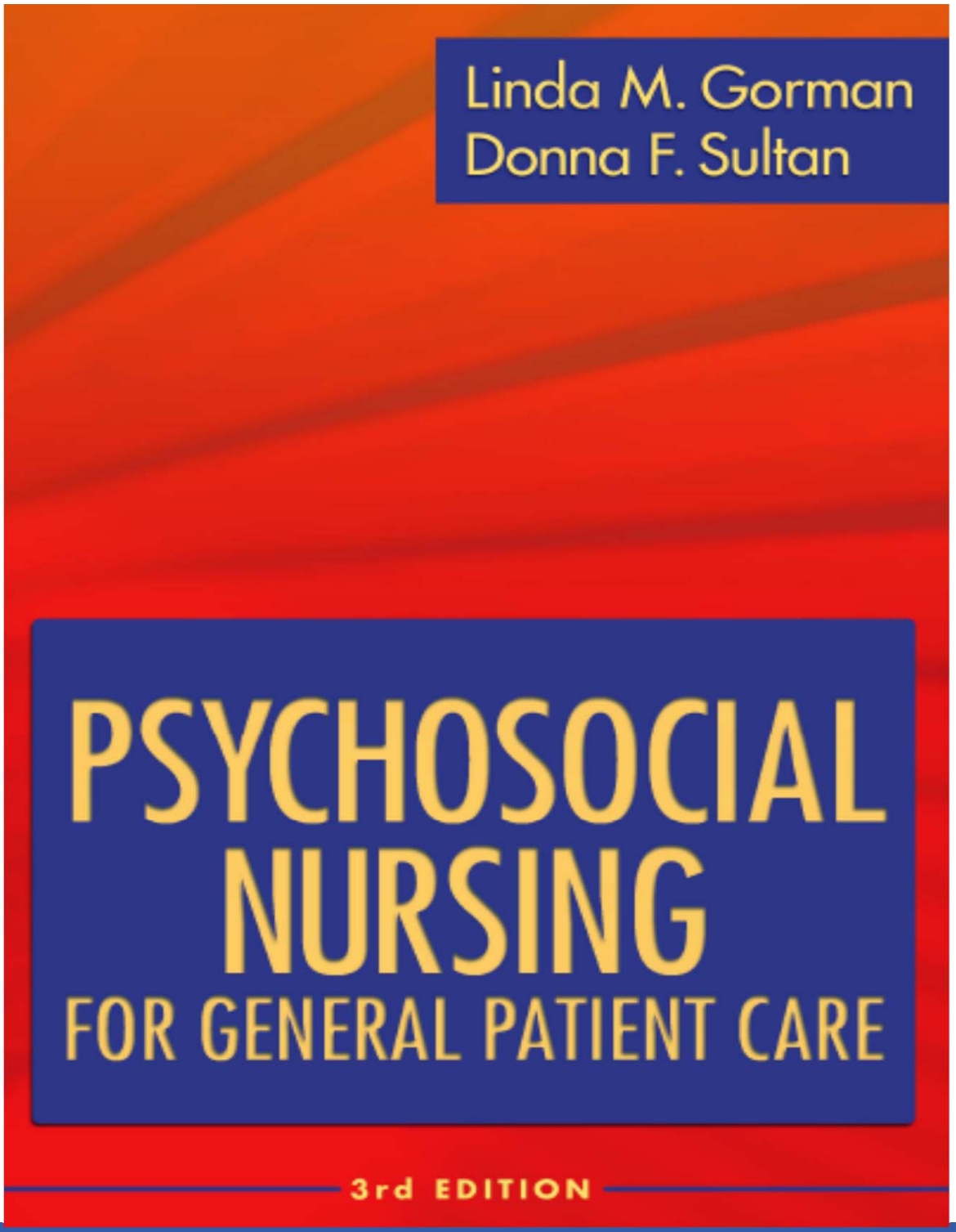

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Commonly Encountered Problems: Pain

The Patient with Anorexia Nervosa or Bulimia

Learning Objectives

After the classroom discussion, the students will be able to:

1. **Describe the similarities and differences between anorexia nervosa and bulimia.**
2. **Formulate nursing diagnoses and interventions for patients with anorexia nervosa or bulimia.**
3. **Identify common nurses' reactions to the patient with anorexia nervosa or bulimia.**
4. **Describe the complications of anorexia nervosa and bulimia.**

Useful Terminologies

- *Anorexia nervosa* – A potentially life-threatening eating disorder characterized by self-starvation in a relentless pursuit of thinness, an intense fear of becoming fat, and delusional disturbance of body image.

- *Binge eating disorder* – Recurrent episodes of binge eating that lead to feelings of distress. Not associated with purging.

- *Binge* – Rapid consumption of large amounts of food in a short period of time (usually less than 2 hours).

- *Bulimia (bulimia nervosa)* – An eating disorder characterized by some of the following: consuming large quantities of food in a short time terminating in abdominal pain, sleep, social interruption, self-induced vomiting, and laxative use.

