

Clinical and Social Aspects of Obesity and Eating Disorders

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Abstract

Obesity and Eating Disorders (ED) are characterized by organic, psychological, functional and social consequences. If the acute events of these disorders can cause great concern in family members and the healthcare professionals, obesity and ED are almost always chronic conditions with significant consequences both physically, both socially and economically, from which it is difficult to recover. Disabilities that a long term accompanying these pathologies include negative effects on training professional and employment, fertility and parenting, interpersonal and family relationships. ED and obesity consequently have high social costs which affect both the expenditure of the National Health Service, both on the family and on the person himself in terms of relationships, of experiences and social functioning. Families are dealing with very difficult situations and they feel helpless. Patients tend to isolate themselves and all activities of daily life (work, studying, dating friends, providing home or basic needs) become difficult.

Hence, the need to take charge of obesity and ED, both in the preventive phase and in the path of care, which takes into account aspects that pertain to social functioning. In the prevention of obesity and ED, the socio-cultural factors that propose models will be addressed of female identity (but also male) stereotyped and linked to the image, the physical form, the beauty, to thinness intended as vehicles and a guarantee of well-being, social acceptance and success. Media communication, school, diet industry and the world play a role in this field of dance and gyms, sport (competitive and otherwise). Hence the need to inform / train the operators operating in these sectors to correctly communicate about ED and obesity and to achieve paths that make it easier to collect information and / or help questions. In the treatment of obesity and ED, the socio-cultural aspects will have to be considered on an equal basis organic and psychological. The relationship with school or work, with family and friends becomes decisive in promoting effective functional recovery and from disease in general.

Key words: *Eating Disorder, Healthcare, Obesity, Prevention*

Introduction

Obesity and Eating Disorders (ED) have in common the characteristics of chronicity and comorbidity, the high costs in terms of disability and the serious overall impact on quality of life [1-6]. Several studies have highlighted common biological and environmental risk factors behavioral between obesity and ED. Social stigma, family eating behavior, intra-family relationships, the ideal of beauty and thinness seem to play a role in pathogenesis of both these pathologies [1-6]. The same applies to body image disorders and dissatisfaction with one's body or depression. Subjects with obesity or ED seem to have in more compromised interpersonal functioning and greater cognitive rigidity are also common. Although the extent of the eating disorder can manifest itself in a different way from the point of view behavioral and dysfunctional (relationships, feelings and convictions towards food and food eating) in obesity and ED, there are many similarities between these pathologies [7,8]. An impaired inhibitory control, both cognitive and linked to the neurobiological processes of reward, with greater risk of impulsive or compulsive behavior, it has been invoked in the genesis of ED (BED and BN above all) and non-BED obesity [9,10]. From a behavioral point of view, subjects with obesity or ED have a common frequent use of biologically incorrect food patterns and an important dependence on the media for choices dietetic [11]. Eating in the absence of hunger and disinhibited eating (excess nutrition in response to emotions or the simple presence of food, the alternation of phases of restriction/disinhibition) are present in both ED and obesity [12]. Although the results of the studies are not univocal, some authors have also highlighted a common role of genetics for these pathologies. Common brain pathways (related to dopamine and ghrelin in particular) have been identified between obesity and ED regarding food addiction and reward.

Another point of contact between obesity and ED is represented by bariatric surgery. Most of the patients who resort to this are affected by a ED and several studies highlight how the ED can persist or develop after surgery [13,14].

Several scientific societies, particularly in the pediatric field, have expressed themselves on the need for consider the consequences of obesity and ED as well as screening for these conditions in a manner integrated. The same inclusion of ED among the main diagnoses of DSM-5 confirms the sensation that it is necessary to consider obesity and ED as two aspects of the same continuum of disorders characterized by a problematic weight control ability [1]. From a therapeutic point of view-rehabilitation both obesity and ED require interdisciplinary and multidimensional therapeutic paths, often long and complex, which address the symptoms, causes and complications of these diseases, in the setting of more appropriate care from time to time.

Methods

The generalist prevention programs of ED and obesity must coincide. The first generation programs adopted a psychoeducational approach, which provided information on nutrition, body image, eating disorders and their harmful effects, on healthy or harmful lifestyles. Those of the second generation have more directly addressed some risk factors identified by the research. Those of the third generation used an interactive and experiential educational approach and strategies aimed at modifying dysfunctional attitudes and unhealthy behaviors. The school prevention programs that have obtained the best results are those of secondary or selective prevention on groups of girls identified at greater risk, aged 15 and over, using multiple meetings, in small groups, conducted by professionals and focused on acceptance of the body. It is essential to promote the early diagnosis of ED, through the awareness of general practitioners and pediatricians of free choice, the creation of advice points, the awareness of patients, families and teachers. Preventive interventions should also be promoted in high-risk areas, such as the sports, fashion and dance sectors. The evolution from a prevention model based on personal responsibility to a public health model is desirable. Public health institutions are responsible for implementing interventions such as controlling advertising and the diet industry and promoting public health programs targeting the "toxic"

environment, which promotes food intake excess and sedentary behaviors, stimulating strategies for changing lifestyles in the general population, with healthy eating and physical activity behaviors.

