

# **ANOREXIA NERVOSA/BULIMIA NERVOSA**

## **DSM-IV**

307.1 Anorexia nervosa

307.51 Bulimia nervosa

307.50 Eating disorders NOS

Binge-eating disorder (proposed, requiring further study)

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.

Binge-eating is defined as recurrent episodes of overeating associated with subjective and behavioral indicators of impaired control over and significant distress about the eating behavior but without the use of inappropriate compensatory behaviors (e.g., purging, fasting, excessive exercise).

## **ETIOLOGICAL THEORIES**

### **Psychodynamics**

The individual reflects a developmental arrest in the very early childhood years. The tasks of trust, autonomy, and separation-individuation are unfulfilled, and the individual remains in the dependent position. Ego development is retarded. Symptoms are often associated with a perceived loss of control in some aspect of life and may center on fears of sexual maturity/intimacy. Although these disorders affect women primarily, approximately 5% to 10% of those afflicted are men. Additionally, eating disorders are often associated with depression, anxiety, phobias, and cognitive problems.

### **Biological**

These disorders may be caused by neuroendocrine abnormalities within the hypothalamus. Symptoms are linked to various chemical disturbances normally regulated by the hypothalamus. Furthermore, a physiological defect may make it difficult for the individual to interpret sensations of hunger and fullness.

### **Family Dynamics**

Issues of control become the overriding factors in the family of the client with an eating disorder. These families often consist of a passive father, a domineering mother, and an overly dependent child. There is a high value placed on perfectionism in this family, and the child believes she or he must please others and satisfy these standards.

## **CLIENT ASSESSMENT DATA BASE**

### **Activity/Rest**

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 require control of weight (athletics, such as gymnasts, swimmers, jockeys, wrestlers; modeling, flight attendants)

### **Circulation**

Feeling cold even when room is warm

Low BP; tachycardia, dysrhythmias

## **Ego Integrity**

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 after overeating [binge-eating])  
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 (females)  
Concerned with achieving masculine body build (males), rather than actual weight or weight gain  
Stress factors (e.g., family move/divorce, onset of puberty)  
High self-expectations  
Suppression of anger; emotional states of depression, withdrawal, anger, anxiety, pessimistic outlook

## **Elimination**

Diarrhea/constipation  
Decreased frequency of voiding/urine output, urine dark amber (dehydration)  
Vague abdominal pain and distress, bloating  
Laxative/diuretic use

## **Food/Fluid**

Constant hunger or denial of hunger; normal or exaggerated appetite that rarely vanishes until late in the disorder (anorexia)  
Intense fear of gaining weight (female); may have prior history of being overweight (particularly males)  
Inordinate pleasure in weight loss, while denying self pleasure in other areas  
Refusal to maintain body weight at or above minimal norm for age/height (anorexia)  
Recurrent episodes of binge-eating; a feeling of lack of control over behavior during eating binges; minimum average of 2 binge eating episodes a week for at least 3 months (bulimia); ingests large amounts of food when not feeling physically hungry, often consuming as much as 20,000 calories in a 2-hour period; eating much more rapidly than normal in a discrete period of time (e.g., within a 2-hour period), an amount of food that is definitely larger than most people would eat (binge-eating); feels uncomfortably full  
Regularly engages in either self-induced vomiting (binge-purge syndrome [bulimia]) independently or as a complication of anorexia or strict dieting or fasting; excessive gum chewing  
Weight loss/maintenance of body weight 15% or more below that expected (anorexia) or weight may be normal or slightly above or below (bulimia)  
Cachectic appearance; skin may be dry, yellowish/pale, with poor turgor  
Preoccupation with food (e.g., calorie-counting, gourmet cooking; hiding food, cutting food into small pieces, rearranging food on plate)  
Peripheral edema  
Swollen salivary glands; sore, inflamed buccal cavity, erosion of tooth enamel; gums in poor condition; continuous sore throat (bulimia)  
Vomiting; bloody vomitus (may indicate esophageal tearing—Mallory-Weiss)

## **Hygiene**

Increased hair growth on body (lanugo); hair loss (axillary/pubescent); hair dull/not shiny  
Brittle nails  
Signs of erosion of tooth enamel; gum abscesses, ulcerations of mucosa

