NARAYANA
COLLEGE OF NURSING

UNIT–X Nursing management of patients with Personality, sexual and Eating disorders

Dr.Anjani devi M.Sc.(N)., Ph.D. M.B.A Associate Professor cum HOD Department of Mental Health Nursing Narayana college of Nursing

Personality Disorders

- Normal personality can be defined as, “the characteristic pattern of behaviors or modes of thinking that determine a person’s adjustment to environment”.
- It includes the factors such as intellectual abilities, attitude, beliefs, moral values, emotional reactivity.

•Most definition of normal personality includes some or all of the following features,

- Present since adolescence.
- Stable overtime despite fluctuations in mood.
- Manifest in different environment.
- Recognizable to friends and acquaintance.

DEFINE PERSONALITY DISORDER

- According to WHO abnormal personality can be defined as “deeply ingrained maladaptive pattern of behavior, continuing throughout the most of adult life, although often becoming less obvious in middle or old age

•Maladaptive behavior results in loneliness, suspiciousness and withdrawn behavior.

•Personality disorders falls somewhere within the maladaptive range. The degree of maladaptiveness depends on the type of disorder and its severity of symptoms.

CHARACTERISTIC OF PERSONALITY DISORDER

- It is not a mental illness.
- It is a maladaptive behavior.
- It is long lasting, most of time lifelong problems.
- It causes significant impairment in social or occupational functioning.
- It produces distress to the individual and to others.

•Personality disorder is different from mental illness. Whereas the symptoms of personality disorder are continuous and start from adolescence or even before.

- These patients are odd but no mad.

INCIDENCE:

The most common estimations range of all personality disorder is about 10-23%.

- Paranoid 0,5-2,5%
- Schizoid and Schizotypal 3%
- Antisocial 3%
- Borderline 2%
- Histrionic 2-3%
- Narcissistic less than 1%
- Avoidant 0,5-1%
- Dependent 2,5-25%

CLASSIFICATION:

According to ICD 10

F60 Specific personality disorders

F60.0 Paranoid personality disorder

F60.1 Schizoid personality disorder

F60.2 Dissocial personality disorder

F60.3 Emotionally unstable personality disorder

.30 Impulsive type

.31 Borderline type

F60.4 Histrionic personality disorder

F60.5 Anankastic personality disorder

F60.6 Anxious [avoidant] personality disorder

F60.7 Dependent personality disorder

F60.8 Other specific personality disorders

F60.9 Personality disorder, unspecified.

F61- Mixed and other personality disorders

F62- Enduring personality changes ,not attributable to brain damage and disease

F63- Habit and Impulse disorders

F64-Gender identity disorders

F65- Disorders of sexual preference

CLASSIFICATION OF PERSONALITY DISORDER

In DSM IV, personality disorder are coded on axis

II and have been divided into three clusters,

1. Cluster A (odd and eccentric)
2. Cluster B (dramatic, emotional, erratic)
3. Cluster C (anxious and fearful)

1. **Cluster A (odd and eccentric)**

a. Paranoid personality disorder.

b. Schizoid personality disorder.

c. Schizotypal personality disorder.

2. **Cluster B (dramatic, emotional, erratic)**

a. Antisocial personality disorder.

b. Histrionic personality disorder.

c. Narcissistic personality disorder.

d. Borderline personality disorder.

3. **Cluster C (anxious and fearful)**

a. Avoidant personality disorder

b. Dependent personality disorder

c. Obsessive compulsive personality disorder

ETIOLOGY FACTORS:

1. Biological factors.
2. Developmental factors.
3. Social cultural factors.
4. Psychological stressors.

1. **Biologicalfactors:**

- Genetic
- Low level of serotonin.
- Those with family history of alcoholism or other psychiatric problems.
- Especially among the people with a clusterA.

2. Developmental factors:

- Early traumatic experience
- Losses suffered by the attachment figure.
- Childhood abuse.
- Sexual abuse.
- Lack of parental care.

3.Socio cultural factors:

- Isolation
- Long term psychiatric problems.
- Chronic institutionalization
- Immigration.
- Lack of close family ties which promotes loneliness.

4.Psychodynamic factors:

- Anxiety
- Increased autonomy
- Separation
- Lack of coping
- Abandonment
- Dependency, etc

Cluster A (odd andeccentric)

a. Paranoid personality disorder:

- Paranoid personality disorder is more prevalent in male then females.
- This disorder is marked by a distrust of other people and a constant unwarranted suspicion that others have sinister motive.

Definition:

Persons with paranoid personality disorder are characterized by long-standing suspiciousness and mistrust of persons in general. They refuse responsibility for their own feelings and assign responsibility to others. They are often hostile, irritable, and angry.

- Person with this disorder search for hidden meanings and hostile intention in everything others say or do.

SIGNS AND SYMPTOMS:

- Suspicious.
- Mistrustful.
- Argumentative.
- Stubborn.
- Self-importance.
- Hypersensitive.
- Jealous and
- Irritable.

b.Schizoid personality disorder:

•Schizoid personality disorder is characteristic by detachment and social withdrawal.

•People with this disorder are commonly described as loners, with solitary interest and occupations and no close friends.

Definition

Schizoid personality disorder is diagnosed in patients who display a lifelong pattern of social withdrawal. Their discomfort with human interaction, their introversion, and their bland, constricted affect are noteworthy. Persons with schizoid personality disorder are often seen by others as eccentric, isolated, or lonely.

- Typically they maintain a social distance even from family members and seem unconcerned about others

SIGNS AND SYMPTOMS:

- Emotionally cold.
- Humorless.
- Aloof.
- Introspective.

- No desire for enjoyment of close relationship.
- Inability to experience pleasure.

c. Schizotypal disorder:

- This disorder is marked by odd thinking and behavior, a pervasive pattern of social and interpersonal deficits and acute discomfort with others

SIGN AND SYMPTOMS

- Inappropriate affect.
- Odd believes or magical thinking.
- Social withdrawal.
- Odd, eccentric or peculiar behavior.
- Lack of close relationship.
- Social isolation.
- Not fitting easily with others.

Cluster B (dramatic, emotional, erratic)

a. Antisocial personality disorder.

- Antisocial personality disorder is characterized by chronic antisocial behavior that violates other rights or social norms which predisposes the affected person to the criminal behavior

- The person is unable to maintain the consistent, responsible functioning at work, school or as a parent.

SIGN AND SYMPTOMS

- Failure to sustain the relationship.
- Impulsive actions.
- Low tolerance to frustration.
- Tendency to cause violence.
- Lack of guilt
- Inability to maintain close personal or sexual relationship

b. Histrionic personality disorder.

- Patient with this disorder is characteristically have a pervasive pattern of excessive emotionality and attention seeking behavior and are drawn to momentary excitement and fleeting adventure.

- This disorder is most common in female.
- People with this disorder need to be the center of attention at all time

SIGN AND SYMPTOMS

- Dramatic emotionality (emotional blackmail, angry scenes, demonstrative suicide attempts.)
- Attention seeking behavior.
- Lack of considerations for other
- Self-dramatization.

c. Narcissistic personality disorder.

