THE FIRE LINE

Fond du Lac Fire/Rescue Monthly Newsletter

FOND DU LAC FIRE / RESCUE

October, 2019 Edition

FROM THE BALCONY

A message from Chief Peter O'Leary

Strategic Planning

Next month we will be joined by members from the Center for Public Safety Excellence (CPSE) as they work with us on our second Community Driven Strategic Plan. Five years ago I recall a heightened level of anxiety of the unknown prior to their visit. This time around I am excited about the opportunity to have our community and many of you weigh in on where we've come in five years and where we need to be in the years ahead.

We have experienced extensive growth since 2015. The strategic planning process can help us identify what we should keep doing and maybe some things we need to change to get even better. The worst thing we can do is assume that we have no place for growth. If we sit back on our top ISO rating or accreditation status from five years ago, we will be set up for failure. We have to be open to the possibilities that we have yet to encounter and mindful to the feedback we will receive both externally and internally. Every voice matters in the process. No matter how many years of service you have, the input that helps drive strategic planning is owned equally by all participants.

When we receive our updated Community Driven Strategic Plan we will have a living and breathing document which we all should take ownership of and work together to accomplish the tasks set forth in the report. This process will benefit us in 2020 when we embark on reaccreditation.

If you are chosen to participate, please give your absolute best effort during the process. If you were not chosen, please encourage your co-workers and know they are going to speak for all of us as we pave the roadway for 2020 and beyond. Thank you all in advance for your support and participation. Together we are better.

Until next month,

Be Safe and Be Well

INSIDE THIS ISSUE:

UPCOMING EVENTS

Fire Prevention Week Open House
Tuesday, Oct. 8
4:30—6:30pm

Trick or Treating Hours
Saturday, Oct. 26
3:30—5:30pm

FOND DU LAC FIRE RESCUE OPERATIONS

By: Assistant Chief Erick Gerritson

Moving up the Ladder

As we move into the "season" of the promotional process for Lieutenant and Engineer, we face challenging situations with expertise and aggressiveness. For some of us, however, we find it difficult to handle the doubt and bittersweet feelings that come with the progression from firefighter to officer, "junior" officer to "senior" officer, and finally to chief.

Book vs. Street

If you've devoted endless hours to study; have prepared yourself mentally, physically, and emotionally; and have been a student of the national or worldwide fire service; you're ready to accept the promotion to the next rank. Now we all know people who are "book smart" and lack real-world experience, and we also know people on the other end of the spectrum who pass the promotional exam or assessment center but may not be as particularly astute to the technical way of doing things.

There are arguments about which one of these types is better, but fortunately most of us probably fall somewhere in the middle of these two extremes. That being said, being honest with yourself and recognizing where you fall on this scale may be the most important insight you'll have.

If you're the book smart, newly promoted officer, you should strive to learn the hands-on craft of the position you're being promoted to prior to the promotion. That means observing the people currently in that position to see how they do their jobs. It means getting the bigger picture on the position from a firefighter who concentrates on your particular job and position on any given alarm, the lieutenant who's responsible for the rest of the crew, the captain who must worry about a company and/or firehouse, and the members who report and respond within them.

Conversely, the senior member who's been there and done that may need to get into the less exciting administrative functions that come with each promotional step. It's part of the territory and shouldn't be a surprise. And if you're only taking the promotion for financial reasons, you'll need to embrace this part of the job or it has the potential to torture you all the days of your working life.

It's A Big World

Confidence (not cockiness) is the key here. If you look at a promotion as a good and positive thing, then the good will outweigh the relatively short-term negative feelings of loss from having to leave your comfort zone.

That big world exists no matter where you work and no matter how large or small your department may be. Leaving a firehouse area can be a breath of fresh air to what may have become a comfortable and perhaps complacent way of doing your job. You may not even realize this until you're out and about working in other places.

FOND DU LAC FIRE RESCUE OPERATIONS

By: Assistant Chief Erick Gerritson

Moving up the Ladder, continued...

