

Obesity

(Also called Morbid Obesity, Extreme Obesity, Overweight)

Description of the Disability

Obesity was once blamed on lack of willpower and overindulgence by the individual. This is not true. Some research suggests that people with obesity do not eat more than the average person. Today, physicians see it as a medical condition caused by a complex interaction of genetic, metabolic, behavioral and environmental factors that we don't completely understand and with no simple cure. Obesity is best thought of as a chronic condition requiring long-term treatment.

Obesity is usually defined with the Body Mass Index (BMI), which is height (in centimeters) divided by weight (in grams) squared. A Body Mass Index of 18.5 to 24.9 is considered normal, 25 – 29.9 is defined as overweight, 30 – 34.9 is defined as class I obesity, 35 – 39.9 is Class II obesity, and 40 and above is Class III or extreme obesity. (The term morbid obesity is rarely used today).

Significant obesity correlates to higher risk of more than 30 other medical conditions, including hypertension, type 2 diabetes, coronary heart disease, osteoarthritis, coronary heart disease, stroke, sleep apnea, respiratory conditions, stress incontinence, depression, and some types of cancer (endometrial, breast, prostate, and colon). Each of these conditions can, of course, have its own functional issues for independent living and employment.

In recent years, experts have realized that 1) most people who are treated for obesity do not reach their ideal weight, 2) most people treated for obesity who lose significant weight, regain it within 5 years, 3) repeated cycles of significant weight loss and weight gain (yo-yo dieting) can be more dangerous than obesity, and 4) even modest weight loss can significantly improve the complications of obesity. Currently, treatment goals have shifted towards modest weight loss (5-10% of body weight) and reasonable weight control. Most diet treatments now focus on gradual, long-term change in diet and exercise habits rather than strict dietary regimens. Behavior therapy is a large part of most commercial and non-clinical weight loss programs. Drug therapy is growing in popularity as a way to reach modest weight loss. Surgery is usually reserved for those with severe obesity or with life-threatening complications from modest obesity. Even then, many individuals choose not to have surgery because it has so many dangerous possible side effects.

For most individuals with obesity, the biggest concern about employment is harassment and discrimination. By the time you meet them, most people with obesity will have endured years of cruel remarks and rude behavior from others. They may be deeply embarrassed, angry, or bitter about having a disability that is instantly visible to everyone and which everyone seems to blame on them. In addition, physicians may have refused them certain types of medical treatment because of their weight. Obesity activists call it socially sanctioned abuse and have commented, "It is still OK in this society to hate fat people." One can find heartbreaking first-person examples of this discrimination on many online support groups for obesity. Counselors report

that a significant number of individuals choosing to have surgery for obesity do so because of social pressure or employment concerns rather than for health reasons.

As with all disabilities, different individuals will show different responses to their situation. There may be underlying issues of depression and anxiety. There may be a fear of meeting the public. There may be a defensive attitude of aggression, cultivated indifference, cultivated cheerfulness, or passivity.

Incidence Statistics

- 95-98% of all diets fail over three years
- Factors such as food quantity, food choices, and exercise typically account for only 10-20% of body weight. The rest is controlled by the metabolism "set point" for your body.
- Thin men who do not exercise are three times more likely to die prematurely than obese men who do exercise.
- The muscle most damaged by dieting is the heart
- Obesity appears to lower the incidence of several cancers, including pre-menopausal breast cancer, stomach cancer, lung cancer, meningioma, and colon cancer.
- Obesity appears to reduce the incidence of osteoporosis and hip fractures.

Common Treatments, Medications, and Side Effects

Most treatment for obesity begins with diet and exercise programs. If those do not succeed for an individual, their physician may use drug treatment or a surgical treatment.

Drugs used to support weight loss include appetite suppressant Noradrenergic drugs, such as phentermine resin (Ionamin), mazindol (Sanorex), phenylpropanolamine (Dexatrim), phendimetrazine (Plegine) and diethylpropion (Tenuate). None of these have been approved for long-term treatment (see Drug entry on Appetite Suppressants for side effects). Other drugs include lipase inhibitors such as Orlistat (Xenical), which has been approved for long term treatment (see Drug entry on Lipase Inhibitors for side effects).

