

EATING DISORDERS: ANOREXIA NERVOSA/BULIMIA NERVOSA

Anorexia nervosa is an illness of starvation, brought on by severe disturbance of body image and a morbid fear of obesity.

Bulimia nervosa is an eating disorder (binge-purge syndrome) characterized by extreme overeating followed by self-induced vomiting. It may include abuse of laxatives and diuretics.

Although these disorders primarily affect women, approximately 5%–10% of those afflicted are men, and both disorders can be present in the same individual.

CARE SETTING

Acute care is provided through inpatient stay on medical or behavioral unit and for correction of severe nutritional deficits/electrolyte imbalances or initial psychiatric stabilization. Long-term care is provided in outpatient/day treatment program (partial hospitalization) or in the community.

RELATED CONCERNS

Dysrhythmias

Fluid and electrolyte imbalances

Metabolic alkalosis (primary base bicarbonate excess)

Total nutritional support: parenteral/enteral feeding

Psychosocial aspects of care

Patient Assessment Database

ACTIVITY/REST

- May report:** Disturbed sleep patterns, e.g., early morning insomnia; fatigue
Feeling “hyper” and/or anxious
Increased activity/avid exerciser, participation in high-energy sports
Employment in positions/professions that stress/require weight control (e.g., athletics such as gymnasts, swimmers, jockeys; modeling; flight attendants)
- May exhibit:** Periods of hyperactivity, constant vigorous exercising

CIRCULATION

- May report:** Feeling cold even when room is warm
- May exhibit:** Low blood pressure (BP)
Tachycardia, bradycardia, dysrhythmias

EGO INTEGRITY

- May report:** Powerlessness/helplessness lack of control over eating (e.g., cannot stop eating/control what or how much is eaten [bulimia]); feeling disgusted with self, depressed or very guilty because of overeating
Distorted (unrealistic) body image, reports self as fat regardless of weight (denial), and sees thin body as fat; persistent overconcern with body shape and weight (fears gaining weight)
High self-expectations
Stress factors, e.g., family move/divorce, onset of puberty
Suppression of anger
- May exhibit:** Emotional states of depression, withdrawal, anger, anxiety, pessimistic outlook

ELIMINATION

- May report:** Diarrhea/constipation
Vague abdominal pain and distress, bloating
Laxative/diuretic abuse

FOOD/FLUID

- May report:** Constant hunger or denial of hunger; normal or exaggerated appetite that rarely vanishes until late in the disorder (anorexia)
 Intense fear of gaining weight (females); may have prior history of being overweight (particularly males)
 Preoccupation with food, e.g., calorie counting, gourmet cooking
 An unrealistic pleasure in weight loss, while denying self pleasure in other areas
 Refusal to maintain body weight over minimal norm for age/height (anorexia)
 Recurrent episodes of binge eating; a feeling of lack of control over behavior during eating binges; a minimum average of two binge-eating episodes a week for at least 3 mo
- May exhibit:** Regularly engages in self-induced vomiting (binge-purge syndrome bulimia) either independently or as a complication of anorexia; or strict dieting or fasting
 Weight loss/maintenance of body weight 15% or more below that expected (anorexia), or weight may be normal or slightly above or below normal (bulimia)
 No medical illness evident to account for weight loss
 Cachectic appearance; skin may be dry, yellowish/pale, with poor turgor (anorexia)
 Preoccupation with food (e.g., calorie counting, hiding food, cutting food into small pieces, rearranging food on plate)
 Irrational thinking about eating, food, and weight
 Peripheral edema
 Swollen salivary glands; sore, inflamed buccal cavity; continuous sore throat (bulimia)
 Vomiting, bloody vomitus (may indicate esophageal tearing [Mallory-Weiss syndrome])
 Excessive gum chewing

HYGIENE

- May exhibit:** Increased hair growth on body (lanugo), hair loss (axillary/pubic), hair is dull/not shiny
 Brittle nails
 Signs of erosion of tooth enamel, gums in poor condition, ulcerations of mucosa

NEUROSENSORY

- May exhibit:** Appropriate affect (except in regard to body and eating), or depressive affect
 Mental changes: Apathy, confusion, memory impairment (brought on by malnutrition/starvation)
 Hysterical or obsessive personality style; no other psychiatric illness or evidence of a psychiatric thought disorder present (although a significant number may show evidence of an affective disorder)

