Artículo de Revisión / Review Article

A nutritionist approach to psychiatric treatment: Notes from a brief experience

Un enfoque del nutricionista en el tratamiento psiquiátrico: Notas de una breve experiencia

Carla Maria Vieira^{1*}, <https://orcid.org/0000-0002-4486-4527>

Flávia Machado Seidinger Leibovitz¹, <https://orcid.org/0000-0003-1933-8039>

Débora Bicudo de Faria Schützer², <https://orcid.org/0000-0001-7918-6714>

Rodrigo Almeida Bastos², <http://orcid.org/0000-0002-6159-8048>

Maria Rita Marques de Oliveira³, <https://orcid.org/0000-0003-1226-4364>

Egberto Ribeiro Turato¹, <https://orcid.org/0000-0002-7857-1482>

1. Laboratory of Clinical-Qualitative Research (LPCQ), School of Medical Sciences, State University of Campinas (UNICAMP), Campinas, Brazil.

2. Department of Gynecology and Obstetrics, School of Medical Sciences, State University of Campinas (UNICAMP), Campinas, Brazil.

3. Biosciences Institute, Department of Education, São Paulo State University (UNESP), Botucatu, Brazil.

*Corresponding author: Carla Maria Vieira, Laboratory of Clinical-Qualitative Research (LPCQ), School of Medical Sciences/State University of Campinas (UNICAMP), Petrópolis 219/315, Campinas, São Paulo, Brazil. CEP:13104150
E-mail: vcarlamaria@gmail.com

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ABSTRACT

Objective: This study aims to describe the work of the nutritionist in a psychiatric outpatient clinic of a university hospital, with patients with excess weight due to the use of certain psychiatric medications. Method: Content analysis of the clinical history and brief field notes, as complementary material. The clinical-qualitative method was applied in data collection and analysis. Results: Conversations with patients focused on their relationship with food were more effective in managing excessive weight gain than insistence on individualized and restrictive diets. The role of the family was important to strengthen the bond and favor dietary changes. Efforts to identify the emotions involved in eating, including the pleasures given by emotional, cultural, and social factors were also important. Conclusions: Nutritional care in the psychiatric field should emphasize dialogue related to the eating practices of patients. Strict dietary prescriptions can have the same unproductive effect as traditional biomedical practices if they do not consider subjective aspects of patients.

Keywords: Feeding Behavior; Mental Health; Nutrition Therapy; Obesity; Qualitative Research.

RESUMEN

Objetivo: El objetivo de este estudio fue describir el trabajo del nutricionista en una clínica ambulatoria de psiquiatría de un hospital universitario, en pacientes con exceso de peso debido al uso de ciertos medicamentos psiquiátricos. Método: Análisis del contenido de la historia clínica y de breves notas de campo, como material complementario. Se aplicó el método

clínico-cualitativo en la recolección y análisis de los datos. Resultados: El autor principal de este artículo, una nutricionista, indica que las conversaciones con pacientes centradas en su relación con la comida fueron más efectivas para manejar el aumento de peso excesivo do que la insistencia en las dietas individualizadas y restrictivas. El rol de la familia fue importante para fortalecer el vínculo e favorecer los cambios alimentarios. También fueron importantes los esfuerzos para identificar las emociones involucradas en la alimentación, incluidas los placeres dados por factores emocionales, culturales y sociales. Conclusiones: La atención nutricional en el campo psiquiátrico debe enfatizar el diálogo relacionado con las prácticas alimentarias de los pacientes. Las prescripciones estrictamente dietéticas pueden tener el mismo efecto improductivo que las prácticas biomédicas tradicionales si tampoco toman en cuenta los aspectos subjetivos de los pacientes.

Palabras clave: Comportamiento alimentario; Estudio cualitativo; Obesidad; Salud Mental; Terapia alimentaria.

INTRODUCTION

Obesity has complex roots and involves various dimensions of eating behavior¹. According to some authors, one of these dimensions is the emotional relationship that patients develop with food². Thus, the food culture has been recognized as important to clinical practice³. The management of nutritional issues associated with patients' psychosocial aspects is a challenge for health professionals and a common reality in clinical practice. Specifically, chronic diseases have been highlighted in these discussions and, among them, mental disorders^{4,5}.

In patients with mental disorders, psychoactive medication must be prescribed and taken regularly⁶. In addition, weight gain can be related to family bonds that involve eating, cultural identity, and social insertion, as well as economic and genetic factors^{5,7}.