## **Neurosensory**

Appropriate affect, except in regard to body and eating; or depressive affect (depression)  
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**

Headaches, sore throat, general vague complaints

## **Safety**

Body temperature below normal

Recurrent infectious processes (indicative of depressed immune system)

Eczema/other skin problems

Abrasions/callouses may be noted on the back of hands (sticking finger down throat to induce vomiting)

## **Sexuality**

Absence of at least 3 consecutive menstrual cycles (decreased levels of estrogen in response to malnutrition)

Promiscuity or denial/loss of sexual interest

History of sexual abuse

Breast atrophy, amenorrhea

## **Social Interactions**

Middle-class or upper-class family background

Passive father/dominant mother, family members enmeshed, togetherness prized, personal boundaries not respected

History of being a quiet, cooperative child

Problems of control issues in relationships, difficult communications with others/authority figures; poor communications within family of origin

Engagement in power struggles

Altered relationships or problems with relationships (not married/divorced), withdrawal from friends/social contacts

Abusive family relationships

Sense of helplessness

May have history of legal difficulties (e.g., shoplifting)

## **Teaching/Learning**

High academic achievement

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/practices (e.g., certain foods have “too many” calories, use of “health” foods)

No medical illness evident to account for weight loss

## **DIAGNOSTIC STUDIES**

**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 (T<sub>4</sub>) levels usually normal; however, circulating triiodothyronine (T<sub>3</sub>) levels may be low.

**Pituitary Function:** Thyroid-stimulating hormone (TSH) response to thyrotropin-releasing factor (TRF) is abnormal in anorexia nervosa. Propranolol-glucagon stimulation test (studies the response of human growth hormone) reveals depressed level of GH in anorexia nervosa. Gonadotropic hypofunction is noted.

**Cortisol:** Metabolism may be elevated.

**Dexamethasone Suppression Test (DST):** Evaluates hypothalamic-pituitary function, dexamethasone resistance indicates cortisol suppression, suggesting malnutrition/depression.

**Luteinizing Hormone Secretions Test:** Pattern often resembles those of prepubertal girls.

**Estrogen:** Decreased.

**Blood Sugar and Basal Metabolic Rate (BMR):** May be low.

**Other Chemistries:** AST elevated, increased carotene level; decreased protein and cholesterol levels.

**MHP 6 Levels:** Decreased, suggestive of malnutrition/depression.

**Urinalysis and Renal Function:** BUN may be elevated; ketones present reflecting starvation; decreased urinary 17-ketosteroids; increased specific gravity (dehydration).

**EKG:** 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 client to develop realistic body image/improve self-esteem.
4. Provide support/involve SO, if available, in treatment program to client/SO.
5. Coordinate total treatment program with other disciplines.
6. Provide information about disease, prognosis, and treatment.

## 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.

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### NURSING DIAGNOSIS

**May Be Related to:**

**Possibly Evidenced by:**

### NUTRITION: altered, less than body requirements

Inadequate food intake; self-induced vomiting

Chronic/excessive laxative use

Body weight 15% (or more) below expected (anorexia), or may be within normal range (bulimia, binge-eating)

Pale conjunctiva and mucous membranes; poor skin turgor/muscle tone, edema

Excessive loss of hair; increased growth of body hair (lanugo)

Amenorrhea

Hypothermia

Bradycardia, cardiac irregularities, hypotension

Electrolyte imbalances

**Desired Outcomes/Evaluation Criteria—**

**Client Will:**

Verbalize understanding of nutritional needs.

Establish a dietary pattern with caloric intake adequate to regain/maintain appropriate weight.

Demonstrate weight gain toward expected goal range.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Establish a minimum weight goal and daily nutritional requirements.

Malnutrition is a mood-altering condition leading to depression and agitation and affecting cognitive functioning/decision-making. Improved nutritional status enhances thinking ability, and psychological work can begin.

Involve client with team in setting up/carrying out program of behavior modification. Provide reward for weight gain as individually determined; ignore loss.

Provides structured eating stimulation while allowing client some control in choices. Behavior modification may be effective only in mild cases or for short-term weight gain. **Note:** Combination of cognitive-behavioral approach is preferred for treating bulimia.

