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SunCloud Health Continuing Education Series

Transdiagnostic, integrated care for people with complex co-occurring disorders.

First Do No Harm: Practical Guidance for the Discussion of Health, Wellness, and Body in Clinical Settings

Elizabeth E. Sita, MD
Medical Director of Adult Services

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CLINICAL COLLABORATIVE LEARNING SERIES

A BROADER LENS ON CARE: TRAINING THAT EXTENDS BEYOND ADOLESCENCE

Built for licensed clinicians working across populations and care settings, this series delivers advanced, case-based training grounded in evidence-informed practice.
Each session offers 1.5 nationally recognized CE credits.

SEPT 16
11:00AM - 12:30PM CST

The Hormonal Conversation:
How Stress and Cycles Shape Eating Disorder Symptoms — Physiology and Psychology

Krista Day-Gloe, LCSW
Healing Roots Wellness Center

Scan To RSVP

OCT 07
11:00AM - 12:30PM CST

Trauma Healing Through the Lens of Internal Family Systems (IFS)

Dr. Angele Close, PhD

Scan To RSVP

NOV 18
11:00AM - 12:30PM CST

Centering Survivor Agency:
Ethical Integration of AI in Therapeutic and Violence-Prevention Practice

Aislinn Conrad, LMSW, PhD
Associate Professor
School of Social Work, University of Iowa

Scan To RSVP

DEC 10
11:00AM - 12:30PM CST

Pour Decisions:
The Burnout-Alcohol Loop Professional Women Know All Too Well (Dr. Lori's Version)

Dr. Lori Nabors, PsyD

Scan To RSVP

This activity is jointly accredited by Amedco LLC and Sero Mental Health to provide nationally recognized continuing education for physicians, nurses, psychologists, social workers, counselors, marriage and family therapists, and addiction professionals. Please contact us to ensure this activity meets your individual state or board requirements.

FOR MORE INFORMATION, VISIT OUR WEBSITE AT WWW.SUNCLOUDHEALTH.COM OR CONTACT US AT 877.260.8477.

First Do No Harm: Practical Guidance for the Discussion of Health, Wellness, and Body in Clinical Settings

Navigating Weight-Related Health Conversations Without Feeding Eating Disorders

Elizabeth Sita, MD
Medical Director of Adult Services | SunCloud Health

Learning Objectives

Identify sources of weight stigma in healthcare
Use patient-centered, non-stigmatizing language
Integrate medical risk assessment with ED-informed care

I have nothing to disclose.

Naming the Tension

“I need to address metabolic health, but I’m afraid of causing harm.”

The fear is valid
AND
Avoidance also causes harm
BUT
Addressing medical risk and
Minimizing ED harm need not be in conflict

What I See in Practice

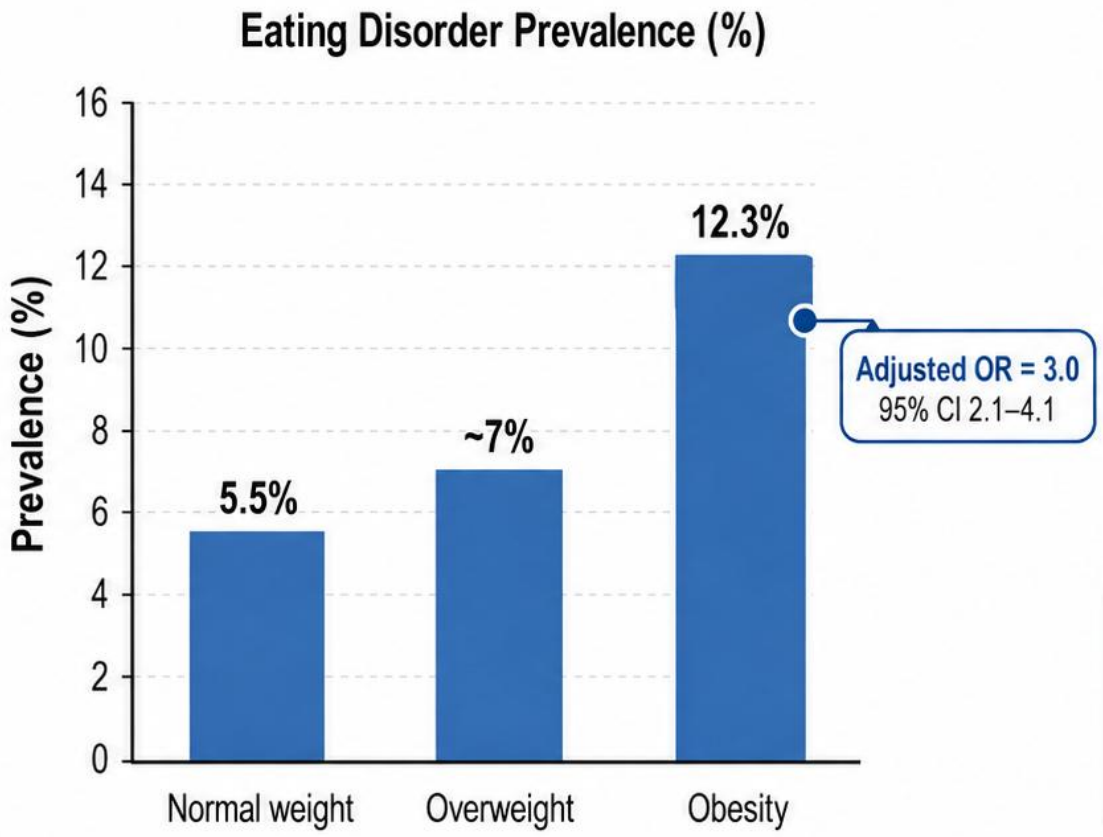
Eating disorders occur across all body sizes
AAN can be as medically severe as AN
Healthcare encounters can prevent—or reinforce—harm