- Patient with Narcissistic personality disorder is self-centered, self-absorbed and lacking in empathy for others.
- He typically takes advantages of people to achieve his own ends, and uses them without regards to their feelings.

SIGN AND SYMPTOMS:

- Attention seeking
- Dramatic behavior
- Unable to face criticism.

- Lack of empathy.
- Arrogances.
- Exploitative behavior

d. Borderline personality disorder

- Borderline personality disorder is marked by a pattern of instability in interpersonal relationship, mood, behavior, and self-image.

•The 4 main categories of SIGNAND SYMPTOMS are,

- Unstable relationship.
- Unstable self-image
- Unstable emotions
- Impulsivity.

- ***Other S/S includes,***

- Lack of control of anger.
- Recurrent suicidal threats or behavior.
- Uncertainty about personal identity.
- Chronic feeling of emptiness

3. Cluster C (anxious and fearful)

a. <u>Avoidant personalitydisorder</u>

•People with this disorder have low self-esteem, and poor self-confident, they will be negative and have a difficulty in viewing situation and interactions objectives.

SIGNS AND SYMPTOMS

- Fear of disapproval or rejection.
- Unwillingness to become involved with people.
- Shyness.
- Insecurity.

- The persons having this disorder also have other psychiatric disorder like – social phobia, anxiety disorder, OCD, depressive disorder, somatoform disorder, etc.

b. Dependent personality disorder

•This disorder is characterized by an extreme need to be taken care of, which leads to submissive and fear of separation or rejection.

- People with this disorder, let other make important discussion for them and have a strong need for constant reassurance and support

SIGN AND SYMPTOMS:

- Feeling uncomfortable and helplessness.
- Inability to make decisions.

- Low self-esteem and lack of self-confidence.
- Hypersensitivity.

c. Obsessive compulsive personality disorder:

- The individual places a great deal of pressure on himself and other not to make a mistake.
- Believes his way of doing something is the only correct way, may force himself and others to follow right moral principles.

SIGN AND SYMPTOMS

- Feeling of excessive doubt and caution.
- Perfectionism.
- High standards

TREATMENT

1. ANXIOLYTIC DRUGS:

- ***To treat severe stress,***

- Alprazolam
- Ativan
- Librium
- Diazepam, etc

2. NEUROLEPTIC DRUGS: ANTIPSYCHOTIC

- ***It can be useful in case of paranoid and schizotypal personality disorder.***

- Olanzapine
- Haloperidol
- Droperidol

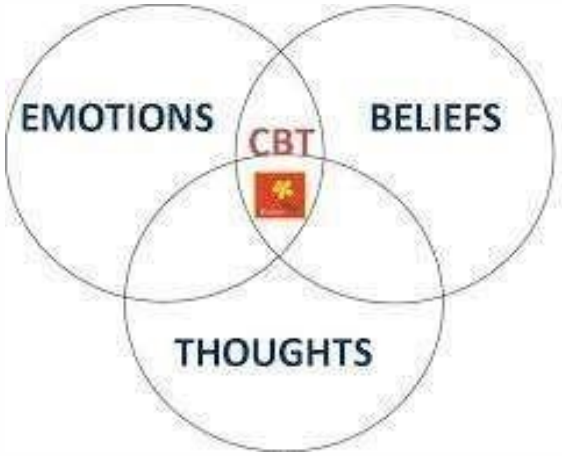
3. PSYCHODYNAMIC TREATMENT:

- It’s also known as the insight oriented therapy, focuses on unconscious processes as they are manifested in a person’s present behavior.

- The goal of psychodynamic therapy is a client's self-awareness and understanding of the influence of the past on present behavior

4. COGNITIVE AND BEHAVIOUR TEHRAPY

- Most cognitive behavioral approaches address specific aspects of thought, feelings, behavior, or attitude and do not claim to treat the entire personality disorder of the person.



SEXUAL DISORDERS

INTRODUCTION

- In ICD10 gender identity disorders, disorders of sexual preference and sexual development and orientation disorders are listed under disorders of adult personality and behavior (f6), while sexual dysfunctions are listed under behavioral syndromes associated with physiological disturbances and physical factors (f5).
- It is a disturbances in the sexual desire.

The sexual response cycles

Phase I. Desire
Phase II. Excitement
Phase III. Orgasm
Phase IV. Resolution

DEFINITION

- Any disorder involving sexual functioning , desire, or performance

OR

- Sexual disorder is difficulty experienced by an individual or a couple during any stage of a normal sexual activity, including physical pleasure, desire, preference, arousal or orgasm.

CLASSIFICATION

1. Gender identity disorders
2. Psychological and behavioral disorders associated with sexual development and maturation
3. Disorders of sexual preference (paraphilias)
4. Sexual dysfunctions

Gender Identity Disorders

- In these disorders, the sense of one's masculinity or femininity is disturbed. They include;

a) Transsexualism

b) Gender identity disorder of childhood

c) Dual-role transvestism

d) Intersexuality

a)Transsexualism

- In this, there is a persistent and significant sense of discomfort regarding one's anatomic sex and a feeling that it is inappropriate to one's perceived gender..

- The person will be preoccupied with the wish to get rid of one's genitals and secondary sex characteristics and to adopt the sex characteristics of the other sex.

- ***Treatment***
- Counseling to help the individual reconcile with the anatomic sex.
- Sex change to the desired gender [sex reassignment surgery (SRS)] in selected cases.

- **Gender identity disorder of childhood:**

This is a disorder similar to transsexualism, with a very early age of onset.

- **Dual-role transvestism:**

It is characterized by wearing clothes of the opposite sex in order to enjoy the temporary experience of membership of the opposite sex but without any desire for permanent sex change.

- **Intersexuality:**

  The patients have gross anatomical or physiological features of the other sex. For example, Turner's syndrome, congenital adrenal hypoplasia.

Psychological and Behavioral Disorders Associated with Sexual Development and Maturation

- **Homosexuality**

In this, sexual relationships are maintained between persons of the same sex. Female homosexuals are called as 'lesbians' and male homosexuals are called 'gay.'

Types

1. Obligatory homosexuality
2. Preferred homosexuality
3. Bisexuality
4. Situational homosexuality
4. Latent homosexuality

Treatment:

- **Behavior therapy**: Aversion therapy, covert sensitization, systematic desensitization
- Supportive psychotherapy
- Psychoanalytic psychotherapy

Disorders of Sexual Preference (ICD10-F6) or Paraphilias (DSMV)

- In paraphilias, sexual arousal occurs persistently and significantly in response to objects, which are not a part of normal sexual arousal. These disorders include:

Paraphilia

- Fetishism

Sadism

- Masochism
- Voyeurism
- Pedophilia
- Frotteurism
- Transvestites
- Exhibitionism
- Other paraphilia**:** Partialism, Zoophilia, Coprophilia, Klismaphilia, Urolagnia

1. Fetishism:

- Sexual arousal occurs with a non-living object which is usually intimately associated with the human body. The fetish object may include bras, underpants, shoes, gloves, etc.