Use a consistent approach. Sit with client while eating; present and remove food without persuasion and/or comment. Promote pleasant environment and record intake.

Client detects urgency and reacts to pressure. Any comment that might be seen as coercion provides focus on food. When staff member responds consistently, client can begin to trust her or his responses. The single area in which client has exercised power and control is food/eating, and she or he may experience guilt or rebellion if forced to eat. Structuring meals and decreasing discussions about food will decrease power struggles with client and avoid manipulative games.

Provide smaller meals and supplemental snacks, as appropriate.

Gastric dilation may occur if refeeding is too rapid following a period of starvation dieting. **Note:** Client may feel bloated for 3–6 weeks while body readjusts to food intake.

Make selective menu available and allow client to control choices, as much as possible.

Client who gains self-confidence and feels in control of environment is more likely to eat preferred foods.

Be alert to choices of low-calorie foods/beverages; hoarding food; disposing of food in various places such as pockets or wastebaskets.

Client will try to avoid taking in what is viewed as excessive calories and may go to great lengths to avoid eating.

Maintain a regular weighing schedule, such as Monday/Friday before breakfast in same attire, on same scale, and graph results.

Provides accurate ongoing record of weight loss/gain. Also diminishes obsessing about changes in weight.

Weigh with back to scale (depending on program protocols).

Avoid room checks and other control devices whenever possible.

Provide 1:1 supervision and have the client remain in the dayroom area with no bathroom privileges for a specified period (e.g., 2 hours) following eating, if contracting is unsuccessful.

Monitor exercise program and set limits on physical activities. Chart activity/level of work (pacing, and so on).

Maintain matter-of-fact, nonjudgmental attitude if giving enteral feedings, parenteral nutrition, etc.

Be alert to possibility of client disconnecting tube and emptying parenteral nutrition, if used. Check fluid measurements and tape tubing snugly.

### **Collaborative**

Consult with dietitian/nutritional therapy team.

Refer for dental care.

Provide diet and snacks with substitutions of preferred foods when available.

Administer liquid diet, tube feedings/parenteral nutrition as appropriate.

Blenderize and tube feed anything left on the tray after a given period of time if indicated.

Avoid giving laxatives.

Although some programs prefer client to see the results of weighing, this approach can force the issue of trust in client who usually does not trust others.

External control reinforces client's feelings of powerlessness and are therefore usually not helpful.

Prevents vomiting during/after eating. Client may desire food and use a binge-purge syndrome to maintain weight. **Note:** Purging may occur for the first time in a client as a response to establishment of weight gain program.

Moderate exercise helps maintain muscle tone/weight and combat depression. However, client may exercise excessively to burn calories.

Perception of punishment is counterproductive to promoting self-confidence and faith in own ability to control destiny.

Sabotage behavior is common in attempt to prevent weight gain.

Helpful in determining individual dietary needs and appropriate sources. **Note:** Insufficient calorie and protein intake can lower resistance to infection and cause constipation, hallucinations, and liver damage.

Periodontal disease and loss of tooth enamel leading to caries and loose fillings requires prompt intervention to improve nutritional intake and general well-being.

Having a variety of foods available will enable the client to have a choice of potentially enjoyable foods.

When caloric intake is insufficient to sustain metabolic needs, nutritional support can be used to prevent malnutrition while therapy is continuing. High-calorie liquid feedings may be given as medication, at times separate from meals, as an alternate means of increasing caloric intake. Enteral feedings are preferred as they preserve GI function and reduce atrophy of the gut. TPN is usually reserved for life-threatening situations.

May be used as part of behavior modification program to provide total intake of needed calories.

Laxative use is counterproductive, as it may be used by client to rid body of food/calories. **Note:** Metamucil/bran may be used to treat constipation.

Monitor laboratory values, as appropriate (e.g., prealbumin, transferrin, serum protein levels; electrolytes).

Administer medications as indicated, e.g.,  
Cyproheptadine (Periactin);

Tricyclic antidepressants, e.g., amitriptyline (Elavil, Endep), imipramine (Tofranil), desipramine (Norpramin); selective serotonin reuptake inhibitors, e.g., fluoxetine (Prozac);

Antianxiety agents, e.g., alprazolam (Xanax);

Antipsychotics, e.g., chlorpromazine (Thorazine);

MAO inhibitors, e.g., tranylcypromine sulfate (Parnate).