Have Confidence

Once you have made the PFC list through a promotional exam and assessment procedure, you should be confident that the people and the process put you into this new position and you should be ready to take the reins.

Will there be a learning curve? Of course-there always is. Will you make mistakes? Of course you will. But if you've invested time beforehand to observe people in those positions, then you'll have allowed yourself opportunities to learn from their mistakes in addition to the ones you're bound to make.

It's Never Too Early

As a young firefighter with aspirations to move up the ranks someday, it's never too early to watch the officers currently in those positions. How they handle the day-to-day routine, administrative function, and emergency responses will be valuable learning opportunities-don't let them pass you by. Emulate the officers you like/respect/admire and think about the actions of the ones you don't. Ask what you would do differently in the same situation (use caution though, you may not be privy to all the facts in any given scenario or situation).

If you don't participate in the promotional process, then someone else will. Think of some of the officers who rank above you. Could you do the job better than they can? If the answer is yes, why wouldn't you take that challenge and grasp the opportunity to do it better?

Source; FireRescue magazine, Stephen Marsar

Until next month…Stay Safe!!!

OPERATIONS BY THE NUMBERS

AUGUST, 2019	THIS MONTH		YEAR–TO–DATE	
PREVENTION	**Last Year**	**This Year**	**Last Year**	**This Year**
Total Inspections	164	248	2,048	2,131
Total Defects	122	201	1,416	1,330
SUPPRESSION				
Alarms Involving Fire	7	10	98	77
Fire Mutual Aid Given	0	1	11	7
Fire Mutual Aid Received	0	0	0	0
Service/Good Intent Calls	39	45	376	346
False Alarms & False Calls	36	31	200	259
Other Calls	29	12	113	121
Total Fire Alarms & Calls	111	98	787	803
EMS				
Total Ambulance Calls	558	540	4,047	4,177
Total Fire & Ems Responses	651	638	4,834	4,980
Fire Property Loss	$115,750.00	$3,700.00	$315,165.00	$313,538.00
Fire Contents Loss	$36,000.00	$9,015.00	$136,260.00	$138,196.00
Engine Assisted EMS Calls	244	215	1,721	1,818

Brian Munson ~ Garth Schumacher ~ Andy Aird ~ Jake Fisher ~ Andrew Behnke

Not every hero wears a cape!
Plan and practice your escape!
Fire Prevention Week—October 6-12, 2019

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at City of Fond du Lac Fire/Rescue

follow us on twitter
at fdlfire

The Code Summary

By: Todd Janquart
Assistant Chief of EMS

5 Tips for Airway Management in the Bariatric Patient

Pre-oxygenate, evaluate for LEMONS and position a patient of any size correctly to help secure an airway

This is really a great article on dealing with difficult airways and not just bariatric patients. Airway control in general is extremely difficult in these types of patients regardless of the adjunct being utilized. Unfortunately training scenarios and manikins cannot replicate the difficulty of dealing with these types of airways and we must rely on specific techniques to overcome the hurdles of what appears to be an impossible intubation.

The 911 call was for cardiac arrest, and I was in the enviable position of second-in medic; do all the procedures and none of the paperwork. I'll admit I was pretty cocky as I arrived, ready to strut in, do all the easy stuff (ALS procedures being "easy" compared to chest compressions, though not nearly as important) and clear the scene in a blaze of glory, leaving bewildered cops and firefighters to exclaim, "Who *was* that masked man?"

And then I saw the patient.

FIGURE 1A. Patient with super morbid obesity with large neck and a beard

He weighed well over 600 pounds and had collapsed in the hallway. His head and shoulders – with no neck visible – were in the hall, and his entire lower body was still in the bedroom. The first-in crew was in the bedroom – they'd had to climb over the patient – already doing CPR as best they could, and the medic looked up hopefully and asked, "Get the airway?"

Maybe this second-in medic stuff isn't that sweet a deal, after all, I mused as I lay down at the patient's head, assembling my equipment as my partner knelt in the bathroom doorway and attempted BVM ventilation as best she could. Thirty seconds later, I had a patent 8.0 tube, and was delivering effective ventilations with 100% oxygen.