2. Transvestism:

- Sexual arousal occurs by wearing clothes of the opposite sex.

3. Sexual sadism:

- The person is sexually aroused by physical and psychological humiliation, suffering or injury of the sexual partner.

4. Sexual masochism:

- Here the person is sexually aroused by physical or psychological humiliation or injury inflicted on self by others.

5. Exhibitionism:

- In this, the person is sexually aroused by the exposure of one's genitalia to an unsuspecting stranger.

6. Voyeurism:

- This is a persistent or recurrent tendency to observe unsuspecting persons naked (usually of the other sex) and engaged in sexual activity.

7. Frotteurism:

- This is a persistent or recurrent involvement in the act of touching and rubbing against an unsuspecting, non-consenting person.

1. Pedophilia:

- It is characterized by persistent or recurrent involvement of an adult in sexual activity with prepubertal children

9. Zoophilia

Involving in sexual activity with animals.

10. Other paraphilia's:

Sexual arousal occurs with urine, feces, enemas, etc.

- ***Treatment***
- Behavior therapy: Aversion therapy
- Drug therapy: Antipsychotics have been used for severe aggression associated with paraphilia

SEXUAL DYSFUNCTIONS

- Sexual dysfunction is a significant disturbance in the sexual response cycle, which is not due to an underlying organic cause.
- The common dysfunctions are:

Sexual dysfunctions

- Frigidity
- Impotence
- Premature ejaculation
- Non-organic vaginismus
- Non-organic dyspareunia

- **Frigidity:**
  - Absence of desire for sexual activity
- **Impotence:**
  - This disorder is characterized by an inability to have or sustain penile erection till the completion of satisfactory sexual activity.

- **Premature ejaculation:**
  - Ejaculation before the completion of satisfactory sexual activity for both partners.

- **Non-organic vaginismus:** An involuntary spasm of lower l/3rd of vagina, interfering with coitus.
- **Non-organic dyspareunia;** Pain in the genital area of either male or female during coitus.

- ***Treatment***
- Psychoanalysis
- Hypnosis
- Group psychotherapy
- Behavior therapy

Nursing Intervention for Patient with Sexual Disorder

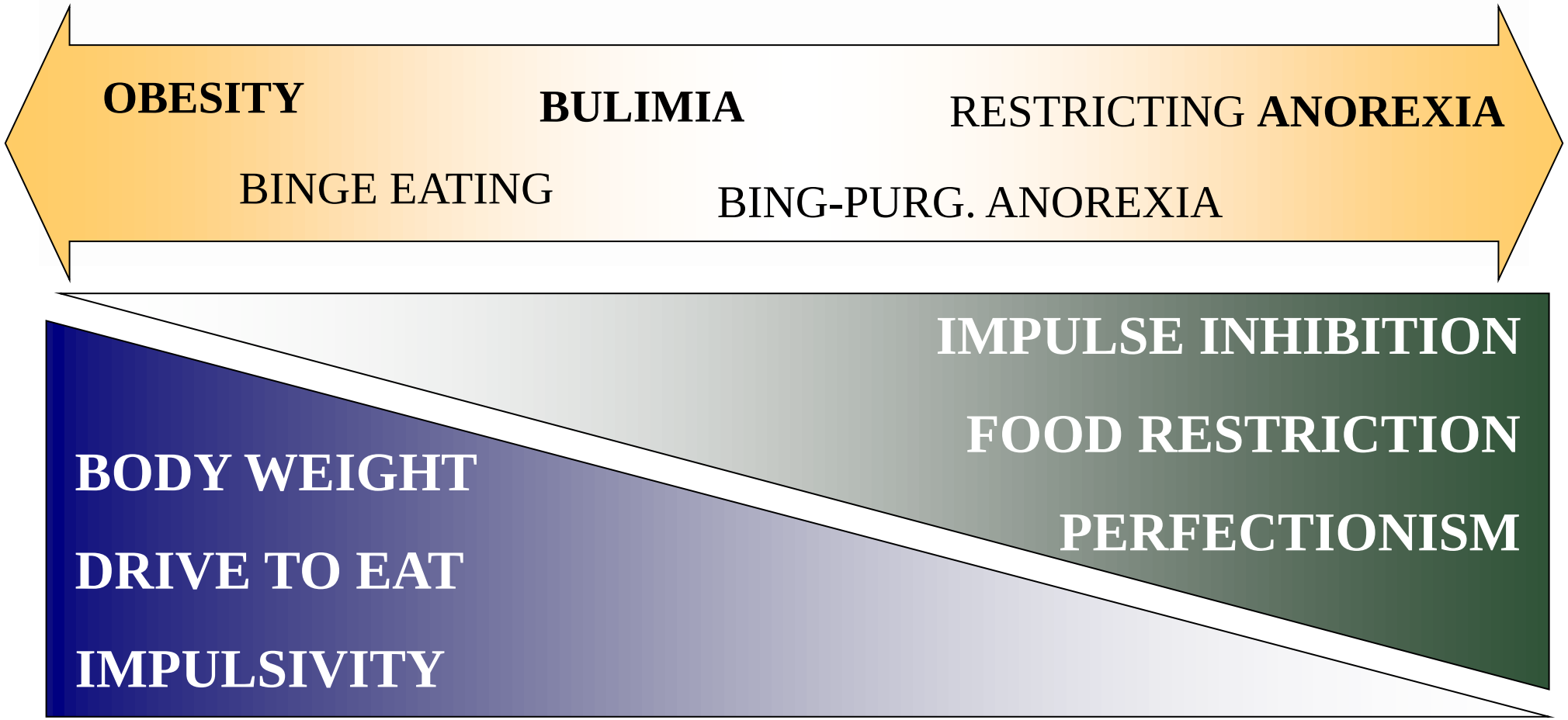
- Assess patient's sexual history and previous level of satisfaction in sexual relationships; also assess patient's perception of the problem
- Assess for any medications which might be affecting libido

- Assist therapist as necessary in plan of behavior modification to help decrease variant behavior.
- Refer for additional counseling or sex therapy if required.

EATING DISORED

Eating Disorders

SPECTRUM OF EATING DISOREDRS



- **Definition**: **Anorexia nervosa** is an eating disorder characterized by immoderate food restriction, inappropriate eating habits or rituals, obsession with having a thin figure, and an irrational fear of weight gain as well as a distorted body self-perception.