Objective 1

SOURCES OF WEIGHT STIGMA AND FAT PHOBIA IN HEALTHCARE

Eating Disorders Exist at Every Size

Prevalence is highest among individuals with obesity
High-BMI patients may already have an eating disorder
Risk is often missed when weight is elevated



[1] Geerinck et al., 2025, *BMC Public Health*.

Atypical Anorexia Nervosa

Meets AN symptoms except low weight
Can be medically and psychologically severe
Screen before celebrating weight loss

How Weight Stigma Fuels Disordered Eating

Systematic Review

242 studies: greater weight stigma — experienced, anticipated, and internalized — is consistently associated with more disordered eating cognitions and behaviors.

[13]

Experienced weight stigma → **Internalized weight stigma** → **Binge eating**

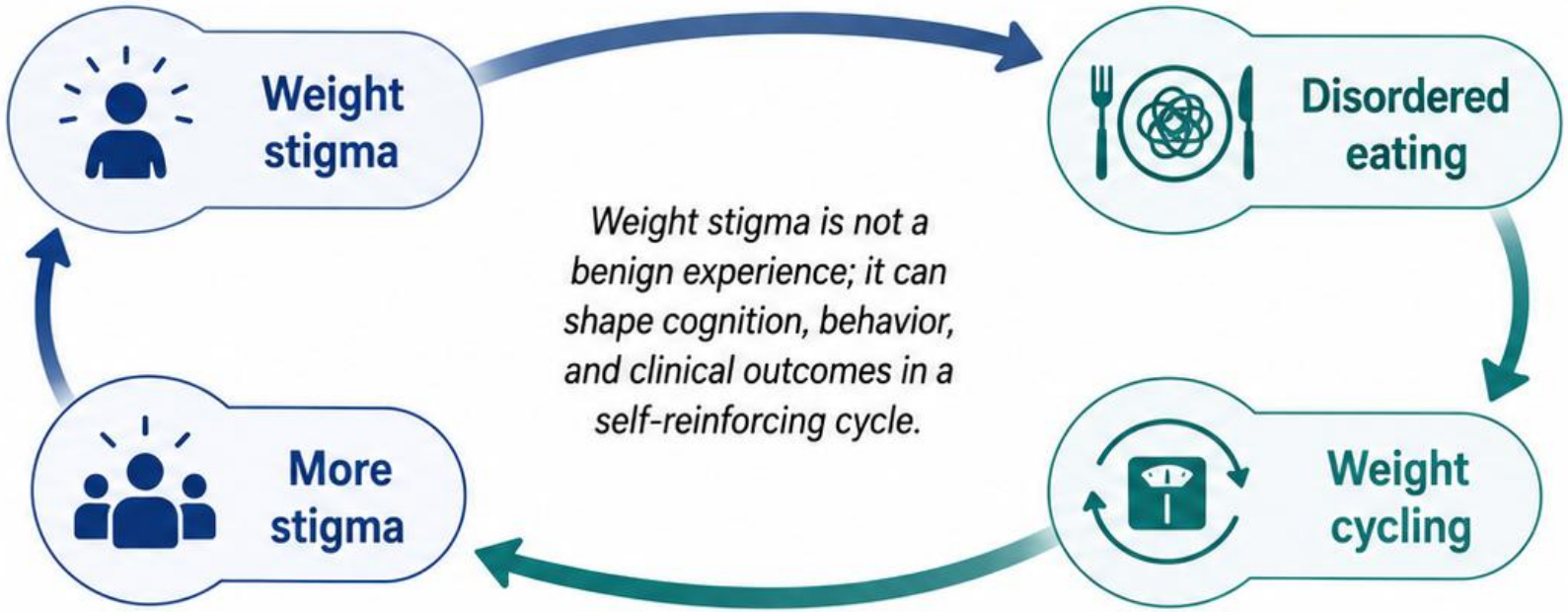
Longitudinal mediation significant in higher-weight individuals