The rest of the resuscitation went pretty smoothly as resuscitations go, despite the fact that we were essentially two code teams in two separate rooms. Securing the airway that easily in a patient that challenging gained me a reputation among my colleagues as an airway samurai, and did little to help my already bloated ego.

Pride, as they say, goeth before the fall.

It was barely six months later that we ran a bariatric patient in respiratory failure, who lived, predictably, in the back bedroom of a cramped frame house. He was struggling, but he wanted to move himself, and realistically, there was no way we could have moved him to our stretcher ourselves anyway.

Turns out, a stand and pivot onto a stretcher three feet away was more than he had in him, and he stopped breathing as we were securing the straps. This time I did not coat myself in glory. I managed to secure a tube … eventually, but not without a great deal of failed BVM ventilation, sweating, cursing and using every trick in my airway bag.

All this is to say that, like Forrest Gump's bawx o' chawklits, when it comes to airway management in the bariatric patient, you never know what you're gonna get.

With that in mind, here are some ventilation tips that will work with a patient of *any* size, but may serve you well in managing the bariatric patient airway:

1. **Size matters not.** With apologies to Yoda, size actually *does* matter, but perhaps not in the way you think. Don't approach airway management in the bariatric patient as an impossible feat, or that mental attitude will make the prospect of a failed airway a self-fulfilling prophecy. However, size *does* matter when it comes to tidal volumes. Remember that tidal volumes are calculated on ideal body weight, not actual. It doesn't matter if your patient weighs 700 pounds, if he's of average height, his calculated tidal volume is going to be the same as that of an average-sized male. If you need to improve oxygenation, do it with inspired FiO_2 and PEEP, not bigger breaths.

The Code Summary

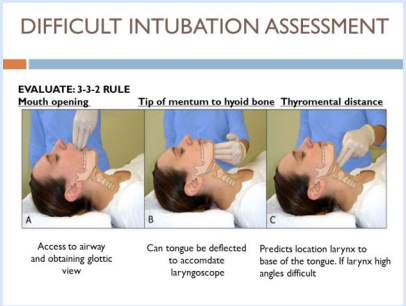
By: Todd Janquart
Assistant Chief of EMS

5 Tips for Airway Management in the Bariatric Patient, continued...

2. Pre-oxygenate. The mantra you need to follow here is, resuscitate, then intubate. Your patient is dying from hypoxia, not lack of an ET tube. Utilize effective two-person BVM ventilation and start with a minimum of 5.0 cm H20 of PEEP. Use the NO-DESAT apneic oxygenation technique, and get your patient's oxygen saturation above 95% (if you can) for at least three minutes before you attempt an advanced airway adjunct. Doing so will broaden your intubation window from seconds into many minutes before hypoxia sets in. This will give you time to formulate an airway plan, and speaking of plans …

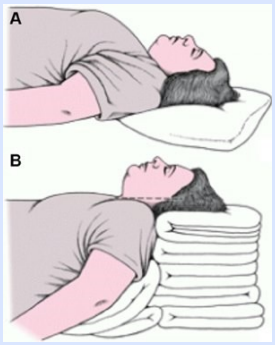
3. Evaluate for LEMONS. Every intubation attempt requires a plan, and the first part of planning is knowing what you're facing. Evaluate the LEMONS mnemonic, and formulate a treatment plan while you're pre-oxygenating:

- **L**ook externally
- **E**valuate the 3-3-2 rule
- **M**allampati
- **O**bstructions/**o**besity
- **N**eck mobility
- **S**aturation



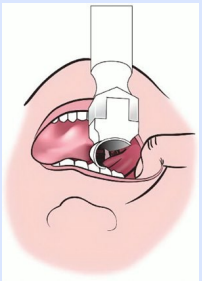
Plan A is your preferred airway, Plan B is your backup airway and Plan C is cricothyrotomy. And remember, your supraglottic airway device might be the preferred one instead of the backup, depending upon your skill level at intubation and what you learn from LEMONS.