PAIN/DISCOMFORT

- May report:** Headaches, sore throat/mouth, generalized vague complaints

SAFETY

- May exhibit:** Body temperature below normal
 Recurrent infectious processes (indicative of depressed immune system)
 Eczema/other skin problems, abrasions/calluses may be noted on back of hands from sticking finger down throat to induce vomiting

SEXUALITY

- May report:** Absence of at least three consecutive menstrual cycles (decreased levels of estrogen in response to malnutrition)
 Promiscuity or denial/loss of sexual interest
 History of sexual abuse
 Homosexual/bisexual orientation (higher percentage in male patients than in general population)
- May exhibit:** Breast atrophy, amenorrhea

SOCIAL INTERACTION

- May report:** Middle-class or upper-class family background
 History of being a quiet, cooperative child

Problems of control issues in relationships, difficult communications with others/authority figures, poor communication within family of origin
 Engagement in power struggles
 An emotional crisis of some sort, such as the onset of puberty or a family move
 Altered relationships or problems with relationships (not married/divorced), withdrawal from friends/social contacts
 Abusive family relationships
 Sense of helplessness
 History of legal difficulties (e.g., shoplifting)

May exhibit: Passive father/dominant mother, family members closely fused, togetherness prized, personal boundaries not respected

TEACHING/LEARNING

May report: Family history of higher than normal incidence of depression, other family members with eating disorders (genetic predisposition)
 Onset of the illness usually between the ages of 10 and 22
 Health beliefs/practice (e.g., certain foods have “too many” calories, use of “health” foods)
 High academic achievement
 Substance abuse

Discharge plan considerations: **DRG projected mean length of inpatient stay: 6.4 days**
 Assistance with maintenance of treatment plan
Refer to section at end of plan for postdischarge considerations.

DIAGNOSTIC STUDIES

Complete blood count (CBC) with differential: Determines presence of anemia, leukopenia, lymphocytosis. Platelets show significantly less than normal activity by the enzyme monoamine oxidase (thought to be a marker for depression).

Electrolytes: Imbalances may include decreased potassium, sodium, chloride, and magnesium.

Endocrine studies:

Thyroid function: Thyroxine (T₄) levels usually normal; however, circulating triiodothyronine (T₃) levels may be low.

Pituitary function: Thyroid-stimulating hormone (TSH) response to thyrotropin-releasing hormone (TRH) is abnormal in anorexia nervosa. Propranolol-glucagon stimulation test studies the response of human growth hormone (GH), which is depressed in anorexia. Gonadotropic hypofunction is noted.

Cortisol metabolism: May be elevated.

Dexamethasone suppression test (DST): Evaluates hypothalamic-pituitary function. Dexamethasone resistance indicates cortisol suppression, suggesting malnutrition and/or depression.

Luteinizing hormone (LH) secretions test: Pattern often resembles those of prepubertal girls.

Estrogen: Decreased.

MHP 6 levels: Decreased, suggestive of malnutrition/depression.

Serum glucose and basal metabolic rate (BMR): May be low.

Other chemistries: AST elevated. Hypercarotenemia, hypoproteinemia, hypocholesterolemia.

Urinalysis and renal function: Blood urea nitrogen (BUN) may be elevated; ketones present reflecting starvation; decreased urinary 17-ketosteroids; increased specific gravity/dehydration.

Electrocardiogram (ECG): Abnormal tracing with low voltage, T-wave inversion, dysrhythmias.

NURSING PRIORITIES

1. Reestablish adequate/appropriate nutritional intake.
2. Correct fluid and electrolyte imbalance.
3. Assist patient to develop realistic body image/improve self-esteem.
4. Provide support/involve significant other (SO), if available, in treatment program.
5. Coordinate total treatment program with other disciplines.
6. Provide information about disease, prognosis, and treatment to patient/SO.

DISCHARGE GOALS

1. Adequate nutrition and fluid intake maintained.
2. Maladaptive coping behaviors and stressors that precipitate anxiety recognized.
3. Adaptive coping strategies and techniques for anxiety reduction and self-control implemented.

4. Self-esteem increased.
5. Disease process, prognosis, and treatment regimen understood.
6. Plan in place to meet needs after discharge.

NURSING DIAGNOSIS: Nutrition: imbalanced, less than body requirements

May be related to
 Inadequate food intake; self-induced vomiting
 Chronic/excessive laxative use

Possibly evidenced by
 Body weight 15% (or more) below expected, or may be within normal range (bulimia)
 Pale conjunctiva and mucous membranes; poor skin turgor/muscle tone; edema
 Excessive loss of hair; increased growth of hair on body (lanugo)
 Amenorrhea
 Hypothermia
 Bradycardia; cardiac irregularities; hypotension

DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:

Knowledge: Diet (NOC)
 Verbalize understanding of nutritional needs.