- It typically involves excessive weight loss and is diagnosed approximately nine times more often in females than in males

DIAGNOSIS OF ANOREXIA NERVOSA

- A DSM-5 diagnosis of anorexia nervosa requires each of the following criteria :

- ●Restriction of energy intake that leads to a low body weight, given the patient's age, sex, developmental trajectory, and physical health

- ●Intense fear of gaining weight or becoming fat, or persistent behavior that prevents weight gain, despite being underweight

- Distorted perception of body weight and shape, undue influence of weight and shape on self-worth, or denial of the medical seriousness of one's low body weight


Anorexia
Nervosa

Severity (DSM 5)

- Mild – BMI 17 to 18.49 kg/m^2
- Moderate – BMI 16 to 16.99 kg/m^2
- Severe – BMI 15 to 15.99 kg/m^2
- Extreme – BMI <15 kg/m^2

Types of Anorexia

- Purging
  - Weight loss achieved by vomiting, laxatives, or diuretics

- **Restricting**
  - Weight loss achieved by restricting calories
    - Following diets, fasting, and exercising to excess

Associated mental disorders

- Anxiety disorders
- Obsessive-compulsive disorder
- Body dysmorphic disorder
- Posttraumatic stress disorder
- Mood disorders
- Substance use disorders
- Disruptive, impulse control, and conduct disorders

Personality disorders

- ●Obsessive-compulsive
- (15 percent of patients with anorexia nervosa)
- ●Avoidant (14 percent)
- ●Dependent (7 percent)
- ●Narcissistic (6 percent)
- ●Paranoid (4 percent)
- ●Borderline (3 percent)

Comorbid traits

- ●Perfectionism – pursuing unrealistically high standards despite the occurrence of adverse consequences
- ●Compulsivity – insisting upon order, symmetry, exactness, and control
- ●Narcissism – craving admiration and external validation from others; excessive concern with physical appearance

Why Do People Develop Eating Disorders?

- Behaviors are unhealthy coping mechanisms
  - Factors to consider:
    - Psychological
    - Interpersonal
    - Social & Cultural
    - Biological

Psychological Factors

- Low Self-esteem
- Feelings of inadequacy or failure
- Feelings of being out of control
- Response to change (puberty)
- Response to stress (sports or dance)
- Personal illness

Psychological Factors

- Vulnerable Personality Characteristics
  - Identity difficulties
  - Need for approval
  - Perfectionist
  - Obsessive tendencies
  - Irrational thinking
  - Difficulty coping
  - Inability to accept self

Interpersonal Factors

- Troubled family and personal relationships
- Difficult expressing emotions and feelings
- History of being teased or ridiculed based on size or weight
- History of physical or sexual abuse