4. Position your patient appropriately. It doesn't matter if your patient weighs five pounds or 500, the sniffing position is the same; face parallel with the ceiling, and external auditory canal horizontally aligned with the top of the shoulder or the sternum. The only thing that varies is where and how much you pad. Most people think of the sniffing position as neck extension, but in reality, it's neck flexion of 15 degrees or so, with the head extended about 10 degrees on the neck. Think of someone extending a flower for you to sniff, and that's the position you want your patient in.



In the five-pound neonate, that may mean a couple of inches of towels padded under the shoulders. In the bariatric patient, it means ramping, using whatever means you have at hand: towels, blankets, sofa cushions or your partner's knees.

Ramping allows you to position your patient appropriately to align the oral and laryngeal axes, and keep the airway open to allow all that nasal oxygen to diffuse down to the alveoli and broaden that normoxic window to get the airway device secured.



5. Remember that airway management is a team sport. Every winning team utilizes all its players effectively, and plays with the proper equipment. A video laryngoscope is an extremely useful adjunct and growing so affordable these days that there is little excuse not to have one. You should also be using a bougie. Have your suction unit ready and be prepared to utilize suction assisted laryngoscopic airway decontamination (SALAD). Use bimanual laryngeal manipulation using the backwards, upwards, rightward pressure on the larynx (BURP) method, and have your partner provide lip retraction to the right corner of the mouth.

These tips may not only help you manage your bariatric patient's airway, but will also be useful in managing an airway in a patient of any size.

Author Kelly Grayson from August 27th, 2019 online edition of EMS1.com

Respect your efforts, respect yourself. Self-respect leads to self-discipline.
When you have both firmly under your belt, that's real power. Clint Eastwood

News from the Station

Members of the Command Staff from Fire/Rescue were on hand at two different 9/11 events. Chief O'Leary spoke to a group gathered at Hamilton Park. Later that day MPTC dedicated a memorial to Fire/Rescue and the Police Dept. in honor of those who lost their lives on that horrific day.

The ARC Fond du Lac recently stopped for a visit at Station 1. The crew showed them around the station and let them sit in the trucks. Sparky was even on hand to give a high five and take pictures with the group!

City of Fond du Lac Fire/Rescue and the Fond du Lac Police Department held a ribbon cutting and open house for the Public Safety Training Center on Rolling Meadows Drive.

What a great day and celebration of vision, mutual cooperation and teamwork. Thank you Fond du Lac!

Fire/Rescue had fun grilling hot dogs and serving up A&W root beer at the Hamilton Park Under the Stars Movie Night held recently. What a great night spending time in the community!

FDLFR joined their law enforcement partners at Dunkin Donuts to raise money for Special Olympics.

Well trained people are the best defense against fire.

By: James Knowles III
Assistant Chief Training/Safety

Vehicle Rollover Prevention

Emergency vehicle rollovers are an all too frequent cause of vehicle damage, serious injury and fatalities. Very often, however, these incidents are of a highly preventable nature. All emergency vehicles are subject to rollovers, but tankers, pumper tankers and ambulances are particularly vulnerable because of their high center of gravity.

The simplest method of prevention is for the emergency vehicle driver to simply slow down. Excessive speed greatly reduces the driver's ability to control the vehicle on curves or when making evasive steering moves. Driving at a reduced speed will increase the driver's ability to keep the vehicle under control during a wider range of circumstances. Excessive speed increases the likelihood that the weight will shift and cause the vehicle to be uncontrollable.

In addition to excessive speed and shifting weight, another leading cause of vehicle rollover is oversteering after dropping off the road surface onto the shoulder of the road. Oversteering will cause the vehicle to rollover by causing the weight to severely shift from one side to the other and/or by the vehicle tires gripping the road at an excessive angle once brought back off of the shoulder.

The potential for this type of incident increases as the difference in height between the road surface and the shoulder increases. The greater the difference in height, the greater the angle of steering must be applied to overcome the resistance of the road surface against the tires of the vehicle. Once the tires are at a great enough angle to overcome the resistance and return to the driving surface, they will either grip and shoot the vehicle in the opposite direction, or will buckle and roll. Either way, the results are the same . . . a wrecked vehicle.

