CHAPTER 18
Eating Disorders

Eating Disorders
• Anorexia nervosa
• Bulimia nervosa
• Binge eating disorder
• Eating disorder NOS

Etiology
• Biological factors
  • Genetics
  • Neurobiological
    • Serotonin
    • Tryptophan
  • Psychological factors
  • Environmental factors

Etiology (Continued)
• Psychoanalytic theory
  • Anorexia nervosa is an unconscious conflict of developing sexuality thus a regression into the prepubertal phase of development
  • Compulsive overeating represents overcompensation for unmet oral needs during infancy
  • Obesity represents a defense against intimacy with life partner

Etiology (Continued)
• Behavioral Theory
  • Positive reinforcement
• Family Theory - controversial
• Sociocultural models
  • Incidence of eating disorders increases in societies in which women have a choice in social roles

Thin Commandments
1. If you aren't thin you aren't attractive.
2. Being thin is more important than being healthy.
3. You must buy clothes, style your hair, take laxatives, starve yourself, do anything to make yourself look thinner.
4. Thou shall not eat without feeling guilty.
5. Thou shall not eat fattening food without punishing oneself afterwards.
6. Thou shall count calories and restrict intake accordingly.
7. What the scale says is the most important thing.
8. Losing weight is good/gaining weight is bad.
9. You can never be too thin.
10. Being thin and not eating are signs of true willpower and success
Prevalence and Co-Morbidity

• Estimated lifetime prevalence rate for developing **anorexia nervosa:**
  - Women, 1%
  - Men, 0.3%

• Estimated lifetime prevalence rate for developing **bulimia nervosa:**
  - Women, 1.5%
  - Men, 0.5%

(Continued)

Prevalence and Co-Morbidity (continued)

• Actual number of individuals with EDs is not known because disorders may exist for a long time before the person seeks help.

• EDs are **culturally influenced** with varying prevalence, depending on the culture and social norms.

• Female and male athletes demonstrate an increased incidence of EDs.

(Continued)

Prevalence and Co-Morbidity (continued)

• Anorexia nervosa appears in early to middle adolescence.
• Bulimia nervosa appears in late adolescence.
• Women (aged 35 to 65 years): Changes in appearance and role potentially increase the risk for EDs.
• EDs are almost always co-morbid with other psychiatric illnesses.
• More than 50% of people with anorexia and 95% of those with bulimia have one other psychiatric disorder.

Prevalence and Co-Morbidity (continued)

• Significant co-morbidity with:
  - Mood and anxiety disorders
  - Substance abuse
  - Body dysmorphic disorders
  - Impulse control disorders
  - Personality disorders, especially borderline and obsessive-compulsive personality disorders

• The AED advises to always assess for psychiatric risk, including suicidal and self-harm thoughts, plans, and/or intent.

Anorexia Nervosa – DSM V

• Purposeful weight loss to <85% of expected
• Intense fear of gaining weight or becoming fat even though underweight
• Body image disturbance
• Postmenarchal amenorrhea
• Specify type
  - Binge eating/purging type
  - Restricting type

Anorexia Nervosa: Clinical Presentation

• Constipation
• Low weight
• Amenorrhea
• Yellow skin
• Lanugo
• Postmenarchal amenorrhea
• Muscle weakness
• Impaired renal function
### Anorexia Nervosa Phenomena
- Terror of gaining weight
- Food preoccupation
- View self as fat
- Peculiar food handling habits
- Possible rigorous exercise regimen
- Possible purging, laxative, diuretics
- Self-worth judged by weight

### Case Study
Addie, age 15, is brought to the school nurse after fainting during gym class. She is grossly underweight, wears baggy clothes, and has dry skin. She complains of feeling cold despite wearing two sweaters. As the nurse examines her perfunctorily, she notices that Addie’s skin seems slightly yellow, and a gentle scrape of her skin shows signs of dehydration.

### Eating Disorders: Admission Criteria
- Weight loss over 30% over 6 months
- Temperature <36°C or 96.8°F
- Heart rate < 40
- SBP < 70 mmHg
- Hypokalemia (<3mEq/L)
- EKG changes
- Rapid loss or inability to gain weight outpatient
- Suicidal, out-of-control or self-mutilating behaviors
- Family crisis, severe depression, psychosis
- Failure to comply with treatment

### Therapeutic Relationship: Building Trust and Having Empathy In Anorexia Nervosa
- Perfectionism
- Obsessive thoughts and actions relating to food
- Need to control

### Bulimia Nervosa – DSM V
- Recurrent episodes of binge eating
- Recurrence of compensatory behavior to prevent weight gain
- Both occur on average at least twice a week for 3 months
- Self-evaluation is unduly influenced by body shape and weight
- Specify type:
  - Purging type
  - Non-purging type

