbs). Repeated weight losses/gains since that time.**
- **Eating pattern frequently alternates between restricted caloric intake (approximately 1000 kcal/day) and periods described as "out of control" with intakes up to 4000 kcal/day. Cycles initially lasted as long as 2-3 weeks, but now occur every few days. Has difficulty recalling specific foods and amounts. Denies purging behaviors and history of eating disorders.**
- **Social history: married x 22 years, 1 independent adult child, husband encourages weight loss, works full time as a nurse in a local hospital.**
- **Past medial history: C/S (breech) 21 yrs ago, fx L femur in MVA age 30.**
- **Family history: father with asthma, maternal grandmother died age 68 Alzheimer's.**
- **Medications: ASA or Tylenol 4-5x/mo for HA or pain.**
- **NKDA.**
- **ROS: unremarkable.**

O/

- **Ht: 64"**
- **Wt: 144 lbs**
- **BMI: 24**
- **BP: 112/68**
- **P: 80**
- **R: 16**
- **HEENT: WNL**
- **Lungs: CTAB**
- **Heart: RRR without murmur**
- **Peripheral vascular: WNL**
- **Abdomen: WNL**
- **Neuro: WNL**
- **MS: WNL**

As a provider, what are you concerned about?

What are you reassured by?

What other information would be necessary?

A/....

What are your primary diagnoses?

How do you proceed in the formulation of a solid plan of care based on the new paradigm?

P/.....

What is your plan of care?

To view how the authors would use the new paradigm approach to assist this client, click "next" below.

NEXT

Case Presentation #2:
(Authors' Plan of Care)

A New Paradigm Application

S/

- **Wanda T. is a 42 y/o female. Presents to your primary care office requesting Meridia to "help stop her yo-yo dieting". States she would like to reach goal weight of 120 lbs to "look great and feel better".**
- **Health maintenance: non-smoker, non-drinker, has intermittently participated in aerobic dance classes for weight loss throughout adult life (currently sedentary), wears seat belt. Last physical 6 months ago. States weight 115 lbs with first diet at age 18 (wanted to lose 5 lbs). Repeated weight losses/gains since that time.**
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- **Neuro: WNL**
- **MS: WNL**

As a provider, what are you concerned about?

- **Weight cycling, possible disordered eating and/or eating disorder**
- **Dissatisfaction with body/appearance**

- **Sedentary lifestyle**
- **Reinforcement of body dislike by husband**

What are you reassured by?

- **Apparent open communication with provider**
- **Physical exam WNL**
- **Medical and family history essentially negative**

What other information would be necessary?

- **Detailed assessment for eating disorder**
- **Does the client have any psychosocial issues that are contributing to her beliefs and behaviors?**
- **What does the client believe your role is?**
- **What does she expect of you?**

A/....

What are your primary diagnoses?

- **Body image disturbance r/t dissatisfaction with weight**
- **R/O eating disorder**
- **Chronic restrained eating**
- **Sedentary lifestyle**

How do you proceed in the formulation of a solid plan of care based on the pew paradigm?

..... First, identify your own beliefs regarding weight-related concerns and prescriptions for weight loss medications. It is the authors' belief that these old paradigm interventions are ineffective and potentially harmful, and as such are inappropriate for use with clients. Next, you should acknowledge the client's frustration with previous failures at weight loss and assist her in understanding why dieting and exercise for weight loss usually fail. Determine whether or not the client is open to interventions other than what she has requested (Meridia). If she is not, the plan should consist of gentle explanation as to why you cannot provide this medication or assist with weight loss efforts. An open invitation for future assistance with improving body image, normalizing eating, and increasing activity should be given.

..... Because this client suffers from chronic restrained eating and possibly firmly entrenched values regarding body size, a team approach may be needed. In addition to you as the primary care provider, the team may consist of a size-friendly nutritionist and therapist. Incorporation of new paradigm principles into lifestyle needs to be a slow, individualized process and may require extended time (years).

..... Notice how the plan of care does not focus on weight loss, but rather emphasizes overall health promotion. Interventions assist with improving body image, normalizing eating, and the incorporation of enjoyable physical activity.

P/.....

What is your plan of care?

· Empower the patient to establish goals, and develop an individualized plan according to her personal priorities (Unit IV Lesson A)

· Assist the client in improving body image and positive self-thoughts (Unit IV Lesson B)

· Focus on the development of healthy, unrestrained eating (Unit IV Lesson C)

and/or

· Promote increased physical activity (Unit IV, Lesson D)

· Consider on-going collaborative relationship with plan evaluation & revision at each visit

****Notice that the new paradigm is flexible. Care is highly individualized and empowers the patient to make self-paced decisions regarding weight-related concerns. Moving toward size acceptance, healthy, unrestrained eating, and a physically active lifestyle is as much a process as it is a goal.**

Next

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