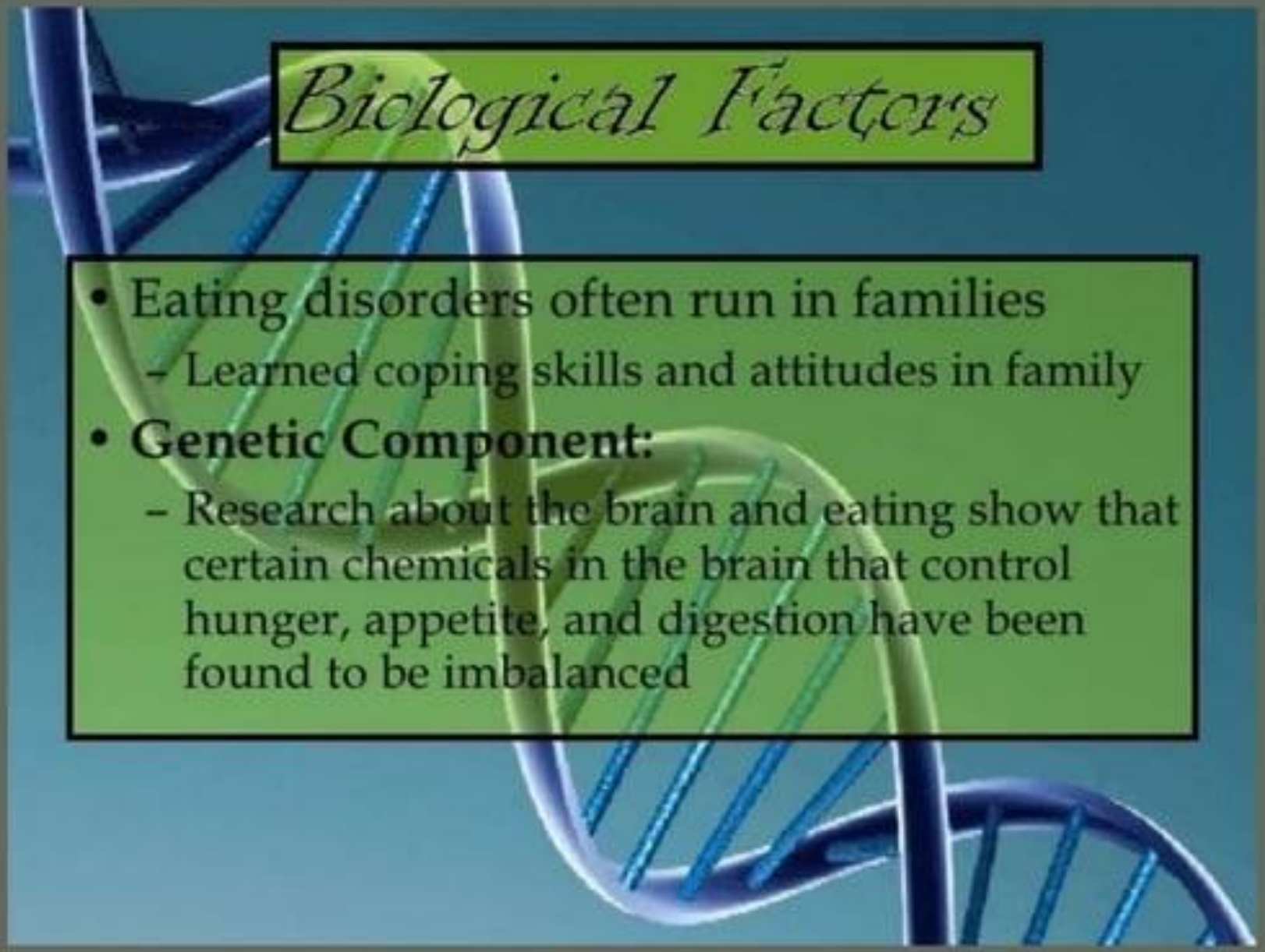
Social & Cultural Factors

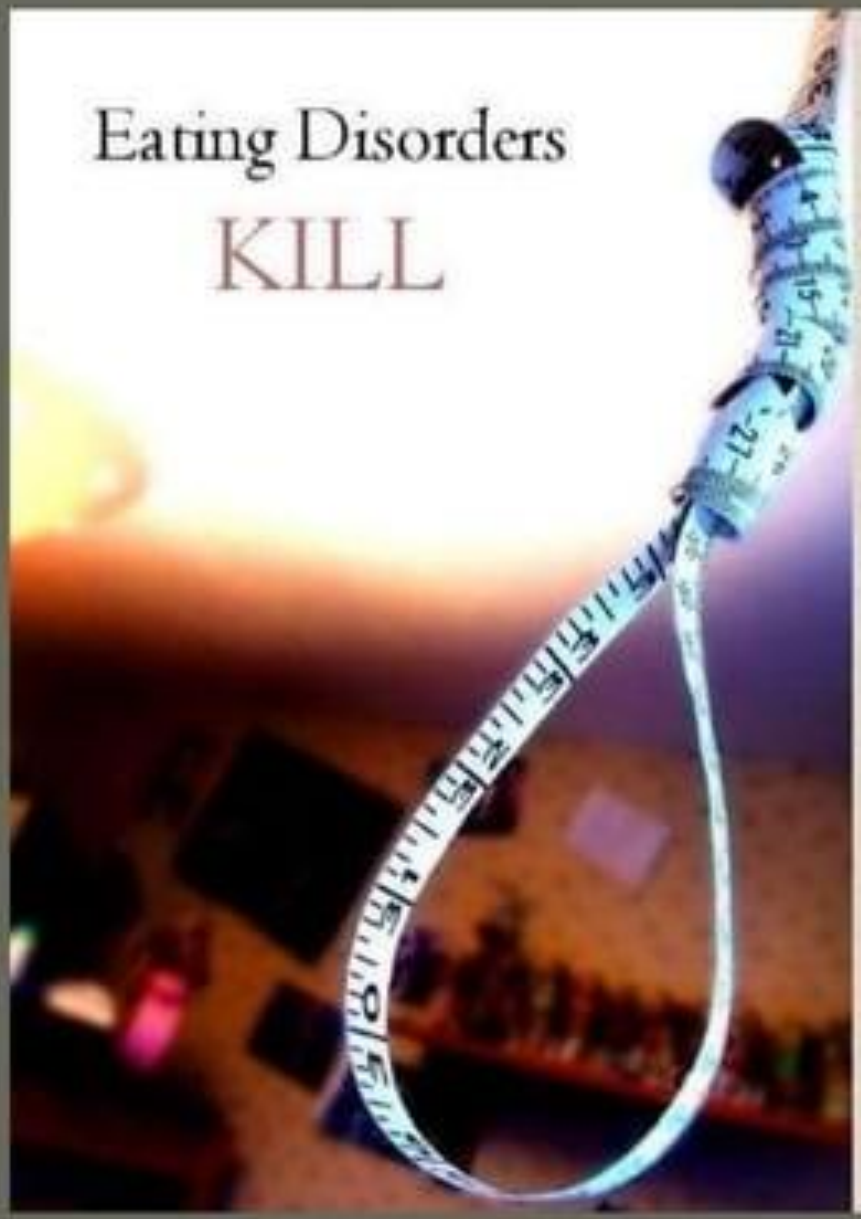
- Cultural pressures that glorify thinness and place value on obtaining the perfect body
- Narrow definitions of beauty that include women and men of specific body weights and shapes

- Cultural norms that value people on the basis of physical appearance and not on inner qualities and strengths

Barbie Doll Body

- Seven feet tall
- 38 inch chest
- 21 inch waist
- 36 inch hips
- Virtually unattainable for an adult woman


Biological Factors
• Eating disorders often run in families
– Learned coping skills and attitudes in family
• Genetic Component:
– Research about the brain and eating show that certain chemicals in the brain that control hunger, appetite, and digestion have been found to be imbalanced



Consequences Of Eating Disorders

- Tears up the mind and body
  - Mind:
    - distorted and obsessive thoughts regarding food, exercise and body image
    - Takes over one's life—loss of life in other areas such as social, financial, spiritual, professional and academic
    - Anything that pulls you out of balance can destroy your life or make things very miserable

Common Medical Symptoms

- •Amenorrhea
- •Infertility
- •Exertional fatigue
- •Weakness
- •Cold intolerance
- •Palpitations
- •Dizziness
- •Abdominal pain and bloating
- •Early satiety
- •Constipation
- •Swelling of the feet
- Irritability is often present as well.

Common physical signs

- •Low body mass index (<17.5 kg/m^2)
- •Emaciation (body weight less than 70 percent of ideal body weight)
- •Hypothermia (core temperature <35°C or 95°F)
- •Bradycardia (pulse <60 beats per minute)
- •Hypotension (systolic blood pressure <90 mmHg and/or a diastolic blood pressure <50 mmHg)
- •Hypoactive bowel sounds
- •Xerosis (dry, scaly skin)
- •Brittle hair and hair loss

Laboratory assessment

- ●Serum electrolytes
- ●Blood urea nitrogen
- ●Serum creatinine
- ●Serum glucose
- ●Serum calcium, phosphorous, and magnesium
- ●Serum albumin and prealbumin
- ●Liver function tests (aspartate aminotransferase, alanine aminotransferase, and alkaline phosphatase)

- ●Internationalized Normalized Ratio (INR)
- ●Complete blood count (CBC) including differential
- ●Thyroid stimulating hormone (TSH)
- ●20-OH Vitamin D
- ●Electrocardiogram (ECG)
- ●Urinalysis for specific gravity

Excluding medical disorders

- ●Neoplasm
- ●Chronic infections (eg, tuberculosis or acquired immunodeficiency syndrome)
- ●Uncontrolled diabetes mellitus
- ●Hyperthyroidism
- ●Malabsorption syndromes (eg, celiac disease)
- ●Inflammatory bowel disease (eg, Crohn disease)
- ●Pregnancy
- ●Primary ovarian failure
- ●Polycystic ovary disease
- ●Pituitary prolactinoma

Medical complications

- **Cardiovascular** **(structural)**

- Decreased cardiac mass
- Decreased cardiac chamber volumes
- Mitral valve prolapse (20%)
- Myocardial fibrosis
- Pericardial effusion

- Improve with weight gain

- **Cardiovascular (functional) :**

- Bradycardia
- Hypotension
- QT dispersion
- Occasionally QT prolongation
- Decreased heart rate variability

- ST,T changes AV block Vent.arrhythmias

Gastrointestinal

- Gastroparesis with bloating
- Constipation
- Severe pancreatitis
- Mild rise in LFTS
- Superior mesentric artery syndrome (rare)

Haematologic

- Anaemia 83%
- Leucopenia 79%
- Thrombocytopenia 25%

- Bone marrow:
- Normal 11%
- Aplastic or Hypoplastic 39%
- Gelatinous degeneration with serous fat atrophy 50%

Renal and electrolytes

- Decreased GFR
- Decreased concentration
- Electrolyte abnormalities
- (Purging > Restrictive)

Pulmonary

- Dyspnoea
- (weakness and wasting of resp. muscles)
- Pneumothorax /Pneumomediastinum
- (weakening of alveolar walls)
- Aspiration pneumonia

- PFTS:
- decreased maximal inspiratory pressures (59% of predicted)
- expiratory pressures (35%), and
- increased residual volume (162%).
- Diffusion capacity (98.1 +/- 16.2%) and transfer coefficient (98.4 +/- 16.2%) were also normal

Endocrine

- Hypoglycemia
- Hypothalamus and pituitary:
- Decreased GRH
- Increased activation of HPA axis> Raised Cortisol
- Increased GH and decreased IGF-1
- Decreased ADH levels
- Abnormalities of thermoregulation

- Osteoporosis: In 30% (multifactorial)
- (BMI < 15 and Amenorrhoea >6months)