### Bulimia Nervosa: Clinical Presentation
- Around normal weight
- May be slightly under or overweight
- Dental caries, tooth erosion
- Parotid swelling
- Russell’s sign
- Peripheral edema
- Muscle weakness
- Gastric dilatation/rupture
- Hypokalemia, hyponatremia
- EKG changes/Cardiac dysrhythmias
- Cardiomyopathy (Ipecac toxicity/chronic use)
- Dehydration
Bulimia Nervosa Phenomena
- Binge eating behavior
- Laxative, diuretic use
- History of anorexia in 1/4 to 1/3 of patients
- Increased levels of anxiety
- Depressive s/s
- Problems with:
  - Interpersonal relationships
  - Self-concept
  - Impulsive behaviors (shoplifting)
- Compulsive behaviors (chemical dependency)

Therapeutic Relationship in Bulimia Nervosa: Building Trust and Having Empathy
- Sensitive to perceptions of others
- May feel
  - Shame
  - Out of control
  - Low self-esteem
  - Unworthiness
  - Dysphoria

Binge Eating Disorder – DSM V
- Recurrent episodes of binge eating
- Episodes are associated with three or more additional symptoms
  - Eating much more rapidly than normal, until uncomfortably full, when not hungry, secretively, and feeling disgusted/guilty/depressed about behavior
- Marked distress regarding binges
- Occurs on average 2 days a week for 6 months
- Not associated with inappropriate compensatory behaviors

Binge Eating Disorder
- A variant of compulsive overeating
- No compensatory behaviors
- Frequently symptom of an affective disorder
- Cognitive-behavioral therapy, behavior therapy, dialectical behavior therapy, and interpersonal therapy most effective
Anorexia Nervosa Nursing Process

- Assessment
  - General assessment
  - Self assessment
  - Nursing diagnosis
  - Outcomes identification
- Planning
  - Refeeding syndrome

Nursing Diagnoses: Anorexia Nervosa

- Imbalanced nutrition: less than body requirements
- Decreased cardiac output
- Risk for injury (electrolyte imbalance)
- Risk for imbalanced fluid volume
- Disturbed body image
- Anxiety and chronic low self-esteem
- Deficient knowledge
- Ineffective coping
- Powerlessness and hopelessness

Outcomes Identification
Anorexia Nervosa

Outcomes need to be measurable and realistic.
Patient will:
- Refrain from self-harm
- Normalize eating patterns, as evidenced by eating 75% of three meals per day plus two snacks
- Achieve 85% to 90% of ideal body weight
- Be free of physical complications
- Demonstrate two new, healthy eating habits

Outcomes Identification
Anorexia Nervosa (continued)

Patient will:
- Demonstrate improved self-acceptance, AEB verbal and behavioral data
- Address maladaptive beliefs, thoughts, and activities related to the ED
- Participate in the treatment of associated psychiatric symptoms (e.g., defects in mood, self-esteem)
- Make plans to participate in long-term treatment to prevent relapse

Anorexia Nervosa: Interventions

- Acute phase/basic level intervention
  - Milieu therapy
  - Precise meal times and menus
  - Observation during and after meals
  - Regularly scheduled weighing
  - Monitored bathroom visits
  - Privileges linked to compliance/weight gain
  - Therapeutic communication/counseling
  - Cognitive distortions

- Acute care
  - Pharmacological interventions
    - Fluoxetine (Prozac)
    - Chlorpromazine (Thorazine)
    - Olanzapine (Zyprexa)
  - Integrative medicine
  - Health teaching
    - Self-care
Advanced Practice Interventions

• Psychotherapy
• Individual therapy
• Group therapy
• Family therapy

Anorexia Nervosa: Evaluation

• Nutritional status
• Weight gain behaviors
• Anxiety self control
• Self-esteem
• If weight falls below the goal, treatment is changed

Anorexia: Self-Assessment

• Feelings of exhaustion/defeat
• Resentment toward patient due to manipulation/staff splitting
• Sense of over protection of patient
• Avoidance/anger toward patient
• Failure to monitor patients appropriately
• Feeling repelled/disgusted by patient appearance
• Believing patient is deliberately manipulating staff/family

Case Study/Audience Response Question

Let’s return to Addie, who fainted during gym class. She is grossly underweight, wears baggy clothes, and her skin is dry. To further assess for anorexia nervosa, the school nurse should ask:

A. “Do you often wear heavy clothing in warm weather?”
B. “When was your last menstrual period?”
C. “Do you use any drugs or alcohol?”
D. “Do you ever lose lapses of time?”

Case Study/Audience Response Question

Earlier we learned that Addie’s skin was slightly yellow and her skin showed signs of dehydration. What is yellow skin in anorexia nervosa linked to?

A. Lanugo
B. Amenorrhea
C. Use of street drugs
D. Hypercarotenemia

Case Study/Audience Response Question

Addie condition worsens and she collapses at home. She is admitted to your unit with anorexia. You have completed your physical and biopsychosocial assessment of her. Which common personality trait is likely to present a particular challenge?