Types of Surgery

Bariatric, or Weight Loss Surgery (WLS), is an extreme and problematic solution to obesity. Although the subject is getting a lengthy description here, it does not represent the most common or necessarily the "gold standard" of treatment for obesity. There are significant potential side effects from bariatric surgery and the long-term results are uncertain. In addition, individuals who have surgery to support weight loss will generally need to drastically limit their eating for the rest of their lives. Many people with obesity choose not to have bariatric surgery because of the side effects and risks. Some who do have the surgery wrestle with significant complications

the rest of their lives. However, many individuals have found it useful. The types of surgery are somewhat confusing and complex. They can be summarized as follows:

Biliopancreatic Diversion (also called BPD) (This represents the modern version of the older ileal bypass, now discontinued). In this surgery, the outlet of the stomach is detached from the top of the small intestine and moved farther down. The top portion of the small intestine is left in place, along with its connections to the liver and pancreas, so that their digestive fluids can still flow naturally, but no food passes through that area, reducing overall digestion. There can be serious problems with malnutrition from reduced vitamin absorption, as well as problems with diarrhea and gas. There can also be stress on the liver and pancreas. Patients require life-long follow-up exams, including monthly blood checks.

Roux-en-Y Gastric Bypass (also called RGB or RNY) - A very small section of the top of stomach (about the size of your thumb) is stapled to isolate it from the bottom part. This top portion is then attached directly to the small intestine, bypassing the original outlet at the bottom and creating a new outlet. In effect, the stomach becomes much smaller and the food enters the intestines much more quickly. Because the sense of satiety (satisfaction that you have eaten enough) seems to come from the intestines, this supposedly stops the eating sooner. One major complication is “**Dumping**” – in which the stomach contents are reflexively emptied into the intestine before they have finished being digested by the stomach acids. The body’s reaction to dumping is rapid heartbeat, nausea, cramping, and faintness, sometimes followed by diarrhea. Sugar is a big trigger for dumping and people with RGB have to avoid sugary foods and large amounts of carbohydrates. Also, food can block the new outlet, requiring an emergency room visit. There are several variations on this surgery, especially regarding how much of the small intestine is bypassed.

Duodenal Switch - (BPD/DS) - The stomach is reduced by stapling off one side of it (rather than the top of it, as in RNY), but the natural top and bottom openings are left in place. However, the Duodenum (the tube connection between the stomach and the intestine) is switched over from the top of the intestine to a place lower down, again shunting the food around the top of the intestine and reducing overall absorption/digestion. Typically, much more of the small intestine is bypassed than in RNY, so nutritional consequences are more serious. However, dumping is not a problem because the duodenum is still in place below the stomach.

Vertical Banding Gastroplasty (VGB) (stomach stapling, gastric stapling) - This also reduces the effective size of the stomach while leaving the lower portion still functional. The stomach is stapled to create a small upper section and a larger lower section, but a connection is left between them and no new opening is created as in RNY. A plastic band is wrapped around the connection between the two, keeping it small. As a person eats, the upper pouch fills up quickly and they have to stop. Then the food gradually moves through into the lower section and on down. As with RNY, the person has to be very careful to chew their food thoroughly. Because the stomach feels full before the sense of satiety comes from the intestines, some individuals find themselves drinking milkshakes and other high calorie liquids that can pass quickly through the banded connection quickly and letting them feel satiated. In some cases, the person gains back all the weight lost initially. Malnutrition is not as big a problem as in some other techniques.

Gastric Banding (also called Lapband after a surgical product available in the US). This is a European technique still new to the US. No incision or stapling is involved. Instead, a flexible band is wrapped entirely around the stomach near its top and tightened. The size of the passage created is a little tricky, and there are several ways for adjusting the amount of squeezing after the band is in place. The consequences and side-effects are similar to VGB, and there is some suggestion that the weight loss effects do not last long.

In addition, if rapid weight loss occurs, individuals can be left with large flaps of skin where they used to be larger. This can, in turn, lead to some people to plastic surgery to remove the extra skin.

Possible Functional Issues

- Limited joint motion and strength from arthritis (both osteoarthritis and rheumatoid arthritis)
- Difficulty walking long distances
- Difficulty climbing stairs
- Limited functions in small spaces
- Low heat tolerance
- General pain

Initial Interview Considerations

During the interview, be aware that an individual with obesity may be closely watching for any hint that you dislike them or blame them for their condition. Be supportive, clear, direct, and nonjudgmental when talking about functional issues related to their weight. If you ask about any past weight loss surgery, or any that might be considered in the future, make it clear you are ONLY asking about possible functional issues involved. Be careful not to give the impression you think they need surgery or that you disapprove of surgery.