The following safe driving points will increase the emergency vehicle driver's ability to maintain control of their vehicle should he/she run off of the road surface onto the shoulder.

Things to Do:

- Take your foot off of the accelerator and allow the vehicle to slow down gradually.
- Do not apply full braking! Use soft application of the brakes, natural deceleration and downshifting to bring the vehicle to a safe speed or complete stop.
- Under soft shoulder conditions, feather the accelerator to help maintain control of the vehicle while slowing.
- Once the vehicle has been stopped or been brought down to a safe speed, gently steer the vehicle back onto the road surface using a lower gear and/or feathered acceleration to assist in overcoming the surface drop off or soft shoulder.

Things Not to Do:

- Do not attempt to steer back onto the road surface at speed or under acceleration.
- Do not make any sudden or drastic steering movements.
- Do not apply full braking.
- Do not attempt to accelerate over the surface drop off.

Source: *Risk control services dept. (2011). Vehicle rollover prevention. VFIS. Retrieved from: https://www.vfis.com/Portals/vfis/fire-truck-safety/Vehicle-Rollover-Prevention-VFIS.pdf*

Proclamation

***Whereas**, the city of Fond du Lac is committed to ensuring the safety and security of all those living in and visiting Fond du Lac; and*

***Whereas**, fire is a serious public safety concern both locally and nationally, and homes are the locations where people are at greatest risk from fire; and according to the NFPA home fires killed 2,630 people in the United States in 2017; and*

***Whereas,** when the smoke alarm sounds Fond du Lac residents may have less than two minutes to escape to safety; and residents who have planned and practiced a home fire escape plan are more prepared and will therefore be more likely to survive a fire; and*

***Whereas,** residents should make a home escape plan, drawing a map of each level of the home, showing all doors and windows; and should practice the home fire escape plan with everyone in the household, including visitors at least twice a year, during the day and at night; and residents should get out and stay out, never going back inside the home for people, pets, or things; and*

***Whereas,** our residents are responsive to public education measures and are able to take action to increase their safety from fire, especially in their homes; and*

***Whereas,** the 2019 Fire Prevention Week theme, **"Not Every Hero Wears a Cape. Plan and Practice Your Escape!"** effectively serves to remind us that we need to take personal steps to increase our safety from fire.*

***Therefore,** I, Brian Kolstad, President of the Fond du Lac City Council, do hereby proclaim October 6-12, 2019, as Fire Prevention Week, and I urge all the people of Fond du Lac to be aware of their surroundings, look for available ways out in the event of a fire or other emergency, respond when the smoke alarm sounds by exiting the building immediately, and to support the many public safety activities and efforts of Fond du Lac Fire/Rescue during Fire Prevention Week 2019.*

CITY OF FOND DU LAC

Dated: September 2019

Brian Kolstad

Brian Kolstad
City Council President

FIRE PREVENTION WEEK OPEN HOUSE

TUESDAY, OCTOBER 8, 2019

4:30 – 6:30PM

STATION 1, 815 S. MAIN ST.

FOND DU LAC
EST. 1848
FIRE / RESCUE

Join us for:
Vehicle & Station Tours
Live Burn • Water Games
Fire Prevention Activities

Not every hero wears a cape

Plan & practice your escape!

FIRE PREVENTION ....

That's what it's all about!

By: Troy Haase
Division Chief of Fire Prevention

The History of Fire Prevention Week

Since 1922, the NFPA has sponsored the public observance of Fire Prevention Week. In 1925, President Calvin Coolidge proclaimed Fire Prevention Week a national observance, making it the longest-running public health observance in our country. During Fire Prevention Week, children, adults, and teachers learn how to stay safe in case of a fire. Firefighters provide lifesaving public education in an effort to drastically decrease casualties caused by fires.