Obesity in psychiatric patients has certain specific features, especially the fact that the use of prescribed psychoactive medication can affect patients weight and thus also bring about changes in eating behavior⁸. Studies on the effects of diet, body and illness processes among patients can be further explored in the health field to improve strategies for managing excess weight and obesity^{7,9}.

This study aims to describe the work of the nutritionist in a psychiatric outpatient clinic of a university hospital among patients with excess weight due to the use of certain psychiatric medications. The case report observes the application and integration of different clinical areas to guide the management of complex cases from the reported experience. The report preserves the condition of human complexity while describing and guiding clinical practice¹⁰. The results may aid psychiatric teams to manage obesity in mental health patients and thus produce better outcomes in the continuity of patient drug therapy. It is based on an integrative approach whereby different health practices are integrated in the same care process, considering the patient as a complex subject with psychosocial issues as clinically important as the pathophysiological ones. Nutrition care for obese patients should therefore go beyond strictly biomedical approaches¹¹.

METHODS

This is an experience report about the work between nutrition and psychiatry in a psychiatric outpatient unit

for adults. It was developed during a postdoctoral trainee period of the first author in a university hospital, between February 2013 and September 2014.

The clinical-qualitative method^{12,13} was used to develop the research. This method allows the application of the results directly to clinical practice in health. It demands from the researcher an attitude of acceptance of participant anxieties and discusses the data in order to improve the management of the phenomenon being studied.

The purpose of this manuscript was to discuss the free reports of patients obtained at the nutritional clinic. Nutritional care took place at the request of physicians, considering the population of patients with weight gain due to the use of certain psychiatric medications. Thus, the sample of patients was composed by convenience, obtained from an outpatient population attended during the postdoctoral internship period of the nutritionist. In addition to recording these interviews, the researcher made brief field notes, used as complementary material, such as emotional reactions, non-verbal material, and the language of facial and body expressions.

Data collection took place in the nutritional care, with records made in conventional medical records, which had as reference the "Subjective Objective Analysis Plan" (SOAP) protocol applied to record the history, evolution, and clinical reasoning, as described in the literature¹⁴.

The records of nutritional care were analyzed using the interpretive approach to content analysis, favoring the development of categories based on the organization of meaning flows, as recommended by the clinical-qualitative method¹⁵.

Following the methodological guidance of the research group, the following three pillars of the method were considered: clinical attitude of valuing clinical complaints, psychodynamic attitude of valuing emotional aspects present in personal interaction and existential attitude of valuing natural anxieties of health problems among those in care. For the treatment of the results of the experience of the internship in the service, a theoretical framework of health psychology was considered. We highlight the symbolisms linked to illness and treatment, the emotional transference reactions between health professional and patient, as well as the mental representations associated with the phenomena of adherence or non-adherence to

the recommended therapy: medications and diverse life habits, highlighting the food¹⁶.

The nutritionist participated in the weekly sessions of the psychiatric team, where cases were supervised and discussed by the team. Thirty-six patients were studied and had experienced excessive weight gain, possibly as the result of taking psychiatric medication. This group consisted of 25 women and 11 men. Ages ranged from 17 to 53, mostly between 25 and 45 (n=24). Ten patients attended only one session, eleven came to two, and fifteen between three and ten sessions. There was great variability in the evolution of nutritional status, as is characteristic of this population subjected to the effects of medication and other factors that hinder weight control.

The nutritional status of patients ranged from overweight to different grades of obesity. Body mass indices (BMI) ranged from 26 to 45 kg/m² and rapid weight gain from

psychiatric drug use was significant in many cases, although none could be rated extremely severe.

The focus of nutritional care was not on weight loss given the severity of psychiatric problems. The focus was on talking about food and weight gain during treatment to avoid abandoning treatment and promoting greater acceptance and understanding of eating practices associated with the illness process. However, it was possible to observe that there were good results regarding changes in nutritional status (Table 1). Some patients who attended between three and five sessions experienced weight loss, while others remained overweight or gained weight during treatment. Among patients who attended more than five nutrition sessions, there was weight loss or maintenance. The number of patients with improved nutritional status was proportionally higher among those who underwent a greater number of treatment sessions.

Table 1. Subject characterization, number of nutritional care visits, weight variations and diagnostic hypothesis. Campinas (SP), Brasil, February 2013- September 2014.