Prepare for/assist with electroconvulsive therapy (ECT) if indicated. Discuss reasons for use and help client understand this therapy is not punishment.

Transfer to acute medical setting for nutritional therapy, when condition is life-threatening.

Identifies therapeutic needs/effectiveness of treatment. Electrolyte imbalances can cause cardiac dysrhythmias, severe muscle spasms, and even sudden death.

A serotonin and histamine antagonist 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. Lifts depression and stimulates appetite. SSRIs reduce binge-purge cycles and may also be helpful in treating anorexia. **Note:** Use must be closely monitored owing to potential side effects, although side effects from SSRIs are less significant than those associated with tricyclics. Reduces tension and anxiety/nervousness and may help client to participate in treatment. Promotes weight gain and cooperation with psychotherapeutic program, however, used only when absolutely necessary because of extrapyramidal side effects. May be used to treat depression when other drug therapy is ineffective; decreases urge to binge in clients with bulimia.

In rare and difficult cases in which malnutrition is severe/life-threatening, a short-term ECT series may enable the client to begin eating and become accessible to psychotherapy.

The underlying problem cannot be cured without improved nutritional status. Hospitalization provides a controlled environment in which food intake, vomiting/elimination, medications, and activities can be monitored. It also separates the client from SO(s) and provides exposure to others with the same problem, creating an atmosphere for sharing.

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**NURSING DIAGNOSIS**

**May Be Related to:**

**Possibly Evidenced by (Actual):**

**FLUID VOLUME deficit, risk for or actual**

- Inadequate intake of food and liquids
- Consistent self-induced vomiting
- Chronic/excessive laxative or diuretic use
- Dry skin and mucous membranes, decreased skin turgor
- Increased pulse rate, body temperature; hypotension
- Output greater than input (diuretic use); concentrated urine/decreased urine output (dehydration)
- Weakness

**Desired Outcomes/Evaluation Criteria—  
Client Will:**

Change in mental state

Hemoconcentration, altered electrolyte balance

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

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

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Monitor vital signs, capillary refill, status of mucous membranes, skin turgor.

Indicators of adequacy of circulating volume. Orthostatic hypotension may occur, with risk of falls/injury following sudden changes in position.

Monitor amount and types of fluid intake. Measure urine output accurately as indicated.

Client may abstain from all intake, resulting in dehydration, or may substitute fluids for caloric intake, affecting electrolyte balance.

Discuss strategies to stop vomiting and laxative/diuretic use.

Helping client deal with feelings that lead to vomiting and/or laxative/diuretic use may prevent continued fluid loss. **Note:** The client with bulimia has learned that vomiting provides a release of anxiety.

Identify actions necessary to regain/maintain optimal fluid balance (e.g., specific schedule for fluid intake).

Involving client in plan to correct fluid imbalances improves chances for success.

**Collaborative**

Review results of electrolyte/renal function test results.

Fluid/electrolyte shifts, decreased renal function can adversely affect client's recovery/prognosis and may require additional intervention.

Administer/monitor IV, TPN; potassium supplements, as indicated.

Used as an emergency measure to correct fluid/electrolyte imbalance. May be required to prevent cardiac dysrhythmias.

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**NURSING DIAGNOSIS**

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**THOUGHT PROCESSES, altered**

**May Be Related to:**

Severe malnutrition/electrolyte imbalance

**Possibly Evidenced by:**

Psychological conflicts (e.g., sense of low self-worth, perceived lack of control)  
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/Evaluation Criteria—  
Client Will:**

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**

**Independent**

Be aware of client’s distorted thinking ability.

Allows the caregiver to have more realistic expectations of the client and provide appropriate information and support.

Listen to/avoid challenging irrational, illogical thinking. Present reality concisely and briefly.

It is not possible to respond logically when thinking ability is physiologically impaired. The client needs to hear reality, but challenging the client leads to distrust and frustration.

Adhere strictly to nutritional regimen.