Endocrine

- Euthyroid hypothyroxinemia may develop in anorexia nervosa, marked by
- normal to decreased serum levels of thyroxine (T_4) and triiodothyronine (T_3) levels,
-
- a normal level of thyroid stimulating hormone (TSH),
- and an increased level of reverse T_3

Dermatologic

- ●Xerosis (dry, scaly skin)
- ●Lanugo-like body hair (fine, downy, dark hair)
- ●Telogen effluvium (hair loss)
- ●Carotenoderma (yellowing)
- ●Acne
- ●Hyperpigmentation
- ●Seborrheic dermatitis (erythema and greasy scales)
- ●Acrocyanosis (cold, blue, and occasionally sweaty hands or feet)

Dermatologic

- ●Perniosis (painful or pruritic erythema)
- ●Petechiae
- ●Livedo reticularis (reddish-cyanotic circular patches)
- ●Paronychia (inflamed lateral and posterior nail folds)
- ●Pruritus
- ●Striae distensae (erythematous or hypopigmented linear patches)
- ●Slower wound healing

Treatment

- **Nutritional rehabilitation**
- **Psychotherapy**

- **Nutritional rehabilitation**:
- Supervised meals
- Proscribing binge eating and purging

- Expected weight gain: 0.9 to 1.4 kg/week (in pts)
- 0.2 to 0.5kg/week (out pts)
- 1000 to 1600 kcal /day gradually stepped up
- (30 to 40 kcal/kg)

- Psychotherapy:
  - Cognitive Behavioural Therapy
  - Specialist supportive clinical management
  - Motivational interviewing
  - Family therapy
- Maintenance Psychotherapy

- **Pharmacotherapy:**
- Olanzapine (2.5 to 10mg/day)
- Lorazepam 0.5mg/day
- SSRIs

- **Deep Brain Stimulation** for chronic and treatment refractory Anorexia nervosa
- (Sub callosal singulate gyrus)

- DBS was associated with improvements in mood, anxiety, affective regulation, and anorexia nervosa-related obsessions and compulsions. Seems to be safe

Criteria for hospitalisation

- **American Psychiatric Association** suggest hospitalization for adults, adolescents, and children who meet one or more of the following criteria
- ●Medical instability (eg, bradycardia near 40 beats per minute; blood pressure <80/50 mmHg; dehydration; or compromised cardiac, hepatic, or renal functioning)
- ●Weight <85 percent normal body weight, or rapid weight decline with food refusal despite outpatient treatment or partial hospitalization
- ●Suicidal ideation with high lethality plan or suicide attempt
- ●Poor motivation that necessitates supervision with meals, or cooperation with treatment that is contingent upon a highly structured environment
- ●Comorbid psychiatric conditions (eg, depressive, substance use, or anxiety disorders) that require hospitalization

- Practice guidelines from the **Society for Adolescent Medicine** suggest hospitalization for adolescents with eating disorders who meet one or more of the following criteria :
- ●Failure of outpatient or partial hospital treatment
- ●Acute food refusal
- ●Uncontrollable binging and purging
- ●Severe malnutrition (eg, rapid weight loss and/or weight at a medically concerning level)
- ●Dehydration
- ●Cardiac dysrrhythmia

- •Vital signs unstable
- •Severe bradycardia (eg, heart rate <50 beats per minute during the day or <45 at night)
- •Hypotension (eg, blood pressure <90/50 mmHg)
- •Hypothermia (eg, <96ºF)
- •Orthostatic changes in pulse (>20 beats per minute) or blood pressure (>10 mmHg)
- Electrolyte disturbances (hypokalemia, hyponatremia, or hypophosphatemia)

- Acute medical complication of malnutrition (eg, syncope, seizures, cardiac failure, or pancreatitis)
- •Arrested growth and development
- •Acute psychiatric emergencies (eg, suicidal ideation or behavior, or acute psychosis)
- •Comorbid diagnosis that interferes with the treatment of eating disorders (eg, moderate to severe depression, obsessive compulsive disorder, concurrent substance abuse, or family dysfunction)

Refeeding syndrome

- The refeeding syndrome is defined as the clinical complications that occur as a result of fluid and electrolyte shifts during nutritional rehabilitation of malnourished patients

- ●Hypophosphatemia
- ●Hypokalemia
- ●Vitamin (eg, thiamine) deficiencies
- ●Congestive heart failure
- ●Peripheral oedema

- **Cardiovascular**: Heart failure / Arrhythmias
- **Pulmonary** : Dyspnoea and impaired respiratory function
- **Muscular**: Myalgia / Weakness / Tetany
- **Gastrointestinal**: Impaired LFTS / Nausea, vomiting, diarrhoea
- **Neurological**: Tremors / Paraesthesias / Delirium / Seizures

Prevention

- •Available dietary and nutritional support staff should be consulted to determine the initial daily calories to be ingested
- •Patients should be fed according to a standard protocol that includes a limited intake of sodium and fluids. The amount of daily calories should be raised by 300 to 400 kcal every three to four days.
- Electrolyte deficiencies that are present in patients with anorexia nervosa should be corrected prior to initiating the refeeding process
- The goal for weight gain should be limited to one kilogram per week.
- •Vital signs and weight should be monitored each day
- •The daily physical examination should focus upon the cardiovascular and pulmonary systems, and upon signs of edema

Management

- Reduce nutritional support
- Correct hypophosphatemia, hypokalemia, and hypomagnesemia.
- Moderately to severely ill patients with marked edema or a low serum phosphate level should be hospitalized to intravenously correct electrolyte deficiencies and for close monitoring.
- Continuous telemetry may be needed to monitor cardiopulmonary physiology.

- Anorexia is a serious, potentially life threatening mental illness.
- A person with Anorexia Nervosa has not made a ‘lifestyle choice’, they are actually very unwell and need help.