Variable		N	Weight variation	Weight reduction	Stable weight*	Weight gain
Sex	Female	25	-9,1 a 13,6	10	9	6
	Male	11	-53,3 a 19,7	7	2	2
Age	17 - 25	6	-53,3 a 13,6	3	1	2
	>25 - 45	24	-9,1 a 19,7	10	7	7
	> 45 - 53	6	-2,4 a 3,1	4	1	1
Nutrition care session	1	10	0	0	0	0
	2 - 4	19	-7,2 a 13,6	12	2	5
	5 - 10	7	-53,3 a 12,4	5	0	2
Diagnostic hypothesis**						
Depressive Disorder (F32 and F33)		9	-3,1 a 3,1	4	3	3
Generalized Anxiety Disorder (F40 and F41)		4	-1,3 a 0,0	2	2	0
Schizophrenia (F20)		12	-53,3 a 19,7	7	2	3
Bipolar Affective Disorder (F31)		5	0 a 13,6	0	2	3
Other diseases***		5	-4,6 - 0	4	1	0
No information		1	0,0	0	1	0

*This group includes patients with a nutrition session and other patients with no weight variation.

**Diagnostic hypothesis = disease and coding associates of the International Disease Classification (IDC). Other diseases.

***Other diseases: Persistent Delusional Disorder (F22); Acute and Transient Psychotic Disorders (F23); Persistent Delusional Disorder (F22) Acute and Transient Psychotic Disorders (F23); Histrionic Personality (F60.4) and Hypothyroidism (E03); Mental and Behavioral Disorders (F15).

The research was approved by the Institutional Review Boards at the State University of Campinas, Brazil, CAAE - 07595212.0.0000.5404.

RESULTS AND DISCUSSION

Family context: dialogue on eating practices and nutrition care

The reflections identified in the data showed the family relations established around eating practices as observed during the practices in the outpatient psychiatric unit for adults. Practices involving eating, buying or preparing food and establishing behavioral patterns are elements that can be used by professionals in the treatment of mental disorders. These family relations and eating practices are clinical signs that are useful in observing the development of weight gain in the course of manifestations of mental health problems.

In the field of mental health in general, as well as in the specific area of obesity treatment, one of the central and most widely accepted objectives is patient autonomy. This factor depends largely on the bonds established between professionals and patients and implies the joint development of proposals be put into action¹⁷. To this end, nutritionists and other professionals involved in treatment must listen attentively to patient experiences in gaining weight and should also attempt to identify the meaning of these experiences.

The practice of nutrition care in this context was aimed especially at avoiding or at least reducing the abandonment of treatment that so often occurs. Weight loss in itself was not the focus of the therapeutic proposal. The professionals involved were, in fact, more concerned with identifying mechanisms that could help these obese psychiatric patients develop new meanings regarding food, both individually and in conjunction with their families and caregivers¹⁸.

This re-assigning of significance can be seen as one expression of eating practices from the theoretical perspective of the anthropology of eating^{19,20}. In this perspective, eating practices materialize the structure of society and the interaction of the subjects with socio-environmental questions. It also updates social-cultural representations that are the bases of new meanings for eating in the collective and individual dimensions.

It is important to place eating behavior in its current context, as one of the characteristics of post-modern society's rapid, cultural changes. These changes bring about significant interferences in eating choices and undermine the cultural identities of food, which are part of the manifestation of affectivity and belonging. In this sense, the interests of production have transformed food into a global object without any personal history. The industry provides a flow of food without memory and the consumers eat food with no history or cultural identity²¹.

Social manifestations, as movements against this mass eating culture, but without identity, can be seen in social practices. The proliferation of groups for sustainable foods,

vegetarians, organic consumers, slow food, and others, suggests the need for contemporary humans to recover culinary references and identify themselves culturally through eating²¹.

This proposal for thinking about eating behavior is the basis of a perspective that is different from traditional prescriptive practices in the field of nutrition therapeutics. From the perspective of the anthropology of eating, nutritional clinical practice seeks to reconnect patients with their food in the long-term. To attain the best possible balance, this process demands the involvement of the family in rethinking the day-to-day relationship with eating practices²².

The exploration of family contexts proved to be important in this experience and the results should be discussed. The family is clearly a fundamental component for understanding the cultural identity expressed in patients' ways of eating and for motivating them toward greater sociability and self-care²³. Those patients who returned more often for further sessions and who were therefore more closely identified with treatment had better opportunities to establish dialogue with professionals regarding eating practices and the pleasure involved, as central elements in choosing food items.