Nutritional Status (NOC)
 Establish a dietary pattern with caloric intake adequate to regain/maintain appropriate weight.
 Demonstrate weight gain toward individually expected range.

ACTIONS/INTERVENTIONS	RATIONALE
<p>Eating Disorders Management (NIC)</p> <p>Independent</p> <p>Establish a minimum weight goal and daily nutritional requirements.</p> <p>Use a consistent approach. Sit with patient while eating; present and remove food without persuasion and/or comment. Promote pleasant environment and record intake.</p> <p>Provide smaller meals and supplemental snacks, as appropriate.</p>	<p>Malnutrition is a mood-altering condition, leading to depression and agitation and affecting cognitive function/decision making. Improved nutritional status enhances thinking ability, allowing initiation of psychological work.</p> <p>Patient detects urgency and may react to pressure. Any comment that might be seen as coercion provides focus on food. When staff responds in a consistent manner, patient can begin to trust staff responses. The single area in which patient has exercised power and control is food/eating, and he or she may experience guilt or rebellion if forced to eat. Structuring meals and decreasing discussions about food will decrease power struggles with patient and avoid manipulative games.</p> <p>Gastric dilation may occur if refeeding is too rapid following a period of starvation dieting. <i>Note:</i> Patient may feel bloated for 3–6 wk while body adjusts to food intake.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Eating Disorders Management (NIC)</p> <p>Independent</p> <p>Make selective menu available, and allow patient to control choices as much as possible.</p> <p>Be alert to choices of low-calorie foods/beverages; hoarding food; disposing of food in various places, such as pockets or wastebaskets.</p> <p>Maintain a regular weighing schedule, such as Monday/Friday before breakfast in same attire, and graph results.</p> <p>Weigh with back to scale (depending on program protocols).</p> <p>Avoid room checks and other control devices whenever possible.</p> <p>Provide one-to-one supervision and have patient with bulimia remain in the day room area with no bathroom privileges for a specified period (e.g., 2 hr) following eating, if contracting is unsuccessful.</p> <p>Monitor exercise program and set limits on physical activities. Chart activity/level of work (pacing and so on).</p> <p>Maintain matter-of-fact, nonjudgmental attitude if giving tube feedings, hyperalimentation, and so on.</p> <p>Be alert to possibility of patient disconnecting tube and emptying hyperalimentation if used. Check measurements, and tape tubing snugly.</p>	<p>Patient who gains confidence in self and feels in control of environment is more likely to eat preferred foods.</p> <p>Patient will try to avoid taking in what is viewed as excessive calories and may go to great lengths to avoid eating.</p> <p>Provides accurate ongoing record of weight loss/gain. Also diminishes obsessing about changes in weight.</p> <p>Although some programs prefer patient to see the results of the weighing, this can force the issue of trust in patient who usually does not trust others.</p> <p>External control reinforces feelings of powerlessness and therefore is usually not helpful.</p> <p>Prevents vomiting during/after eating. Patient may desire food and use a binge-purge syndrome to maintain weight. <i>Note:</i> Patient may purge for the first time in response to establishment of a weight gain program.</p> <p>Moderate exercise helps in maintaining muscle tone/weight and combating depression; however, patient may exercise excessively to burn calories.</p> <p>Perception of punishment is counterproductive to patient's self-confidence and faith in own ability to control destiny.</p> <p>Sabotage behavior is common in attempt to prevent weight gain.</p>
<p>Collaborative</p> <p>Provide nutritional therapy within a hospital treatment program as indicated when condition is life-threatening.</p> <p>Involve patient in setting up/carrying out program of behavior modification. Provide reward for weight gain as individually determined; ignore loss.</p> <p>Provide diet and snacks with substitutions of preferred foods when available.</p>	<p>Cure of the underlying problem cannot happen without improved nutritional status. Hospitalization provides a controlled environment in which food intake, vomiting/elimination, medications, and activities can be monitored. It also separates patient from SO (who may be contributing factor) and provides exposure to others with the same problem, creating an atmosphere for sharing.</p> <p>Provides structured eating situation while allowing patient some control in choices. Behavior modification may be effective in mild cases or for short-term weight gain.</p> <p>Having a variety of foods available enables patient to have a choice of potentially enjoyable foods.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Eating Disorders Management (NIC)</p> <p>Collaborative</p> <p>Administer liquid diet and/or tube feedings/hyperalimentation if needed.</p> <p>Blenderize and tube-feed anything left on the tray after a given period of time if indicated.</p> <p>Administer supplemental nutrition as appropriate.</p> <p>Avoid giving laxatives.</p> <p>Administer medication as indicated: Cypripheptadine (Periactin);</p> <p>Tricyclic antidepressants, e.g., amitriptyline (Elavil), imipramine (Tofranil), desipramine (Norpramin); selective serotonin reuptake inhibitors (SSRIs), e.g., fluoxetine (Prozac);</p> <p>Antianxiety agents, e.g., alprazolam (Xanax);</p> <p>Antipsychotic drugs, e.g., chlorpromazine (Thorazine);</p> <p>Monoamine oxidase inhibitors (MAOIs), e.g., tranylcypromine sulfate (Parnate).</p> <p>Prepare for/assist with electroconvulsive therapy (ECT) if indicated. Discuss reasons for use and help patient understand this is not punishment.</p>	<p>When caloric intake is insufficient to sustain metabolic needs, nutritional support can be used to prevent malnutrition/death while therapy is continuing. High-calorie liquid feedings may be given as medication, at preset times separate from meals, as an alternative means of increasing caloric intake.</p> <p>May be used as part of behavior modification program to provide total intake of needed calories.</p> <p>Total parenteral nutrition (TPN) may be required for life-threatening situations; however, enteral feedings are preferred because they preserve gastrointestinal (GI) function and reduce atrophy of the gut.</p> <p>Use is counterproductive because they may be used by patient to rid body of food/calories.</p> <p>A serotonin and histamine antagonist that may be used in high doses to stimulate the appetite, decrease preoccupation with food, and combat depression. Does not appear to have serious side effects, although decreased mental alertness may occur.</p> <p>Lifts depression and stimulates appetite. SSRIs reduce binge-purge cycles and may also be helpful in treating anorexia. <i>Note:</i> Use must be closely monitored because of potential side effects, although side effects from SSRIs are less significant than those associated with tricyclics.</p> <p>Reduces tension, anxiety/nervousness and may help patient to participate in treatment.</p> <p>Promotes weight gain and cooperation with psychotherapeutic program; however, used only when absolutely necessary because of the possibility of extrapyramidal side effects.</p> <p>May be used to treat depression when other drug therapy is ineffective; decreases urge to binge in bulimia.</p> <p>In rare and difficult cases in which malnutrition is severe/life-threatening, a short-term ECT series may enable patient to begin eating and become accessible to psychotherapy.</p>