Improved nutrition is essential to improved brain functioning. (Refer to ND: Nutrition: altered, 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 disturbance/SELF ESTEEM, chronic low**

**May Be Related to:**

Morbid fear of obesity; perceived loss of control in some aspect of life  
Unmet dependency needs, personal vulnerability  
Continued negative evaluation of self

**Possibly Evidenced by:**

Dysfunctional family system

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

Expresses shame/guilt

Overly conforming, dependent on others' opinions

**Desired Outcomes/Evaluation Criteria—**

Establish a more realistic body image.

**Client Will:**

Acknowledge self as an individual.

Accept responsibility for own actions.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Establish a therapeutic nurse/client relationship.

Within a helping relationship, client can begin to trust and try out new thinking and behaviors.

Promote self-concept without moral judgment.

Client sees self as weak-willed, even though part of person may feel a sense of power and control (e.g., dieting/weight loss).

Have client draw picture of self.

Provides opportunity to discuss client's perception of self/body image and realities of individual situation.

State 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.

Consistency is important in establishing trust. As part of the behavior-modification program, client knows risks involved in not following established rules (e.g., decrease in privileges). Failure to follow rules is viewed as the client's choice and accepted by the staff in matter-of-fact manner so as not to provide reinforcement for the undesirable behavior.

Respond (confront) with reality when client makes unrealistic statements such as "I'm gaining weight, so there's nothing really wrong with me."

Client may be denying the psychological aspects of own situation and is often expressing a sense of inadequacy and depression.

Be aware of own reaction to client's behavior. Avoid arguing.

Feelings of disgust, hostility, and infuriation are not uncommon when caring for these clients. Prognosis often remains poor even with weight gain because other problems may remain. Many clients 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/feelings so they do not interfere with care of the client.

Assist client to assume control in areas other than dieting/weight loss (e.g., management of own daily activities, work/leisure choices).

Help client formulate goals for self (not related to eating) and create a manageable plan to reach those goals, a single goal at a time, progressing from simple to more complex.

Discuss the meaning of illness and effect of these behaviors.

Assist client to confront sexual fears. Provide sex education as necessary.

Determine history of sexual abuse and institute appropriate therapy.

Note client's withdrawal from and/or discomfort in social settings.

Encourage client to take charge of own life in a more healthful way by making own decisions and accepting self as is at this moment (including inadequacies and strengths).

Let client know that it is acceptable to be different from family, particularly mother.

Feelings of personal ineffectiveness, low self-concept, and perfectionism are often part of the problem. Client feels helpless to change and requires assistance to problem-solve methods of control in life situations. Helps direct energy away from eating/body image to other life-enhancing and personally satisfying activities.

Client needs to recognize ability to control other areas in life and may need to learn problem-solving skills in order to achieve this control. Setting realistic goals fosters success.

Giving up an illness that has helped form the individual's personal identity, the unconscious benefit of the "sick role," and the overvalued beliefs about an ideal body and the benefits of thinness must be addressed before the client can confront the full role the illness has played in the client's life.

Major physical/psychological changes in adolescence can contribute to development of eating disorders. Feelings of powerlessness and loss of control of feelings (particularly sexual) and sensations lead to an unconscious desire to desexualize themselves. Clients often believe that these fears can be overcome by taking control of bodily appearance/development/function. **Note:** Some clients with anorexia believe staying small and emaciated will help keep them childlike (and therefore sexually unappealing), whereas clients with binge-eating disorders wish to remain obese, believing excess body fat will lessen sexual attraction.

Client may use eating as a means of gaining control in life when sexual abuse has been experienced.

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.

Client often does not know what she or he may want for self. Parents (usually mother) often make decisions for client. Client may also believe she or he has to be the best in everything and holds self responsible for being perfect.

Developing a sense of identity as separate from family and maintaining sense of control in other ways, besides dieting and weight loss, is a desirable goal of therapy/program.

Involve in personal development program, preferably in a group setting. Provide information about proper application of makeup and grooming.

Suggest disposing of “thin” clothes as weight gain occurs. Recommend consultation with an image consultant.

Use interpersonal psychotherapy approach rather than interpretive therapy.

Encourage client to express anger and acknowledge when it is verbalized.

Assist client to learn strategies other than eating for dealing with feelings. Have client keep a diary of feelings, particularly when thinking about food.