Food surveys and psychiatric treatment

Several types of food surveys can be found in the literature²⁴, some of which, traditionally used in nutrition care, were also used in this experience. The objective of such surveys is not only to obtain data on nutrient intake but, mainly, as a means of increasing patients' knowledge, thus allowing them to discuss eating practices, especially their own, more cogently. The instrument applied here became a source of meanings of food and led to broader understanding of food practices for the patients. Between the lines it was also possible to identify ways in which they relate to food, how they organize themselves internally when eating and how they express the place that food occupies as a mediator of everyday relationships.

The literature in this field is generally clear in holding that instruments known as "food surveys," although scientifically validated, do not describe actual food intake. But they do allow those involved to evaluate the individual patients' organization of food and nutrients, and they also bring up symbolic issues related to food behavior²⁴. In this sense, the discussion on the reports of the sessions with the subjects showed that family contexts play an important role in the caring process by opening up sociocultural issues and identifying certain changes that might be made in family eating practices.

The unstable mental organization of many of these patients required creativity in dealing with them clinically. This fact, however, did not prevent the researcher from discussing the topic of eating with them in any of its dimensions, whether nutritional, psychological or cultural. During the sessions the researcher was able to identify strategies for constructing new meanings for food items. Two important topics were identified in the process of analyzing the patients' accounts:

1) the involvement of families when together at table and, 2) the autonomy to deal with being overweight. Both of these factors seemed important in analyzing the sessions.

Earlier clinical studies²⁵ have also given weight to patients' views on the meanings attributed to dieting and weight. In fact, experience shows that clinical work which fails to deal with psychological factors aimed at promoting self-esteem can cause discouragement when optimal nutrition standards are not achieved. In some studies, being overweight was seen as an element of protection, a fact that reaffirms the need to avoid giving too much importance to weight loss during obesity treatment²⁶.

Listening to the emotional reactions of patients can back up the process of reorganizing eating practices and can help patients avoid repeating their mechanisms of compensation and thus lower their abandoning of treatment²⁷.

In the psychodynamic perspective toward eating behavior brings in other elements that contribute to a better understanding of mental attitudes in using food. One may note, for example, that patients use food as a way to meet emotional demands, be they the filling in of affective lacunas or the loss of emotional control^{17,27}.

In general, the difficulty in separating emotional demands from physiological signs of hunger was present in the interviews, understood as the expression of immaturity in facing the real. Food can satisfy questions of the moment, but it is insufficient in relieving emotional hunger, as the mind "urges to get out"^{28,29}.

Mental suffering thus limits the regulating system of the emotions and causes numerous other reactions, including compulsive motor action²⁹. Compulsion has the function of "anesthetizing" the mental suffering and transforming it into physical pain. Compulsive eating seen in serious emotional imbalances is a way of relieving tension and reducing physical pain, which is seen in the body in the form of repetitive acts. What is mental is lived in the body, which suffers from these excesses³⁰ but that also somehow guarantees a possible accommodation²⁸.

CONCLUSIONS

The objective of this report is to describe the experience of a nutritionist in an adult psychiatry outpatient unit of a university hospital. The actions developed at the outpatient clinic aimed mainly at integrating knowledge to improve care for patients with psychiatric disorders, who are thus vulnerable to metabolic disorders and cardiovascular risks. Weight gain resulting from the use of medication is an important determinant of treatment abandonment and clinical nutritional care can collaborate with other health professionals to avoid such an undesirable outcome.

However, a nutritional clinic approach based on prescriptive strategies cannot pay attention to the psychosocial aspects of psychiatric patients at risk of obesity. This limitation of care strategies made non-compliance high, especially in the use of drugs. Integrated care with nutrition, based on an integrative theoretical and practical humanistic framework,

allowed greater sensitivity of the professionals and meant better care of patients with psychiatric disorders.

Insights on how patients symbolize and interpret their food and eating habits in a caring and treatment context showed the importance of dealing with how they see their diets. For chronic patients in psychiatric treatment, this process includes dealing with their reactions to excessive weight gain.

This experience reinforced the importance of nutrition care especially in the specific case of patients with psychiatric disorders, whose medication often affects their appetites. Thus, nutrition care should emphasize dialogue related to the persons' relationships with food practices. Solely dietary prescriptions can have the same unproductive effect as traditional biomedical practices, as they fail to consider subjective aspects of patients. This implies that professionals should stimulate discussion and listen carefully to patients as they describe the emotions involved in their and their families everyday nutrition and culinary habits.

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