NURSING DIAGNOSIS: Fluid Volume actual or risk for deficient

May be related to

Inadequate intake of food and liquids
Consistent self-induced vomiting
Chronic/excessive laxative/diuretic use

Possibly evidenced by (actual)

Dry skin and mucous membranes, decreased skin turgor
Increased pulse rate, body temperature, decreased BP
Output greater than input (diuretic use); concentrated urine/decreased urine output (dehydration)
Weakness
Change in mental state
Hemoconcentration, altered electrolyte balance

DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:

Hydration (NOC)

Maintain/demonstrate improved fluid balance, as evidenced by adequate urine output, stable vital signs, moist mucous membranes, good skin turgor.

Risk Control (NOC)

Verbalize understanding of causative factors and behaviors necessary to correct fluid deficit.

ACTIONS/INTERVENTIONS	RATIONALE
<p>Fluid/Electrolyte Management (NIC)</p> <p>Independent</p> <p>Monitor vital signs, capillary refill, status of mucous membranes, skin turgor.</p> <p>Monitor amount and types of fluid intake. Measure urine output accurately.</p> <p>Discuss strategies to stop vomiting and laxative/diuretic use.</p> <p>Identify actions necessary to regain/maintain optimal fluid balance, e.g., specific fluid intake schedule.</p>	<p>Indicators of adequacy of circulating volume. Orthostatic hypotension may occur with risk of falls/injury following sudden changes in position.</p> <p>Patient may abstain from all intake, with resulting dehydration; or substitute fluids for caloric intake, disturbing electrolyte balance.</p> <p>Helping patient deal with the feelings that lead to vomiting and/or laxative/diuretic use will prevent continued fluid loss. <i>Note:</i> Patient with bulimia has learned that vomiting provides a release of anxiety.</p> <p>Involving patient in plan to correct fluid imbalances improves chances for success.</p>
<p>Collaborative</p> <p>Review electrolyte/renal function test results.</p> <p>Administer/monitor IV, TPN; electrolyte supplements, as indicated.</p>	<p>Fluid/electrolyte shifts, decreased renal function can adversely affect patient's recovery/prognosis and may require additional intervention.</p> <p>Used as an emergency measure to correct fluid/electrolyte imbalance and prevent cardiac dysrhythmias.</p>