[14]

Qualitative Findings in Atypical Anorexia Nervosa (AAN)

- Provider pathologizing of weight triggered eating-disorder behaviors
- Provider praise of weight loss reinforced restriction
- Provider minimization of ED symptoms in larger bodies delayed diagnosis and care

[2]



[13][15]

Where Stigma Lives

Implicit bias and clinical behavior
Language and documentation
Clinic environment and equipment
Praise without screening

Red Flags When a Higher-Weight Patient Loses Weight

Clinical vigilance should be driven by behaviors, trajectory, and medical instability — not just body size.

1. Screen before praising weight loss — always

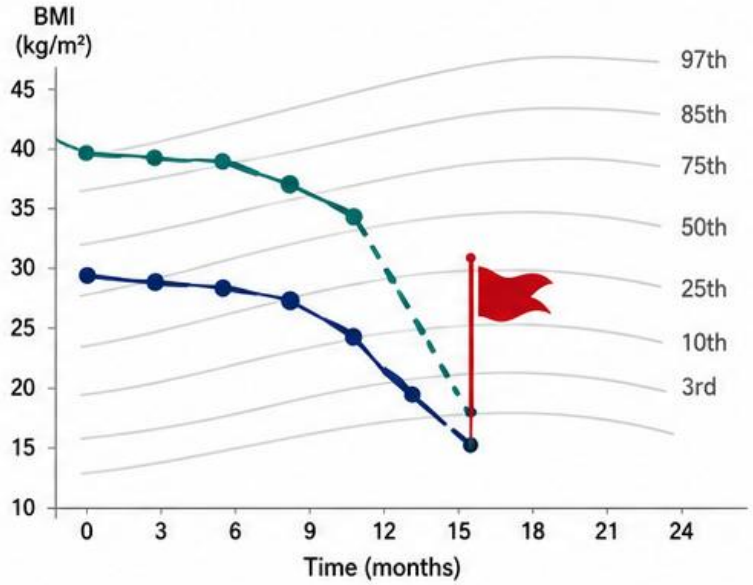
Don't say:

Safer approach:

Before commenting, screen for restriction, purging, bingeing, compulsive exercise, and body image distress.

Weight loss can reflect illness, not health.

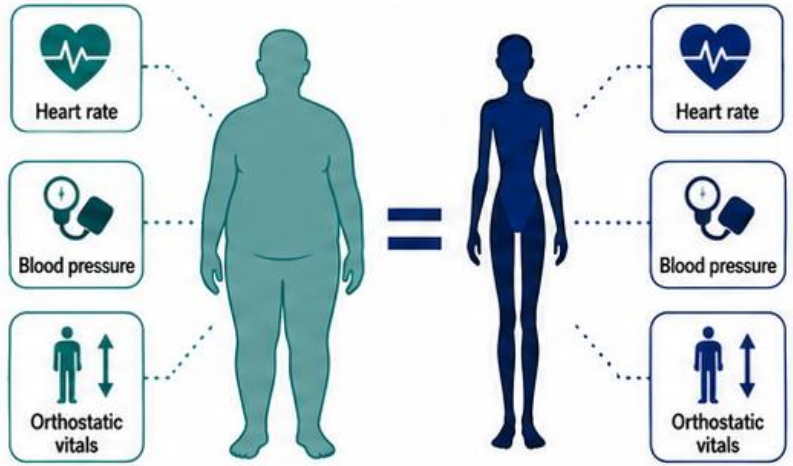
2. Plot the trajectory — rapid decline is a red flag



Rapid decline matters regardless of starting BMI.