Bulimia Nervosa

Historical Background

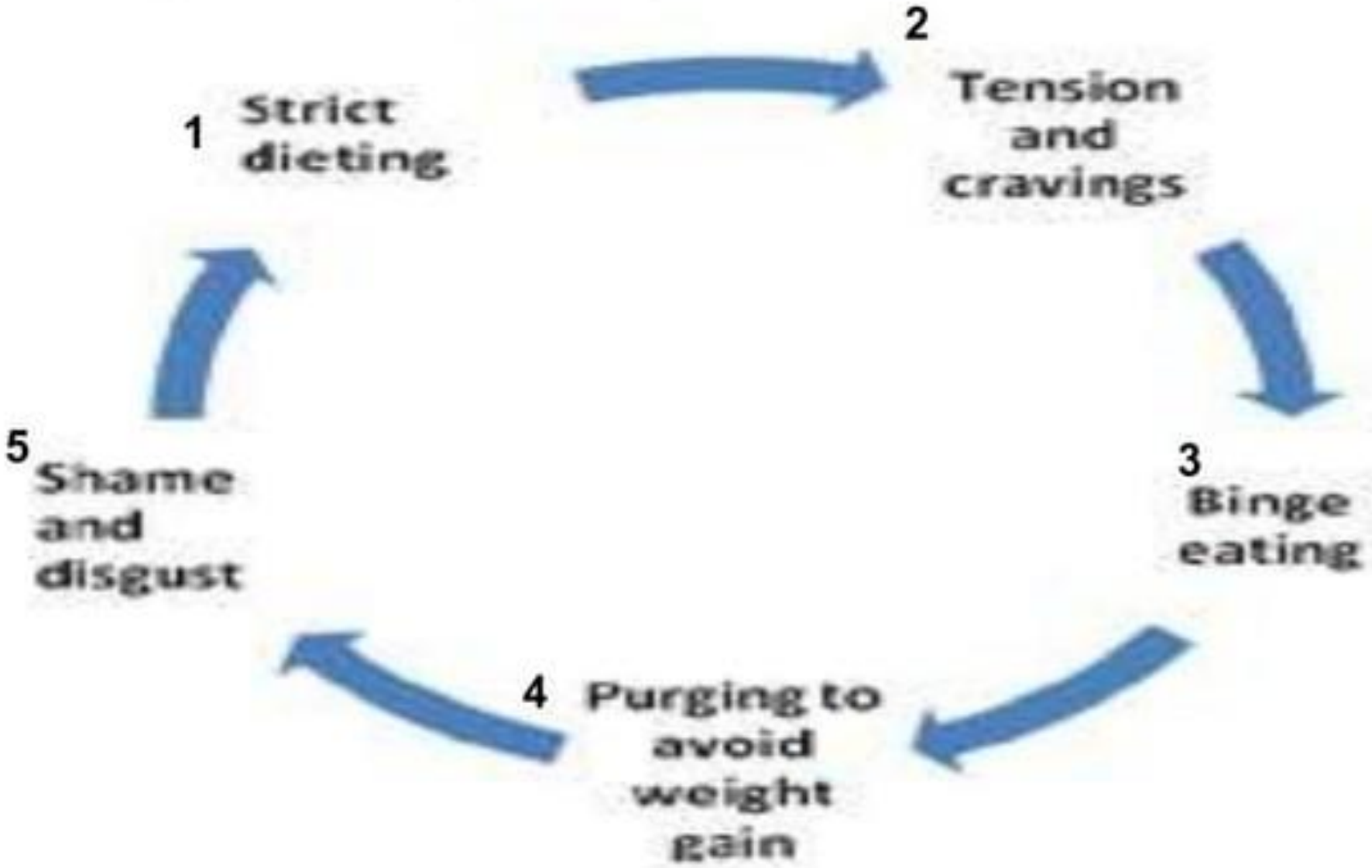
Gerald Russell, was first to name and describe "bulimia nervosa" in 1979.

The word "bulimia" comes from the Greek word **"*boulīmia*"** (meaning "**ravenous hunger**"), literally bulimia nervosa means **disease of hunger affecting nervous system** (Stanley, 1999).

Definition

It is an eating disorder marked by **binge eating** i.e. out of control eating, followed by purging, such as vomiting, taking laxative, and/or excessive activity to prevent the individual from gaining weight (Stanley, 1999).

Binge-Purge Cycle



(Smith, & Segal, 2014).

Age of Onset

The onset of bulimia nervosa is often during adolescence, between **13 and 20 years of age**.

Dieting efforts and body dissatisfaction, however, often occur in the teenage years. Therefore, it is often described as a **developmental disorder** (Eliot & Baker, 2001).

Signs and Symptoms

Physical Signs:

- Frequent changes in weight (loss or gains)
- Signs of damage due to vomiting including swelling around the cheeks or jaw, calluses on knuckles, damage to teeth and bad breath
- Feeling bloated, constipated or developing intolerances to food
- Loss of or disturbance of menstrual periods in girls and women
- Fainting or dizziness
- Feeling tired and not sleeping well (Smith, & Segal, 2014)..

Signs and Symptoms (Cont..)

Psychological:

- Preoccupation with eating, food, body shape and weight
- Sensitivity to comments relating to food, weight, body shape or exercise
- Low self esteem and feelings of shame, self loathing or guilt, particularly after eating
- Having a distorted body image
- Obsession with food and need for control
- Depression, anxiety or irritability (Stanley, 1999).

Signs and Symptoms (Cont..)

Behavioral:

- Evidence of binge eating
- Eating in private
- Repetitive or obsessive behaviors relating to body shape and weight
- Excessive exercising
- Dieting behavior
- Frequent trips to the bathroom during or shortly after meals which could be evidence of vomiting or laxative use (Burby, 1998).

DSM Criteria

- Recurrent episodes of binge eating characterized by both:
  - Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
  - A sense of lack of control over eating during the episode, (such as a feeling that one cannot stop eating or control what or how much one is eating).
- Recurrent inappropriate compensatory behavior to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise (APA, 2000).

DSM Criteria (Cont..)

- The binge eating and inappropriate compensatory behavior both occur, on average, at least twice a week for 3 months.

Type

- **Purging Type:** During the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

- **Non-purging Type:** During the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behavior but has not regularly engaged in self-induced vomiting or misused laxatives, diuretics, or enemas (APA, 2000).

Comorbidity

The bulimics commonly meet criteria for not just one, but several co-morbid psychiatric disorders and other conditions.

These include:

- affective disorders such as depression or general anxiety disorder,
- obsessive compulsive disorder,
- mood disorder,
- substance abuse disorder,
- social phobia, and
- other medical issues (like gastrointestinal issues) (Duncan et al., 2005).

Prevalence and Epidemiology

Adil, Naeem and Ali (2012) reported that 22.75% individuals are at high-risk of eating disorders, with 87.9% females and 12.1% males.

Furthermore, almost all of the epidemiological studies that have been conducted so far have yielded that females are nine times more likely than males to have bulimia nervosa (Veague, 2010).

Etiology and Pathogenesis

Bulimia nervosa is understood to be a complex disorder with multiple factors contributing to its development.

✓ **Neurobiological Mechanism:**

Abnormal levels of many hormones, notably **serotonin**, have been shown to be responsible for some disordered eating behaviors.

Particularly, neurotransmitters **endorphins** and **encephalin** are responsive to binges (Ploog & Walter, 2004).

Etiology (Cont..)

- ✓ **Genetic Factors:**

Research suggests that people who have a **close relative** who has or has had bulimia are four times more likely to develop it than those who do not have a relative with the condition (Ploog & Walter, 2004).

Etiology (Cont..)

- ✓ **Psychological Factors:**

Sensation seeking may cause some individuals to gorge for the pleasure of eating. Bulimics have a compulsion to eat that resembles an addiction.

Bulimia can be triggered because of **environmental stress** such as family dysfunction or traumatic stressful life events such as divorce, or the death of a loved one (Weltzin et al., 1993).

Etiology (Cont..)

- ✓ **Psychological Factors:**

Another theory of etiology, suggests that the purging may be result of **guilt** over eating too much and fear of becoming fat.

The bulimics succumbs to the compulsion to eat, but this temporary pleasure is followed by **guilt and shame**. To allay guilt the bulimic purges and disposes of any evidence of binge (Weltzin et al., 1993).