NURSING DIAGNOSIS: Thought Processes, disturbed

May be related to

Severe malnutrition/electrolyte imbalance
Psychological conflicts, e.g., sense of low self-worth, perceived lack of control

Possibly evidenced by

Impaired ability to make decisions, problem-solve
Non-reality-based verbalizations
Ideas of reference
Altered sleep patterns, e.g., may go to bed late (stay up to binge/purge) and get up early
Altered attention span/distractibility
Perceptual disturbances with failure to recognize hunger; fatigue, anxiety, and depression

DESIRED OUTCOMES/EVALUATIONS CRITERIA—PATIENT WILL:

Distorted Thought Control (NOC)

Verbalize understanding of causative factors and awareness of impairment.
Demonstrate behaviors to change/prevent malnutrition.
Display improved ability to make decisions, problem-solve.

ACTIONS/INTERVENTIONS	RATIONALE
Delusion Management (NIC)	
Independent	
Be aware of patient's distorted thinking ability.	Allows caregiver to have more realistic expectations of patient and provide appropriate information and support.
Listen to/avoid challenging irrational, illogical thinking. Present reality concisely and briefly.	It is difficult to respond logically when thinking ability is physiologically impaired. Patient needs to hear reality, but challenging patient leads to distrust and frustration. <i>Note:</i> Even though patient may gain weight, she or he may continue to struggle with attitudes/behaviors typical of eating disorders, major depression, and/or alcohol dependence for a number of years.
Adhere strictly to nutritional regimen.	Improved nutrition is essential to improved brain functioning. (Refer to ND: Nutrition: imbalanced, less than body requirements.)
Collaborative	
Review electrolyte/renal function tests.	Imbalances negatively affect cerebral functioning and may require correction before therapeutic interventions can begin.

NURSING DIAGNOSIS: Body image, disturbed/Self-Esteem, chronic low

May be related to

Morbid fear of obesity; perceived loss of control in some aspect of life
Personal vulnerability; unmet dependency needs
Dysfunctional family system
Continual negative evaluation of self

Possibly evidenced by

Distorted body image (views self as fat even in the presence of normal body weight or severe emaciation)
Expresses little concern, uses denial as a defense mechanism, and feels powerless to prevent/make changes
Expressions of shame/guilt
Overly conforming, dependent on others' opinions

DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:

Body Image (NOC)

Establish a more realistic body image.

Self-Esteem (NOC)

Acknowledge self as an individual.
Accept responsibility for own actions.