Results and Conclusions

From a therapeutic point of view, the major problems of ED and obesity therapy are the complexity and heterogeneity of the constitutive and/or complicating aspects of ED and the frequent excess weight, which were identified during the assessment and guide the plan. welfare. The most recent contributions suggest a therapeutic strategy with combined and "multistage" or sequential therapies. These deal with the patient's problems identified in succession through periodic diagnostic reformulations: first, they provide the restructuring of nutrition and cognitive-behavioral tools for awareness and self-management; then, they treat binges and experiences related to food intake; subsequently, if present, they alternatively address obesity or the core of bodily concern. Concurrently, any psychiatric and medical comorbidities related to the metabolic syndrome are addressed. The choice of treating obesity with specific treatments in ED patients is supported by evidence, but requires caution, particularly where there is a severe negative body shape experience and a powerful ideal of thinness, with restrictive control behaviors: in this case the obesity cure could flare up or trigger further ED. Appropriate obesity therapy should not be confused with the usual prescriptive dietary approach; it includes measures on active lifestyle and structured CBT, which have as objectives the reduction and maintenance of weight and the modification of nutrition, physical activity and mental aspects related to personal care and the management of difficulties in weight loss. A further issue, topical in patients with severe obesity, concerns the use of restrictive/malabsorptive bariatric surgery: recent guidelines indicate that it can sometimes be indicated, after evaluation multidisciplinary and adequate treatment and in the absence of substantial problems inherent to the body experience. According to some studies, the preoperative diagnosis of ED is predictive of lower outcomes and greater difficulties after bariatric surgery, however, it does not however exclude its use. Other recent studies, on the other hand, do not

confirm this negative predictive value. In patients with ED it is however necessary, as for all obese people with or without ED who require bariatric surgery treatment, to explore the psychological problems and ensure a multidisciplinary, medical, dietary and psychological follow-up over time. As for the subpopulation of patients with ED and a very active psychopathological nucleus on body image, it must be treated with a therapy similar to therapy for the other EDs according to the transdiagnostic theory. Focused therapies for weight loss (BWL) are more effective on weight loss, which is frequently recovered after discontinuation of therapy, but are not effective on the psychopathological core. Treatment of ED also includes drug therapy. Fluoxetine, a drug with a serotonergic action, in high doses (60 mg per day, with periodic monitoring of the ECG for QTc) is officially indicated for the therapy of ED; has good antidepressant effect and compulsive behaviors. Its use does not replace psychotherapy, but is frequently useful to enhance its effects and is also proposed in the long term after the end of psychotherapy. Other drugs, not usable in Italy, are lysdexanfetamine, approved in the United States, and drugs indicated for obesity: orlistat and liraglutide, in addition to metformin, which is also "off label" for obesity. Finally, a consideration concerns the appropriateness of the ED treatment settings. The most appropriate setting is undoubtedly the outpatient one, even if the recent guidelines of SISDCA and SIO suggest possible residential treatments for limited periods in cases resistant to therapy or as the first step start of the therapy itself in cases of greater severity. In any case, a multidimensional approach must be provided in each setting, including internal medical and nutritional, dietary, psychological and psychiatric skills, as well as, in some settings, physiotherapists, educators, psychiatric rehabilitation technicians and nurses.

In conclusion, for both obesity and ED the best therapeutic-rehabilitative treatment is based, according to the guidelines most recent guide, on two general principles:

a. *team approach*: multidimensional, interdisciplinary, multiprofessional integrated approach that involves doctors (internists, clinical nutritionists, psychiatrists, physiatrists), psychologists, psychotherapists, dieticians, physiotherapists and nurses;

b. *multiple settings*: from long-term outpatient management to intensive rehabilitation, semi-residential and residential addressed to severe states of malnutrition due to excess or for defect, in the phases of instability and decompensation of somatic and psychiatric comorbidities and at start a stable lifestyle correction (targeted, in particular, on nutrition and activities physics).

It is an opinion supported by experience as well as by a growing scientific literature that itself team (which, of course, has the necessary skills) can deal with in a work setting that has adequate structural and functional characteristics for patients with malnutrition both by excess and by default (Anorexia, Bulimia, Obesity BED and non-BED), with the obvious program modulations [6].

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