Do NOT recommend weight loss techniques they could try. These individuals know much more about it than you do and have tried everything you can possibly think of. Bringing it up gives the impression you think their problem is simply a matter of willpower and they should just try harder.

Initial Questions

- What medication if any are they taking? Are there significant side effects?
- How often do they have any significant pain or problems with their knees, hips, or feet? Does it limit their mobility?

- Do they have any arthritis? If so, how severe is it?
- What if any other significant medical conditions do they have? What are the consequences?
- Have they had any weight loss or other surgery? What, if any functional side effects are there from it?
- Do they plan to have any surgery in the near future? If so, when and what type?
- How do they feel their weight has caused problems, if at all, in past employment?
- What physical accommodations might help them in a job situation?
- How do they feel about jobs meeting the public (sales, reception, service) compared to office jobs? Do they have a preference?
- How well are they able to drive?
- How much trouble do they have with drowsiness during the day?
- Do they have trouble “getting started” in the morning, initiating things, getting things done during the day? (signs of depression)
- What is their educational history? Their work history?

Initial Observations

Does the person seem to have:

- An attitude of passivity or indifference (low ability to self-advocate)
- Depression
- Walking problems
- Rheumatoid arthritis
- Signs of pain
- Respiratory problems

Interview Accommodations (if any)

- Make sure there are comfortable chairs with no arms available for them to sit in.
- Walking may or may not be an issue, so make sure they do not have to walk a long distance to reach the meeting room.
- Make sure the air conditioning is working well.

Possible Accommodations and Assistive Technology

The most important work issues for obesity may involve office culture and the individual's fear of ridicule. These are difficult to deal with, since many individuals with obesity do not want to attract any attention to their weight and would rather hope a difficult social situation goes away. It may be difficult to have a job supervisor or manager address the topic with the other employees without embarrassing the individual. Similarly, office visits by an advocate may probably make the individual uncomfortable. The best support may be an advocate or support group that the individual contacts regularly and privately during non-work time. This support would help them advocate for themselves or decide if they need to ask for outside help with advocacy.

Other work accommodations might include:

- Comfortable chairs with no arms
- Desk of appropriate height and width
- Limited number of stairs or elevator access
- Transportation between work and home
- A golf-cart or similar cart if long walking distances must be traveled
- Rest breaks
- Appropriately sized uniforms
- Job sharing (if fatigue is an issue)
- Job-seeking skills training (if necessary)
- Job training (if necessary)

Career Planning Issues

- **Realistic activity levels.** It is important to be realistic about the level of physical activity of which that person is currently capable when evaluating possible career choices. When addressing this issue, it is also important to be sensitive to the client's potential embarrassment about the topic. However, do not assume the individual needs a sedentary career. An active job may be a major benefit for them.
- **Meeting the public.** Some individuals may prefer careers that do not involve meeting the public (sales, service, marketing). On the other hand, the individual may enjoy meeting the public but employers may be reluctant to hire them for those positions without advocacy from the VR counselor.
- **Future Surgery.** If the person is planning to have weight loss surgery or any other surgery (knee surgery, hip surgery, etc.) in the future, the employment consequences of that should be discussed.
- **Work History** is not likely to be affected.

- **Intellectual and Educational Skills** are not likely to be affected.
- **Social Skills** are not likely to be affected.
- **Dexterity and Coordination** are not likely to be affected.
- **Problem Solving Skills** are not likely to be affected.

Emerging Issues

- Discrimination and harassment
- Acceptance of “Health at any size” philosophy
- Weight loss techniques
- Insurance coverage for weight loss surgery
- Safety and effectiveness of weight loss surgery

Additional Information Resources

- National Association to Advance Fat Acceptance (NAAFA), www.naafs.org
- Sizewise, www.sizewise.com
- American Obesity Association, www.obesity.org
- The Association for Morbid Obesity Support (AMOS), www.obesityhelp.com/morbidobesity/
- DietFraud, www.dietfraud.com/
- National Library of Medicine fact page on obesity; www.nlm.nih.gov/medlineplus/obesity.html
- www.bodypositive.com
- International Size Acceptance Association: www.size-acceptance.org
- Tipping the Scales of Justice: Fighting Weight-Based Discrimination, by Sondra Solovay