ACTIONS/INTERVENTIONS	RATIONALE
<p>Body Image Enhancement (NIC)</p> <p>Independent</p> <p>Have patient draw picture of self.</p> <p>Involve in personal development program, preferably in a group setting. Provide information about proper application of makeup and grooming.</p> <p>Suggest disposing of “thin” clothes as weight gain occurs. Recommend consultation with an image consultant.</p> <p>Assist patient to confront changes associated with puberty/sexual fears. Provide sex education as necessary.</p>	<p>Provides opportunity to discuss patient’s perception of self/body image and realities of individual situation.</p> <p>Learning about methods to enhance personal appearance may be helpful to long-range sense of self-esteem/image. Feedback from others can promote feelings of self-worth.</p> <p>Provides incentive to at least maintain and not lose weight. Removes visual reminder of thinner self. Positive image enhances sense of self-esteem.</p> <p>Major physical/psychological changes in adolescence can contribute to development of eating disorders. Feelings of powerlessness and loss of control of feelings (in particular sexual sensations) lead to an unconscious desire to desexualize self. Patient often believes that these fears can be overcome by taking control of bodily appearance/development/function.</p>
<p>Self-Esteem Enhancement (NIC)</p> <p>Establish a therapeutic nurse/patient relationship.</p>	<p>Within a helping relationship, patient can begin to trust and try out new thinking and behaviors.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Self-Esteem Enhancement (NIC)</p> <p>Independent</p> <p>Promote self-concept without moral judgment.</p> <p>States rules clearly regarding weighing schedule, remaining in sight during medication and eating times, and consequences of not following the rules. Without undue comment, be consistent in carrying out rules.</p> <p>Respond (confront) with reality when patient makes unrealistic statements such as “I’m gaining weight, so there’s nothing really wrong with me.”</p> <p>Be aware of own reaction to patient’s behavior. Avoid arguing.</p> <p>Assist patient to assume control in areas other than dieting/weight loss, e.g., management of own daily activities, work/leisure choices.</p> <p>Help patient formulate goals for self (not related to eating) and create a manageable plan to reach those goals, one at a time, progressing from simple to more complex.</p> <p>Note patient’s withdrawal from and/or discomfort in social settings.</p> <p>Encourage patient to take charge of own life in a more healthful way by making own decisions and accepting self as she or he is at this moment (including inadequacies and strengths).</p> <p>Let patient know that is acceptable to be different from family, particularly mother.</p>	<p>Patient sees self as weak-willed, even though part of person may feel sense of power and control (e.g., dieting/weight loss).</p> <p>Consistency is important in establishing trust. As part of the behavior modification program, patient knows risks involved in not following established rules (e.g., decrease in privileges). Failure to follow rules is viewed as patient’s choice and accepted by staff in matter-of-fact manner so as not to provide reinforcement for the undesirable behavior.</p> <p>Patient may be denying the psychological aspects of own situation and is often expressing a sense of inadequacy and depression.</p> <p>Feelings of disgust, hostility, and infuriation are not uncommon when caring for these patients. Prognosis often remains poor even with a gain in weight because other problems may remain. Many patients continue to see themselves as fat, and there is also a high incidence of affective disorders, social phobias, obsessive-compulsive symptoms, drug abuse, and psychosexual dysfunction. Nurse needs to deal with own response/feeling so they do not interfere with care of patient.</p> <p>Feelings of personal ineffectiveness, low self-esteem, and perfectionism are often part of the problem. Patient feels helpless to change and requires assistance to problem-solve methods of control in life situations.</p> <p>Patient needs to recognize ability to control other areas in life and may need to learn problem-solving skills to achieve this control. Setting realistic goals fosters success.</p> <p>May indicate feelings of isolation and fear of rejection/judgment by others. Avoidance of social situations and contact with others can compound feelings of worthlessness.</p> <p>Patient often does not know what she or he may want for self. Parents (mother) often make decisions for patient. Patient may also believe she or he has to be the best in everything and holds self responsible for being perfect.</p> <p>Developing a sense of identity separate from family and maintaining sense of control in other ways besides dieting and weight loss is a desirable goal of therapy/program.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Self-Esteem Enhancement (NIC)</p> <p>Independent</p> <p>Use cognitive-behavioral or interpersonal psychotherapy approach, rather than interpretive therapy.</p> <p>Encourage patient to express anger and acknowledge when it is verbalized.</p> <p>Assist patient to learn strategies other than eating for dealing with feelings. Have patient keep a diary of feelings, particularly when thinking about food.</p> <p>Assess feelings of helplessness/hopelessness.</p> <p>Be alert to suicidal ideation/behavior.</p>	<p>Although both therapies have similar results, cognitive-behavioral seems to work more quickly. Interaction between persons is more helpful for patient to discover feelings/impulses/needs from within own self. Patient has not learned this internal control as a child and may not be able to interpret or attach meaning to behavior.</p> <p>Important to know that anger is part of self and as such is acceptable. Expressing anger may need to be taught to patient because anger is generally considered unacceptable in the family, and therefore patient does not express it.</p> <p>Feelings are the underlying issue, and patient often uses food instead of dealing with feelings appropriately. Patient needs to learn to recognize feelings and how to express them clearly.</p> <p>Lack of control is a common/underlying problem for this patient and may be accompanied by more serious emotional disorders. <i>Note:</i> Fifty-four percent of patients with anorexia have a history of major affective disorder, and 33% have a history of minor affective disorder.</p> <p>Intense anxiety/panic about weight gain, depression, hopeless feelings may lead to suicidal attempts, particularly if patient is impulsive.</p>
<p>Collaborative</p> <p>Involve in group therapy.</p> <p>Refer to occupational/recreational therapy.</p> <p>Encourage participation in directed activities, e.g., bicycle tours and wilderness adventures, such as Outward Bound Program.</p> <p>Refer to therapist trained in dealing with sexuality, as indicated.</p>	<p>Provides an opportunity to talk about feelings and try out new behaviors.</p> <p>Can develop interest and skills to fill time that has been occupied by obsession with eating. Involvement in recreational activities encourages social interactions with others and promotes fun and relaxation.</p> <p>Although exercise is often used negatively by these patients, participation in these directed activities provides an opportunity to learn self-reliance, enhance self-esteem, and realize that food is the fuel required by the body to do its work.</p> <p>May need professional assistance to deal with sexuality issues and accept self as a sexual adult.</p>