Fire Prevention Week is observed each year during the week of October 9th in commemoration of the Great Chicago Fire and the Peshtigo Fire, which both began on October 8, 1871, and caused devastating damage. The Great Chicago Fire killed more than 250 people, left 100,000 homeless, destroyed more than 17,400 structures, and burned more than 2,000 acres of land. The Peshtigo Fire burned approximately 1,200,000 acres and is often cited as the deadliest wildfire in American history, with the estimated deaths of around 1,500 people and possible as many as 2,500.

How to make a Home Fire Escape Plan

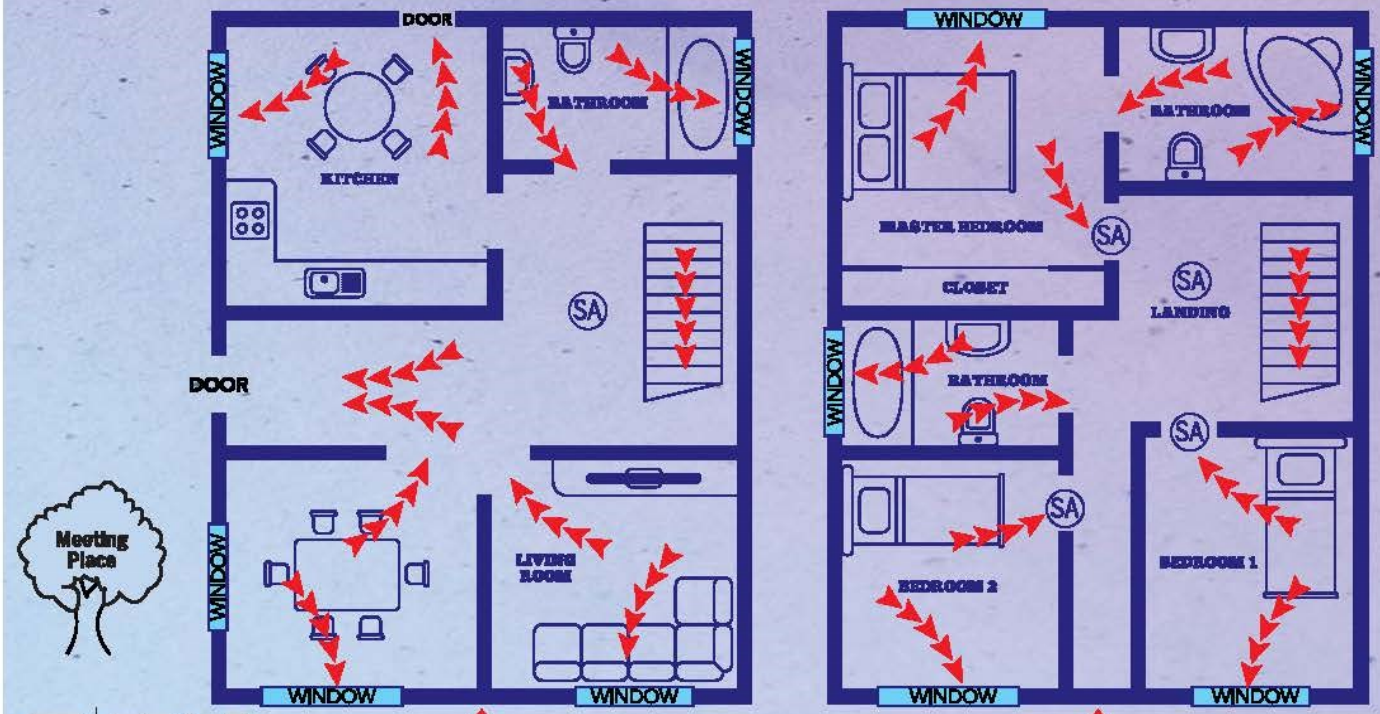
FIRE PREVENTION WEEK™

NFPA® — The Official Sponsor of Fire Prevention Week Since 1922

Visit **Sparky.org** for more activities!