Useful Terminologies

- *Compulsive overeating* – Consuming large volumes of food without purging.
- *Eating disorders* – Gross disturbances in the patterns of ingesting food.
- *Purge* – Planned or unplanned episode to undo damage of binge, including self-induced vomiting, laxative use, or diuretic use.

Introduction

- Dieting is a national obsession, especially with women. Numerous fitness clubs are filled with individuals trying to attain the idealized thin, muscular body.

- Cochrane (1998) reports that more than 50% of American women are on a diet at any one time. Extreme thinness is increasingly common in models and actresses as the idealized image.

- Anorexia nervosa and bulimia (sometimes called “bulimia nervosa”) most commonly occur in young women, and the incidence of these disorders is on the rise.

	Anorexia Nervosa	Bulimia
Epidemiology	• More than 95% female • Younger adolescent onset • Fairly rare	• 90% female • Young adult onset more likely • 2–3 times more frequent than anorexia
Appearance	• Emaciated • Below normal weight	• Normal or overweight • Weight fluctuations
Family	• Rigid, perfectionistic • Overprotection	• More overt conflict
Behavior	• Introverted • Socially isolated • High achiever • Excessive exercise	• Impulsive • More histrionic, acting out
Signs	• Cachexia • Hair loss • Amenorrhea • Dry skin • Pedal edema	• Dehydration • Chronic hoarseness • Chipmunk facies (parotid gland enlargement)
Prognosis	• 5%–18% mortality rate • Frequent life-long problems with food • Bulimia • Depression	• Death is rarer • Life-long problems with food

ETIOLOGY

- Individuals with eating disorders report a premorbid history of dieting and attempts to control their weight.

- Anorexia nervosa may have genetic influences because there is an increased incidence of its occurrence among daughters and sisters of anorexics. The biologic influence may be multifactoral.

- Psychoanalytic theory suggests that the core of anorexia can be a child's fear of maturing and unconscious avoidance of developmental tasks.

- Family dynamics in bulimia are often characterized by a high degree of conflict, marital discord, and acting out.

RELATED CLINICAL CONCERNS

- Anorexic and bulimic patients may have a history of being overweight when young.

- Anorexics have been noted to weigh more at birth. Bulimics may have a history of anorexia when younger, as well as a tendency for obesity within the family.

- Life-threatening complications from anorexia include cardiac arrhythmias, electrolyte imbalance, and cardiomyopathy. Serious bulimia complications can include electrolyte imbalance and erratic blood sugars.

LIFE SPAN ISSUES

Children

- Anorexia and bulimia remain a condition generally seen in adolescence and young adulthood.
- Children as young as 8 years old often admit to preoccupation with diet and atypical eating habits.
- A sense of self-consciousness and insecurity with one's body is a normal part of growth and development; however, children whose self-esteem becomes more closely tied to satisfaction with their body size tend to become more prone to eating disorders.

POSSIBLE NURSES' REACTIONS

- May feel shocked or disgusted by patient's behavior or appearance.
- May resent the patient because of the belief that the disorder is self-inflicted. This may make it difficult to express empathy, which, in turn, may make the patient feel rejected.
- The nurse may feel helpless to change the patient's behavior, leading to anger, frustration, and criticism.
- The nurse may inadvertently re-create family power struggles with patient by trying to make the patient eat by nagging, cajoling, arguing, or even tricking. This will inhibit a trusting nurse-patient relationship.
- The nurse may feel overwhelmed with the patient's problems, leading to feelings of hopelessness or to the setting of rigid limits to feel more in control of the patient's behavior.
- Many nurses become embroiled in power struggles with these patients, which may trigger angry responses in the nurses.

ASSESSMENT

1. Behavior and Appearance
2. Mood and Emotions
3. Thoughts, Beliefs, and Perceptions
4. Relationships and Interactions
5. Physical Responses
6. Pertinent History

COLLABORATIVE MANAGEMENT

1. *Pharmacological*

- The Agency for Healthcare Research and Quality (2006) found that medications were of limited value in treatment of anorexia. Antidepressants, particularly fluoxetine (Prozac), and other selective serotonin reuptake inhibitors (SSRIs) have been used in patients with clinical depression, anxiety, and obsessive-compulsive symptoms for both anorexia and bulimia (Yager et al, 2006).
- Antipsychotic medications may be used in patients who are extremely obsessive compulsive. Tricyclic antidepressants and monoamine oxidase inhibitors are generally not used in anorexia because of increased side effect profile in malnourished individuals.

COLLABORATIVE MANAGEMENT

2. Dietary

- The dietary regimen for the anorexic patient generally involves a slow, steady weight gain of no more than 3 pounds per week (Yager & Anderson, 2005).
- Too rapid weight gain can put undue stress on the heart and precipitate complications.
- Management by a clinical dietitian or nutrition support team is essential.
- These patients need careful assessment of their nutritional needs. In severely ill patients, malnutrition must be treated before any improvement from psychotherapy can be expected.