NURSING DIAGNOSIS: Parenting, impaired

May be related to

Issues of control in family
Situational/maturational crises
History of inadequate coping methods

Possibly evidenced by

Dissonance among family members
Family developmental tasks not being met
Focus on "Identified Patient" (IP)
Family needs not being met
Family member(s) acting as enablers for IP
Ill-defined family rules, function, and roles

DESIRED OUTCOMES/EVALUATION CRITERIA—FAMILY WILL:

Parenting (NOC)

Demonstrate individual involvement in problem-solving process directed at encouraging patient toward independence.
Express feelings freely and appropriately.
Demonstrate more autonomous coping behaviors with individual family boundaries more clearly defined.
Recognize and resolve conflict appropriately with the individuals involved.

ACTIONS/INTERVENTIONS	RATIONALE
<p>Family Therapy (NIC)</p> <p>Independent</p> <p>Identify patterns of interaction. Encourage each family member to speak for self. Do not allow two members to discuss a third without that member's participation.</p> <p>Discourage members from asking for approval from each other. Be alert to verbal or nonverbal checking with others for approval. Acknowledge competent actions of patient.</p> <p>Listen with regard when patient speaks.</p> <p>Encourage individuals not to answer to everything.</p> <p>Communicate message of separation, that it is acceptable for family members to be different from each other.</p> <p>Encourage and allow expression of feelings (e.g., crying, anger) by individuals.</p>	<p>Helpful information for planning interventions. The enmeshed, overinvolved family members often speak for each other and need to learn to be responsible for their own words and actions.</p> <p>Each individual needs to develop own internal sense of self-esteem. Individual often is living up to others' (family's) expectations rather than making own choices. Acknowledgment provides recognition of self in positive ways.</p> <p>Sets an example and provides a sense of competence and self-worth, in that patient has been heard and attended to.</p> <p>Reinforces individualization and return to privacy.</p> <p>Individuation needs reinforcement. Such a message confronts rigidity and opens options for different behaviors.</p> <p>Often these families have not allowed free expression of feelings and need help and permission to learn and accept this.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Family Therapy (NIC)</p> <p>Independent</p> <p>Prevent intrusion in dyads by other members of the family.</p> <p>Reinforce importance of parents as a couple who have rights of their own.</p> <p>Prevent patient from intervening in conflicts between parents. Assist parents in identifying and solving their marital differences.</p> <p>Be aware and confront sabotage behavior on the part of family members.</p> <p>Collaborative</p> <p>Refer to community resources such as family therapy groups, parents' groups as indicated, and parent effectiveness classes.</p>	<p>Inappropriate interventions in family subsystems prevent individuals from working out problems successfully.</p> <p>The focus on the child with anorexia is very intense and often is the only area around which the couple interact. The couple needs to explore their own relationship and restore the balance within it to prevent its disintegration.</p> <p>Triangulation occurs in which a parent-child coalition exists. Sometimes the child is openly pressed to ally self with one parent against the other. The symptom (anorexia) is the regulator in the family system, and the parents deny their own conflicts.</p> <p>Feelings of blame, shame, and helplessness may lead to unconscious behavior designed to maintain the status quo.</p> <p>May help reduce overprotectiveness, support/facilitate the process of dealing with unresolved conflicts and change.</p>