Look at change over time, not just a single BMI point.

3. Check vital signs with the same vigilance as for a thin patient with AN



Clinical red flags

bradycardia • orthostasis • medical instability

Patients in larger bodies can be just as medically compromised.

Key message: Do not let a higher BMI create false reassurance.
Screen, assess trajectory, and monitor vitals with the same urgency as in classic anorexia nervosa.

Objective 2

NON-STIGMATIZING COMMUNICATION THAT PROTECTS AGAINST EATING DISORDERS

Before Discussing Weight

Screen for ED risk first
Assess vulnerability and trajectory
Prioritize stability when risk is present

Primary Care Screening Tools

SCOFF: brief and commonly used
EDS-PC: high sensitivity
SDE: strong classification performance

Use targeted screening when risk is present

“Screen Before You Speak”

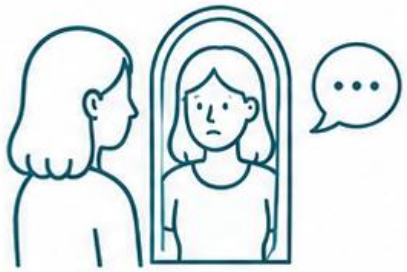
1. Current eating patterns

- Are there any foods you avoid?
- Have your eating habits changed recently?

2. Weight control behaviors

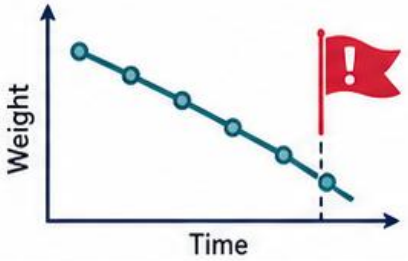
- Have you ever skipped meals, used supplements, or done anything else to try to change your weight? [3]

3. Body image



- How do you feel about your body?
- Has anyone ever made comments about your weight that bothered you?

4. Growth/weight trajectory



- Look for rapid decline, which may indicate restriction even if current weight is elevated [3–4]

5. Vital signs

- Heart rate, orthostatic vitals — bradycardia and orthostatic changes occur in AAN at any weight

When Is Weight Loss Appropriate?

Use caution—especially during growth
Focus on health behaviors and function
If needed, use structured monitoring
Avoid self-guided dieting

Language That Causes Harm

Avoid dieting, restriction, and elimination rules
Avoid weight as worth or sole health proxy
Avoid praising weight loss without context
Use neutral, permission-based language

Language Swaps

	Avoid	Try instead	
Opening the conversation	"We need to talk about your weight"	"Would it be okay to talk about your health and how you're feeling in your body?"	[1–2]
Weight loss noted	"Great job losing weight!"	"I notice a change in your weight. Can I ask you a few questions about how you've been eating and feeling?"	[3–4]
Discussing nutrition	"You need to stop eating junk food" / "Cut your calories"	"Let's talk about adding more variety and nourishing foods rather than taking things away. Consistency and adequacy matter most."	[2, 5]
Discussing labs	"Your labs are bad because of your weight"	"Your labs show some changes in how your body is processing glucose. There are several ways we can support this — nutrition, sleep, stress, and sometimes medication."	[6–7]
Discussing activity	"You need to exercise more to lose weight"	"What kinds of movement do you enjoy? How does your body feel when you're active?"	[2, 5]
Patient asks about dieting	"Yes, you should cut calories"	"I'm glad you're thinking about your health. Let's talk about what nourishing eating looks like — and what to watch out for."	[8–9]

Motivational Interviewing

Not convincing—eliciting
Open questions, affirmations, reflections, summaries
5As: Ask, Advise ↔ Assess, Assist, Arrange

FEATURE	THE 5A's FRAMEWORK	MOTIVATIONAL INTERVIEWING (MI)
WHAT IT IS	Structural Roadmap / Protocol V	Communication Style / Philosophy
CORE FOCUS	Action Steps for Clinician	Resolving Patient Ambivalence
DELIVERY	Brief, 3-5 Minutes	Brief or Deeper Counseling

Case 2: “The Family in Conflict”

Parent uses shaming language in front of child
Validate concern—not shame
Redirect and model safer language
Screen for bullying, body image distress, ED symptoms