Assess feelings of helplessness/hopelessness.

Be alert to suicidal ideation/behavior.

## **Collaborative**

Involve in group therapy.

Refer to occupational/recreational therapy.

Learning about methods of enhancing personal appearance may be helpful to long-range sense of self-concept/image. Feedback from others can promote feelings of self-worth.

Provides incentive to at least maintain and not lose weight. Removes visual reminder of thinner self. Positive image enhances sense of self-esteem.

Interaction between persons is more helpful for the client to discover feelings/impulses/needs from within own self. Client has not learned this internal control as a child and may not be able to interpret or attach meaning to behavior. **Note:** Cognitive therapy is usually more effective for clients diagnosed as bulimic or binge-eaters but may not be useful for anorectic clients during the period of acute hospitalization.

Important to know that anger is part of self and as such is acceptable. Expressing anger may need to be taught to client, because anger is often considered unacceptable in the family, and therefore client does not express it.

Feelings are the underlying issue, and clients often use food instead of dealing with feelings appropriately. Therapeutic writing helps client recognize feelings and how to express them clearly and directly.

Lack of control is a common/underlying problem for this client and may be accompanied by more serious emotional disorders. **Note:** 54% of clients with anorexia have a history of major affective disorder, and 33% have a history of minor affective disorder.

Intensity of anxiety/panic about weight gain, depression, hopeless feelings may lead to suicidal attempts, particularly if client is impulsive.

Provides an opportunity to talk about feelings and try out new behaviors.

Can develop interests 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.

Encourage participation in directed activities (e.g., bicycle tours, wilderness adventures, such as Outward Bound Program).

Refer to therapist trained in dealing with sexuality.

Although exercise is often used negatively by these clients (i.e., for weight loss/control), directed activities provide an opportunity to learn self-reliance, enhance self-esteem, and realize that food is the fuel required by the body to do its work.

May need professional assistance to accept self as a sexual adult.

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**NURSING DIAGNOSIS****May Be Related to:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—  
Family Will:**

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**FAMILY PROCESSES, altered**

Issues of control in family

Situational/maturational crises

History of inadequate coping methods

Dissonance among family members; family needs not being met

Family developmental tasks not being met

Ill-defined family rules, functions, and roles

Focus on “identified patient” (IP); family member(s) acting as enablers for IP

Demonstrate individual involvement in problem-solving processes directed at encouraging client 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.

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**ACTIONS/INTERVENTIONS****Independent**

Identify patterns of interaction. Encourage each family member to speak for self. Do not allow 2 members to discuss a third without that member’s participation.

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**RATIONALE**

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.

Discourage members from asking for approval from each other. Be alert to verbal or nonverbal checking with others for approval. Acknowledge competent actions of client.

Listen with regard when the client speaks.

Encourage individuals not to answer to everything.

Communicate message of separation, that it is acceptable for family members to be different from each other.

Encourage and allow expression of feelings (e.g., crying, anger) by individuals.

Prevent intrusion in dyads by other members of family.

Reinforce importance of parents as a couple who have rights of their own.

Prevent client from intervening in conflicts between parents. Help parents identify and solve their marital differences.

Be aware of and confront sabotage behavior on the part of family members.

### **Collaborative**

Refer to community resources, such as family group therapy, parents' groups, as indicated; and Parent Effectiveness classes.

Each individual needs to develop own internal sense of self-worth. Individual often is living up to others' (family's) expectations rather than making own choices. Acknowledgment provides recognition of self in positive ways.

Sets an example and provides a sense of competence and self-worth in that the client has been heard and attended to.

Reinforces individualization and return to privacy.

Individuation needs reinforcement. Such a message confronts rigidity and opens options for different behaviors.

Often these families have not allowed free expression of feelings and will need help and permission to learn and accept this.

Inappropriate interventions in family subsystems prevent individuals from working out problems successfully.

The focus on the child with an eating disorder is very intense and often is the only area through which the couple interact. The couple needs to explore their own relationship and restore the balance within it to prevent its disintegration.

Triangulation occurs in which a parent-child coalition exists. Sometimes the child is openly pressed to align with 1 parent against the other. The symptom or behavior (eating disorder) is the regulator in the family system, and the parents deny their own conflicts.