<p>NURSING DIAGNOSIS: Skin Integrity, risk for impaired</p> <p>Risk factors may include</p> <p>Altered nutritional/metabolic state; edema Dehydration/cachectic changes (skeletal prominence)</p> <p>Possibly evidenced by</p> <p>[Not applicable; presence of signs and symptoms establishes an <i>actual</i> diagnosis.]</p> <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Risk Control (NOC)</p> <p>Verbalize understanding of causative factors and absence of itching. Identify and demonstrate behaviors to maintain soft, supple, intact skin.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Skin Surveillance (NIC)</p> <p>Independent</p> <p>Observe for reddened, blanched, excoriated areas.</p>	<p>Indicators of increased risk of breakdown, requiring more intensive treatment.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Skin Surveillance (NIC)</p> <p>Independent</p> <p>Encourage bathing every other day instead of daily.</p> <p>Use skin cream twice a day and after bathing.</p> <p>Massage skin gently, especially over bony prominences.</p> <p>Discuss importance of frequent position changes, need for remaining active.</p> <p>Emphasize importance of adequate nutrition/fluid intake. (Refer to ND: Nutrition: imbalanced, less than body requirements.)</p>	<p>Frequent baths contribute to dryness of the skin.</p> <p>Lubricates skin and decreases itching.</p> <p>Improves circulation to the skin, enhances skin tone.</p> <p>Enhances circulation and perfusion to skin by preventing prolonged pressure on tissues.</p> <p>Improved nutrition and hydration will improve skin condition.</p>

<p>NURSING DIAGNOSIS: Knowledge, deficient [Learning Need] regarding condition, prognosis, treatment, self-care and discharge needs</p> <p>May be related to</p> <p>Lack of exposure to/unfamiliarity with information about condition</p> <p>Learned maladaptive coping skills</p> <p>Possibly evidenced by</p> <p>Verbalization of misconception of relationship of current situation and behaviors</p> <p>Preoccupation with extreme fear of obesity and distortion of own body image</p> <p>Refusal to eat; bingeing and purging; abuse of laxatives and diuretics; excessive exercising</p> <p>Verbalization of need for new information</p> <p>Expressions of desire to learn more adaptive ways of coping with stressors</p> <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Knowledge: Illness Care (NOC)</p> <p>Verbalize awareness of and plan for lifestyle changes to maintain normal weight.</p> <p>Identify relationship of signs/symptoms (weight loss, tooth decay) to behaviors of not eating/bingeing-purging.</p> <p>Assume responsibility for own learning.</p> <p>Seek out sources/resources to assist with making identified changes.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Learning Facilitation (NIC)</p> <p>Independent</p> <p>Determine level of knowledge and readiness to learn.</p> <p>Note blocks to learning, e.g., physical/intellectual/emotional.</p>	<p>Learning is easier when it begins where the learner is.</p> <p>Malnutrition, family problems, drug abuse, affective disorders, and obsessive-compulsive symptoms can be blocks to learning requiring resolution before effective learning can occur.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Teaching: Disease Process (NIC)</p> <p>Independent</p> <p>Provide written information for patient/SO(s).</p> <p>Discuss consequences of behavior.</p> <p>Review dietary needs, answering questions as indicated. Encourage inclusion of high-fiber foods and adequate fluid intake.</p> <p>Encourage the use of relaxation and other stress-management techniques, e.g., visualization, guided imagery, biofeedback.</p> <p>Assist with establishing a sensible exercise program. Caution regarding overexercise.</p> <p>Discuss need for information about sex and sexuality.</p> <p>Refer to National Association of Anorexia Nervosa and Associated Disorders, Overeaters Anonymous, and other local resources.</p>	<p>Helpful as reminder of and reinforcement for learning.</p> <p>Sudden death can occur because of electrolyte imbalances; suppression of the immune system and liver damage may result from protein deficiency; or gastric rupture may follow binge-eating/vomiting.</p> <p>Patient/family may need assistance with planning for new way of eating. Constipation may occur when laxative use is curtailed.</p> <p>New ways of coping with feelings of anxiety and fear help patient manage these feelings in more effective ways, assisting in giving up maladaptive behaviors of not eating/binging-purging.</p> <p>Exercise can assist with developing a positive body image and combats depression (release of endorphins in the brain enhances sense of well-being). However, patient may use excessive exercise as a way to control weight.</p> <p>Because avoidance of own sexuality is an issue for this patient, realistic information can be helpful in beginning to deal with self as a sexual being.</p> <p>May be a helpful source of support and information for patient/SO.</p>

POTENTIAL CONSIDERATIONS following acute hospitalization (dependent on patient's age, physical condition/presence of complications, personal resources, and life responsibilities)

Nutrition: imbalanced, risk for less than body requirements—inadequate food intake, self-induced vomiting, history of chronic laxative use.

Therapeutic Regimen: ineffective management—complexity of therapeutic regimen, perceived seriousness/benefits, mistrust of regimen and/or healthcare personnel, excessive demands made on individual, family conflict.