Remember:
The fear is valid
AND
Avoidance also causes harm

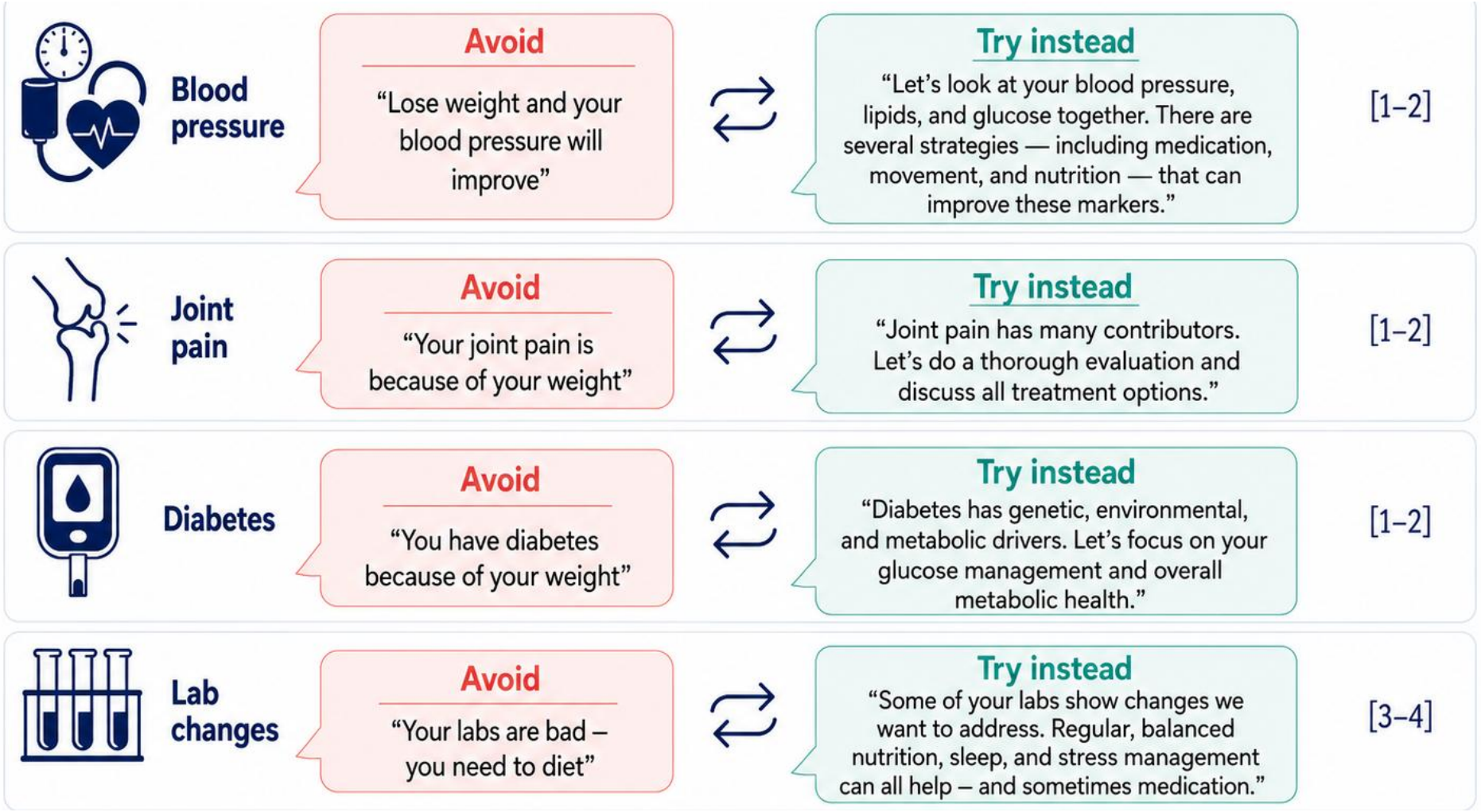
Objective 3

INTEGRATING RISK ASSESSMENT WITH EATING DISORDER-INFORMED CARE

Address Medical Concerns Safely

Anchor in modifiable health factors
Discuss behaviors—not numbers
Discuss metabolic markers—not BMI
Monitor for unintended consequences