- ☐ Draw a map of your home. Show all doors and windows.
- ☐ Visit each room. Find two ways out.
- ☐ All windows and doors should open easily. You should be able to use them to get outside.
- ☐ Make sure your home has smoke alarms. Push the test button to make sure each alarm is working.
- ☐ Pick a meeting place outside. It should be in front of your home. Everyone will meet at the meeting place.
- ☐ Make sure your house or building number can be seen from the street.
- ☐ Talk about your plan with everyone in your home.
- ☐ Learn the emergency phone number for your fire department.
- ☐ Practice your home fire drill!
- ☐ Make your own home fire escape plan using the grid provided on page 2.

Sample Escape Plan



Kids

FIRE PREVENTION ....

That's what it's all about!

By: Troy Haase
Division Chief of Fire Prevention

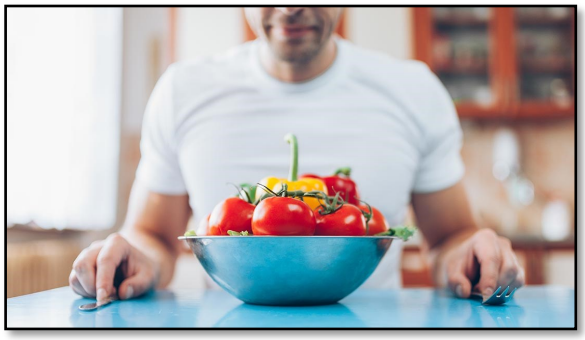
Current Status of New Construction

- Fond du Lac County Garage at 1820 S. Hickory Street- Building is under construction.
- Fond du Lac Airport at 260 S. Rolling Meadows Drive- Building is under construction.
- VGM Storage Units at 450-456 West Arndt St.- Buildings are under construction.
- Mercury Marine Plant 17 at 545 W. Pioneer Road- Building is under construction.
- Mercury Marine Plant 98 Addition at 545 W. Pioneer Road- Building is under construction.
- Lenz Truck Center at 536 Seymour Street- Building is under construction.
- Eilertson Electric at 920 Willow Lawn Road- Building is under construction.
- Fairfield Inn at 935 S. Rolling Meadows Drive- Building is under construction.
- Ducharme Cottages at 100-400 Ducharme Parkway- Buildings are under construction.
- River Hills Mixed Use Development on S. Main Street- Buildings 1, 2, 3, 4, 5 & 8 are complete and 6 & 7 are under construction.

PEER FITNESS TIPS

By: Peer Fitness Trainer
Jack Prall

Study: When Does Clean Eating Become an Unhealthy Obsession



Researchers at York University's Faculty of Health say those who have a history of an eating disorder, obsessive-compulsive traits, dieting, poor body image and a drive for thinness are more likely to develop a pathological obsession with healthy eating or consuming only healthy food, known as orthorexia nervosa (ON). Although eating healthy is an important part of a healthy lifestyle, for some people this preoccupation with healthy eating can become physically and socially impairing.

In the first exhaustive review of the psychosocial risk factors associated with orthorexia nervosa, York University psychology researchers examined all studies published up until the end of 2018 in two popular databases. They looked at studies that examined how orthorexia nervosa is related to psychosocial risk factors that predisposed or made an individual vulnerable or more likely to develop the condition. They then amalgamated all available findings for each risk factor to reach conclusions about which psychosocial factors were most reliably associated with the condition. The results, which were published in *Appetite,* highlight the social and psychological factors associated with orthorexia nervosa (see sidebar).

"The long-term impact of these findings is that they will lead to better recognition among healthcare providers as well as members of the public that so-called healthy eating can, in fact, be unhealthy," explains Jennifer Mills, associate professor in the Department of Psychology and senior author on the study. "It can lead to malnourishment or make it very difficult to socialize with people in settings that involve eating. It can also be expensive and time-consuming."

Previous research has shown that unlike individuals with anorexia nervosa who restrict calories to maintain very low body weight, people who have orthorexia nervosa have a fixation with the *quality* of food eaten and its preparation rather than the number of calories. Over time, they spend increasing amounts of time and effort purchasing, planning and preparing pure and healthy meals, which eventually becomes an all-consuming obsession that interferes with other areas of life and results in weight loss.