COLLABORATIVE MANAGEMENT

3. Psychiatric

- Individual and group psychotherapy is essential in treating patients with bulimia and anorexia nervosa. Because patients with both conditions also commonly exhibit troubled family relationships, family therapy is also needed.
- The treatment plan for anorexia nervosa may include a behavior modification and cognitive therapy program.
- Patients are given rewards for any weight gains and increased restrictions for any weight loss or self-destructive behaviors.

NURSING MANAGEMENT

NUTRITION IMBALANCED: LESS THAN BODY REQUIREMENTS evidenced by weight loss, avoidance of food, excessive exercise, hiding food, self-induced vomiting related to self-starvation, binge-purge cycle.

Patient Outcomes

- Increased oral intake (anorexia nervosa)
- Weight gain at rate of no more than 2 pounds per week or per prescribed treatment plan (anorexia nervosa)
- Reduced incidence of strenuous exercise (anorexia nervosa) and/or purging (bulimia)

NURSING MANAGEMENT

Interventions

- Recognize that patient may be very defensive about eating behavior and attempts to keep it secret. Mealtimes may be very stressful. Create environment of acceptance to encourage a trusting nurse-patient relationship.
- If personnel are available, stay with patient during meals to be sure food is actually eaten. Create a social atmosphere rather than a supervisory one.
- Give patient as much control as possible around eating behavior. Encourage him or her to select some foods. Set limits, however, on length of mealtimes. Lengthy mealtimes tend to increase anxiety and acting-out behaviors.
- Monitor food and fluid intake.

NURSING MANAGEMENT

- Weigh patient regularly, using same scale.
- Set limits on dysfunctional behaviors such as strenuous exercise and use of bathroom after eating.
- Set limits on time spent alone in the bathroom after meals.
- Present meals without threat, coercion, or criticism.
- If you suspect that patient is trying to sabotage the treatment plan, talk openly with patient about your concerns.
- Reinforce the idea that patient can avoid more aggressive interventions, such as tube feedings, by meeting acceptable minimal weight standards, per treatment plan.
- For the patient who binges and/or purges, assess specifically what the patient does including method of self-induced vomiting, laxative, or diuretic use.

NURSING MANAGEMENT

DISTURBED BODY IMAGE evidenced by inaccurate perception of appearance and morbid fear of obesity related to distorted thoughts and inability to perceive body size and physical needs realistically.

Patient Outcomes

- Verbalizes more realistic perception of his or her body
- Refers to body in a more positive way

NURSING MANAGEMENT

Interventions

- Assess patient's previous and current pain behaviors.
- Encourage the patient to learn and use noninvasive pain-relief methods, such as muscle relaxation, deep breathing, guided imagery, distraction, TENS, and application of heat or cold.
- Incorporate family or caregivers in alternative pain-relief measures.
- Use analgesic medications in conjunction with alternative pain-relief measures to effectively control pain.
- Discuss with physician or pharmacist plan for weaning patient off opioids and onto non-narcotics.
- Teach patient and family that oral medication, when prescribed in appropriate dose and frequency, can be as effective as parenteral.

NURSING MANAGEMENT

- Administer a loading dose and then maintain a therapeutic drug level of oral medications when first switching to gain the patient's confidence in new treatment.
- Ask patient to participate in evaluation of pain-relief methods by keeping his or her own pain diary.
- Help family or caregiver to recognize and decrease pain behaviors for secondary gain.
- Promote optimal mobility and meaningful activity in patient.
- Assess patient's nutrition and elimination functions related to use of medications and decreased mobility or activity.
- Assess patient's sleep pattern, levels of depression, or other psychological reactions to prolonged pain. Consider use of adjuvant treatments, as indicated.

NURSING MANAGEMENT

ALTERNATE NURSING DIAGNOSES

1. *Anxiety*
2. *Comfort, Impaired*
3. *Coping, Ineffective*
4. *Fear*
5. *Powerlessness*
6. *Self-Concept, Disturbed*
7. *Sleep Pattern, Disturbed*
8. *Spiritual Distress*
9. *Thought Processes, Disturbed*

WHEN TO CALL FOR HELP

- Pain-relief measures are ineffective.
- Pain levels increase.
- Patient or family is unwilling to learn about alternative methods of pain relief.
- Psychiatric problems are interfering with patient's use of prescribed pain-relief methods.
- There is increased frustration from dealing with the patient's or family's pain behaviors.
- Analgesics ordered are ineffective and physician refuses to make changes.
- Patient continues or increases use of pain behaviors for secondary gain.
- There are concerns over patient's or family's ability to manage pain after discharge.
- Evidence of abuse of opioids.

WHO TO CALL FOR HELP

- Pain team
- Addiction specialists
- Social Worker
- Palliative Care Team/Hospice
- Attending Physician

End of Chapter