Separating Weight-Centric Assumptions from Evidence-Based Risk Assessment

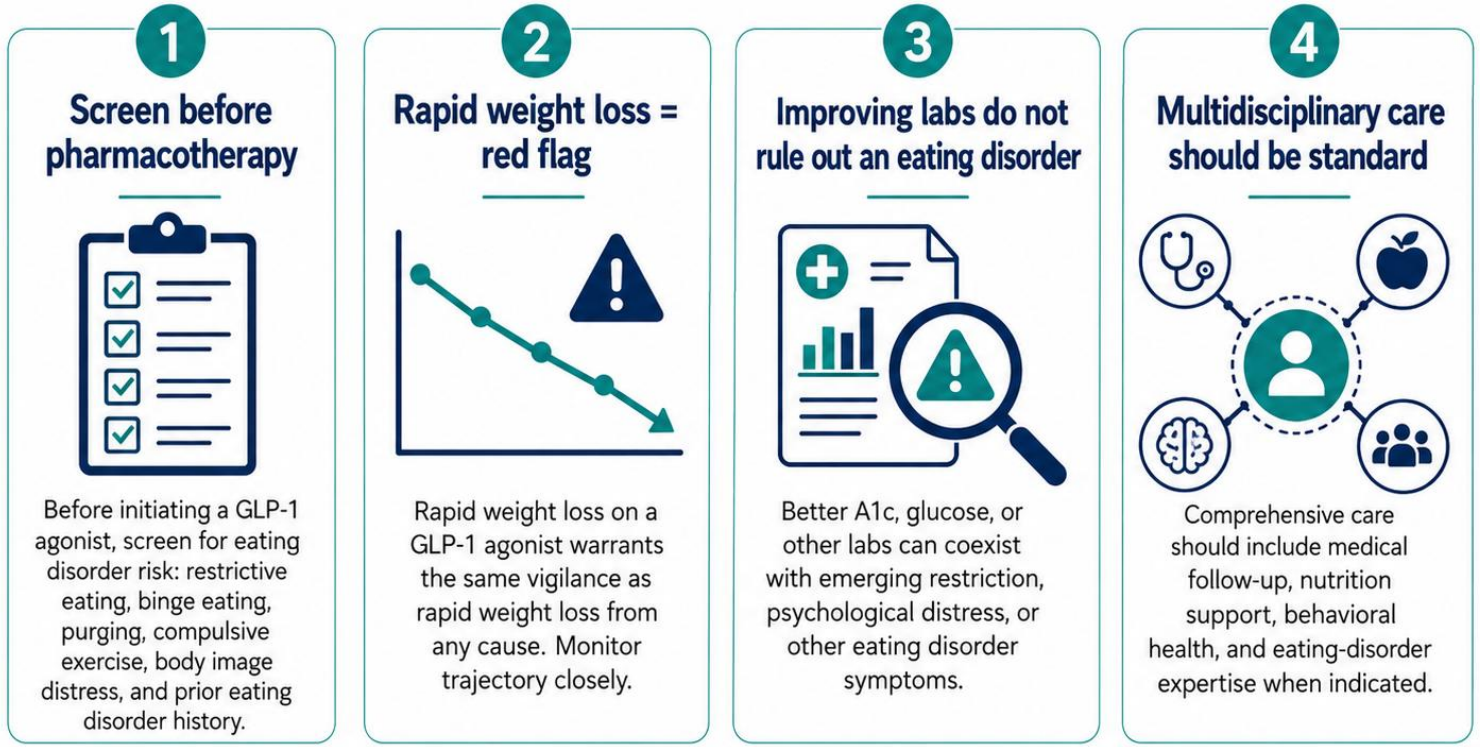


The GLP-1 Era

Screen before prescribing
Monitor rapid loss and restriction
Watch psychological distress
Frame medication as one tool—not the whole plan