Feelings of blame, shame, and helplessness may lead to unconscious behavior designed to maintain the status quo.

May help reduce overprotectiveness, support/facilitate the process of dealing with unresolved conflicts and change.

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### **NURSING DIAGNOSIS**

**May Be Related to:**

**Possibly Evidenced by:**

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### **SKIN INTEGRITY, impaired, risk for or actual**

Altered nutritional state; edema

Dehydration/cachectic changes (skeletal prominence)

Dry/scaly skin with poor skin turgor; tissue fragility

Brittle/dry hair

**Desired Outcomes/Evaluation Criteria—  
Client Will:**

Dry rash, reports of itching, dermal abrasions (from scratching)

Verbalize understanding of causative factors and relief of discomfort.

Identify and demonstrate behaviors to maintain soft, supple, intact skin.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Observe for reddened, blanched, excoriated areas.

Indicators of increased risk of breakdown requiring more intense treatment.

Encourage bathing every other day instead of daily.

Frequent baths contribute to skin dryness.

Use skin cream twice a day and always after bathing.

Lubricates skin and decreases itching.

Massage skin gently, especially over bony prominences.

Improves skin circulation, enhances skin tone.

Discuss importance of frequent change of position, need for remaining active.

Enhances circulation and perfusion to skin by preventing prolonged pressure on tissues.

Emphasize importance of adequate nutrition/fluid intake. (Refer to ND: Nutrition: altered, less than body requirements.)

Improved nutrition and hydration will improve skin condition.

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**NURSING DIAGNOSIS**

**KNOWLEDGE deficit (LEARNING NEED) regarding condition, prognosis, self care and treatment needs**

**May Be Related to:**

Lack of exposure to/unfamiliarity with information resources; misinterpretation

Lack of interest in learning

Learned maladaptive coping skills

**Possibly Evidenced by:**

Verbalization of misconception

Preoccupation with extreme fear of obesity and distortion of own body image

Refusal to eat, binging/purging

Abuse of laxatives/diuretics; excessive exercising

Expression of desire to learn more adaptive ways of coping with stress or of relationship of current situation and behaviors

Inappropriate behaviors (e.g., apathy)

**Desired Outcomes/Evaluation Criteria—  
Client Will:**

Verbalize awareness of and plan for lifestyle changes to maintain desired weight.

Identify relationship of signs/symptoms (e.g., weight loss, tooth decay) to behaviors of not eating/binge-purging.

Assume responsibility for own learning.

Seek out sources/resources to assist with making identified changes.

Formulate plan to meet individual goals for wellness.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Determine level of knowledge and readiness to learn.

Learning is easier when it begins where the learner is.

Note blocks to learning (e.g., physical/intellectual/emotional).

Malnutrition, family problems, drug abuse, affective disorders, obsessive-compulsive symptoms can interfere with learning, requiring resolution before effective learning can occur.

Review dietary needs, answering questions as indicated. Encourage inclusion of high-fiber foods and adequate fluid intake.

Client/family may need assistance with planning for new way of eating. As constipation may occur when laxative use is curtailed, dietary considerations may prevent need for more aggressive therapy.

Discuss consequences of behavior.

Sudden death may occur owing to electrolyte imbalances; suppression of the immune system and liver damage may result from protein deficiency; or gastric rupture may follow binge-eating/vomiting.

Encourage the use of relaxation and other stress-management techniques (e.g., visualization, guided imagery, biofeedback).

New ways of coping with feelings of anxiety and fear will help client manage these feelings more effectively, assisting in giving up maladaptive behaviors of not eating/binging-purging.

Assist with establishing a sensible exercise program. Caution regarding overexercise.

Exercise can help develop a positive body image and combats depression (release of endorphins in the brain enhances sense of well-being). Client may use excessive exercise as a way of controlling weight.

Provide written information for client/SO(s).

Helpful as reminder of and reinforcement for learning.

Discuss need for information about sex and sexuality.

Refer to National Association of Anorexia Nervosa and Associated Disorders, Overeaters Anonymous, and other local resources.

Because avoidance of own sexuality is an issue for this client, realistic information can be helpful in beginning to deal with self as a sexual being.

May be a helpful source of support and information for client and SO(s).