"When taken to the extreme, an obsession with clean eating can be a sign that the person is struggling to manage their mental health."

One of the main reasons for conducting this study was that current research on the condition is limited. Unlike other eating disorders, such as anorexia or bulimia, orthorexia is not recognized in standard psychiatric manuals for healthcare providers.

"It was surprising to me that the overwhelming majority of the articles in this field were of neutral-poor quality, indicating that the results of these studies must be interpreted with caution," says Sarah McComb, a master's student in Mills' lab and first author of the study. "It really suggests a call for more valid measurement tools of orthorexia, so that more reliable conclusions can be drawn about the true prevalence of orthorexia in the population and which psychosocial factors really put a person at risk for developing orthorexia nervosa."

What Does the Research Mean to Health and Exercise Professionals?

As a health and exercise professional, you may have considerable insight into the health-related behaviors of your clients, including their eating habits. While much of your efforts are likely focused on helping clients improve those habits, some of your clients may take an extreme approach, which ultimately may lead to diminished—rather than enhanced—overall health and well-being. So, how can you tell the difference between a highly disciplined client and one who may be taking things too far?

PEER FITNESS TIPS

By: Peer Fitness Trainer
Jack Prall

Study: When Does Clean Eating Become an Unhealthy Obsession, continued…

Researchers found the literature consistently showed that those who have obsessive-compulsive traits, depression and a previous eating disorder, and/or are preoccupied with their appearance and body image, are more likely to be at risk for developing the condition. Other eating habits such as being a vegetarian or vegan also put individuals at higher risk for developing orthorexia nervosa. Lacto-vegetarians were at highest risk for the condition and people who are on a strict eating schedule, spending large amounts of time preparing meals, were also at greater risk.

"In our research, we found equal rates of men and women who struggle with symptoms of orthorexia nervosa," said Mills. "We still think of eating disorders as being a problem that affects mostly young women. Because of that assumption, the symptoms and negative consequences of orthorexia nervosa can fly under the radar and not be noticed or taken seriously."

Of course, it is beyond your scope of practice as a health and exercise professional to diagnose or treat an eating disorder, but that doesn't mean there aren't steps you can take to help reduce your clients' risk of disordered eating behaviors.

"The most impactful thing a health and exercise professional can do to reduce their clients' risk of disordered eating behaviors is to follow the Dietary Guidelines for Americans set forth by the Academy of Nutrition and Dietetics when talking to clients about food," argues Liz Fusco, MS, RDN, sports dietitian for USRowing and a consultant to the U.S. Olympic Committee. "The guidelines emphasize healthy meal patterns rather than eliminating 'bad' foods or hitting macronutrient numbers, which can help clients eat more mindfully and with less guilt and anxiety.

Fusco also recommends focusing on promoting healthy movement rather than "working off" food or losing a certain amount of weight in a certain number of weeks. "This is another simple way to shift the rhetoric around food and exercise from something you can pass or fail to something that is healthy and positive," she says.

Additionally, Fusco urges health and exercise professionals to recognize that disordered eating and exercise behaviors are not gender-specific and occur on a spectrum of severity even within the same person. "Rather than confront clients," urges Fusco, "seek a multidisciplinary approach whenever possible by reaching out to other providers (such as a physician, dietitian, psychologist, etc.) or suggesting that your clients do so to both ensure they get the care they need and to reduce you and your employer's liability risk."

AUTHOR:

American Council on Exercise

Social and Psychological Factors Associated With Orthorexia Nervosa

Social and cultural factors outside of the individual:

- Weight bias and obesity stigma
- Availability of organic/clean food
- Higher income
- Access to food research/ knowledge
- Positive reinforcement from others

Time for food planning/preparation
Psychological factors (thoughts, feelings and behaviors):

- Perfectionism
- Dieting/restrictive eating
- Drive for thinness/thin-ideal internalization
- Neuroticism (anxiety, negative affect)
- Obsessive-compulsive tendencies
- Current or past eating disorder
- Fear of losing control
- Perceived vulnerability to disease