A. Lack of hygiene and cleanliness
B. Lack of interest in self and others
C. Irresistible desire to purge
D. Perfectionism
Bulimia Nervosa Nursing Process

- Assessment
- General assessment
- Nursing diagnosis
- Outcomes identification
- Evaluation

Nursing Diagnoses: Bulimia Nervosa

- Decreased cardiac output
- Disturbed body image
- Powerlessness
- Chronic low self-esteem
- Anxiety
- Ineffective coping (e.g., substance abuse, impulsive responses to problems)

Outcomes Identification

Bulimia Nervosa

Patient will:
- Refrain from binge-purge behaviors
- Demonstrate two new skills for managing anxiety
- Obtain and maintain normal electrolyte balance
- Be free of self-directed harm
- Express feelings in a nonfood-related way
- Name two personal strengths

Bulimia Nervosa: Interventions

- Acute phase/basic level intervention
  - Milieu therapy
  - Interrupt binge-purge cycle
  - Prevent disordered eating behaviors
  - Therapeutic communication/counseling
  - Health teaching
- Long-term treatment/advanced practice interventions
  - Psychotherapy
  - Psychopharmacology
  - SSRI’s and Tricyclic antidepressants

Bulimia Nervosa: Evaluation

- Physiologic safety
- Impulse self-control
- Weight maintenance behavior
- Hope

Compare and contrast the signs and symptoms of anorexia nervosa and bulimia nervosa

**Anorexia Nervosa**
- Self-induced vomiting; use of laxatives and diuretics
- Judges self-worth by weight
- Controls what they eat to feel powerful to overcome feelings of helplessness
- Lanugo
- Cachectic
- Prominent parotid glands, if purging

**Bulimia Nervosa**
- Binge eating
- Self-induced vomiting
- Laxative and diuretic abuse
- History of anorexia nervosa in one-quarter to one-third of individuals
- Depressive signs and symptoms
- Prominent parotid glands, if purging
Compare and contrast the signs and symptoms of anorexia nervosa and bulimia nervosa (continued)

**Anorexia Nervosa**
- Terror of gaining weight
- Preoccupation with food
- Views self as fat even when emaciated
- Peculiar handling of food: Cutting food into small bits
- Pushing food around the plate
- Maintaining a rigorous exercise regimen

**Bulimia Nervosa**
- Self-concept
- Impulsive and compulsive
- Anxiety
- Possible chemical dependency and shoplifting
- Undoes weight after bingeing
- Problems with interpersonal relationships

**Binge Eating Nursing Process**
- Assessment
- General assessment
- Self assessment
- Nursing diagnosis
- Outcomes identification
- Planning

**Binge Eating Interventions**
- Acute care
- Psychosocial interventions
- Pharmacological interventions
  - Belviq (lorcaserin)
  - Qsymia (phentermine and topiramate)
- Health teaching and health promotion
- Advanced practice interventions
- Psychotherapy

**Teamwork and Collaboration are needed to treat EDs effectively**
- Nurse
- Psychiatrist
- Licensed Mental Health Counselor (LMHC)
- Registered dietician
- Internist and pediatrician
- Psychologist
- Social services
- Mental Health Technician
- Family
- Social network
- Support groups

**Teamwork and Collaboration**
- Most effective care includes a multidisciplinary approach, with expertise in treatment of patients with EDs. (AED, 2011)
- Team approach in treatment of EDs includes medical, psychologic, nutritional, and psychopharmacologic services.
- Family and spouses are always encouraged to participate.

**Audience Response Questions**
Which medication is likely to be used in the treatment of patients with EDs?
A. SSRI, such as fluoxetine
B. Antipsychotic medication, such as risperidone
C. Anxiolytic medication, such as alprazolam
D. Anticonvulsant agent, such as carbamazepine
Audience Response Questions

Typical goals of inpatient hospitalization for a patient with anorexia do not include which of the following?

A. Stabilization of the patient’s immediate condition
B. Limited weight restoration
C. Determination of the causes for the ED
D. Restoration of normal electrolyte balance

Audience Response Questions

Which of the following is an example of all-or-nothing thinking, which is a frequent cognitive distortion of patients with an ED?

A. “If I allow myself to gain weight, I’ll be huge.”
B. “I’m unpopular because I’m fat.”
C. “When I’m thin, I’m powerful.”
D. “When people say I look better, they’re really thinking I look fat.”

Self-Assessment: Eating Disorders

• Nurses may find it difficult to appreciate the force of illness, regarding it as trivial (e.g., compared with schizophrenia) and incorrectly believing that weight restriction, bingeing, and purging are self-imposed.
• Nurses may believe that a patient chooses risky behaviors and blame the patient.
• Personality traits and conflicts pose challenges.
• Avoid authoritarianism and coercion.
• Terror of weight gain and resistance cause frustration.