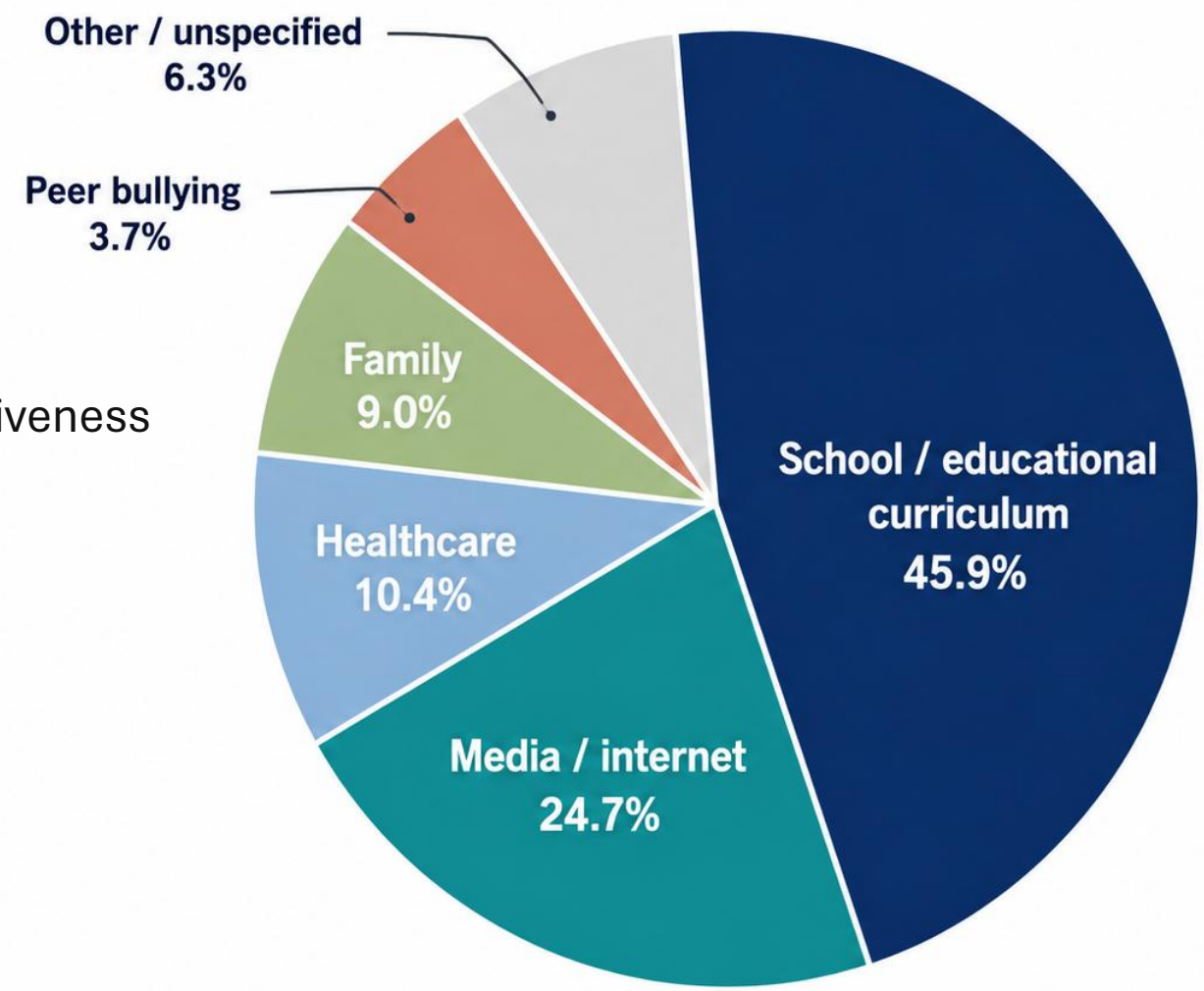
Case 3: “The Referral That Wasn’t”

Semaglutide started without ED screening
A1c improves while restriction escalates
Rapid weight loss warrants vigilance
Improving labs do not rule out ED



Repair After Harm

Name the possibility without defensiveness
Validate the experience
Redirect to safety and nourishment
Bring in supports



[6]

PUTTING IT ALL TOGETHER

Decision Framework

1. Screen
2. Assess metabolic health
3. Ask permission
4. Use neutral language
5. Refer appropriately
6. Monitor over time

Check Your Own Bias

Take the Weight IAT
Reflect before praising weight loss
Question assumptions about ED risk
Document with care

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Supporting Your Practice

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Resources

USPSTF Eating Disorder Screening Statement
APA Eating Disorders Practice Guideline
AAP Identification and Management Report
NEDA Screening Tool
Project Implicit Weight IAT
SCOFF, EDS-PC, SDE

Key Takeaways

EDs occur at all body sizes
AAN can be severe
Language and documentation matter
Structured care protects; self-guided dieting harms
Anchor medical care in specific, modifiable factors
Repair prior harm directly
Ask, language, connect

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