Etiology (Cont..)

✓ **Social factors:**

Societal pressures are very influential in the development of bulimia. These pressures come from an increasingly wider range of sources such as

- mass media,
- parents, siblings, peers, and
- may be direct messages (e.g., weight related teasing) or
- indirect messages (e.g., hearing a friend obsess about weight) (Johnson, 1987).

Etiology (Cont..)

- ✓ **Social factors:**

It may be learned by **modeling** others who engage in binge eating and purging. A mother or father who once suffered from an eating disorder is more likely to put pressure on his/her child to be thin. Even if they do not put pressure on the child, the child may still observe the pressure the adult puts on his/herself and learn from **observing** (Johnson, 1987).

Treatment

Treating bulimia is not one-fit-all approaches. A bulimia treatment plan is tailored to individual needs. Various treatment approaches that can be used separately or in combination include:

- **Psychotherapy**
- **Medication**
- **Nutrition education**
- **Hospitalization**

Treatment

Psychotherapy:

Most treatment for bulimia involved outpatient individual, family and or group psychotherapy. There's evidence that these types of psychotherapy help improve symptoms of bulimia:

I. *Cognitive behavior therapy*
II. *Psychodynamic psychotherapy*
III. *Interpersonal psychotherapy*
IV. *Dialectical behavior therapy*
V. *Process interactional technique*
VI. *Family-based technique*
VII. *Healthy weight program*

Treatment (Cont..)

- ***Cognitive-behavioral therapy (CBT):***

  The research consistently finds that CBT is the most effective type of psychotherapy for adults with bulimia. This therapy helps patients **identify and change distorted thoughts** (about themselves and food) that underlie their compulsive behavior, and find better ways to **cope** with life stresses.

  It is divided into **three stages**. In the **first stage**, the cognitive view on the maintenance of bulimia is presented, and behavioral techniques are implemented to replace binge eating with more stable eating patterns (Waller et al. 1996).

Treatment (Cont..)

In the **second stage**, additional attempts are made to establish healthy eating habits, and emphasis is placed upon the elimination of dieting.

The **final stage** is concerned with maintaining the progress made in therapy once treatment has been terminated, in order to prevent relapse of the binge/purge cycle.

CBT can rapidly break the binge purge cycle, combining it with medication or other types of psychotherapy in a stepped fashion, as the patient improves, is more likely to help patients deal with psychological symptoms and avoid relapse (Waller et al. 1996).

Treatment (Cont..)

- ***Psychodynamic psychotherapy:***

  Psychodynamic strategies involve

  - the exploration of the origins of the eating disorder (particularly focusing the family);
  - the factors maintaining the behavior, and
  - developmental issues for instance, independence, intimacy, loneliness, maturing, the importance of physical appearance, and need for control.

  The aim of this technique is to improve the **insight** of the patient into the dynamics driving the eating disorder so that these dynamics can be resolved and eradicated as motivations for maladaptive behavior (Duncan et al., 2005).

Treatment (Cont..)

- ***Interpersonal psychotherapy:***

  Interpersonal psychotherapy (IPT) is a short-term psychotherapy in which the goal is to help patients **identify and modify** current interpersonal problems, which can draw focus away from eating.

  IPT for bulimia nervosa encompasses **three phases**. The **first phase** of IPT is devoted to identifying specific interpersonal problematic areas currently affecting the patient, and choosing which of these areas to focus on for the remaining treatment (Fairburn, 1997).

Treatment (Cont..)

In the **second phase**, the therapist encourages the patient to take the lead in facilitating change in the interpersonal realm.

The **third phase** covers maintenance of interpersonal gains and relapse prevention.

In clinical trials, IPT has been shown to have a slower effect than CBT in achieving symptom improvement and resolution (Fairburn, 1997).

Treatment (Cont..)

- ***Dialectical behavior therapy:***

  Dialectical behavior therapy (DBT) is a type of CBT developed by **Marsha Linehan**.

  DBT is used to treat illnesses with symptoms of emotional dysregulation, including eating disorders.

  The word "**dialectical**" refers to the concept of **being able to hold onto two seemingly different ideas at once** (Susan, 2014).

Treatment (Cont..)

For instance, it is considered important in DBT for clients to accept themselves as they are *and* also to be motivated to change.

The components of DBT typically consist of **individual therapy sessions** and **skills-training sessions** (usually done in a group therapy setting).

Results are promising for using DBT to treat eating disorders (Susan, 2014).

Treatment (Cont..)

- ***Process-interactional technique:***

Process-interactional technique includes **group activities** such as **role playing, psychodrama** and use **of group interaction** to facilitate insight into member's motivation to maladaptive behavior.

Group therapy has been very effective in relieving symptoms in many bulimics (Yager, 1985).

Treatment (Cont..)

- ***Family-based technique*:**

Family-Based Treatment (FBT) for bulimia nervosa is designed for adolescents.

FBT consists of **three phases**. In the **first phase**, parents are placed in charge of helping their child reestablish healthy eating patterns and prevent binge eating and purging episodes from occurring (Lock, 2007).

Treatment (Cont..)

In the **second phase** of treatment, once the acute symptoms have abated and a regular pattern of eating a variety of foods is established, control over eating is returned to the adolescent

The **third phase** of treatment addresses termination and issues of family structure and normal adolescent development.

The focus of FBT is not on what caused the bulimia nervosa, but on what can be done to resolve this serious disorder (Lock, 2007).

Treatment (Cont..)

- ***Healthy Weight Program:***

  The healthy weight program for bulimia nervosa consists of **six sessions** designed to help the patient engage in **weight control strategies** that do not pose the same physiological and psychological liabilities as the inappropriate compensatory behaviors inherent to the disorder (e.g., purging, fasting, excessive exercise) (Stice & Presnell, 2007).

Treatment (Cont..)

These healthier strategies include **alerting food consumption** (like, cutting out high fat foods) and increasing **exercise** to achieve a energy balance and a slim, healthy figure.

Unlike CBT for bulimia nervosa, the pursuit of a thin body is not challenged, binge eating and purging are not directly targeted and **dieting is encouraged** rather than discouraged (albeit in a healthier manner than bulimics typically employ) (Stice & Presnell, 2007).

Treatment (Cont..)

Medications:

Antidepressants may help reduce the symptoms of bulimia when used along with psychotherapy. The only antidepressant specifically approved by the FDA to treat bulimia is **fluoxetine (Prozac)**, a type of **selective serotonin reuptake inhibitor (SSRI)**, which may help even if not depressed.

Moreover, **anticonvulsants (diphenylhydantoin)** and **tricyclics (imipramine)** have been tried as medication for bulimia (Kaye, 2005).

Treatment (Cont..)

- **Nutrition education and achieving healthy weight:**

If underweight due to bulimia, the first goal of treatment will be to start getting back to a **healthy weight**.

Dietitians and other health care providers can design an **eating plan** to help achieve a healthy weight, normal eating habits and **good nutrition** (Mayo-clinic, 2012).

Treatment (Cont..)

- **Hospitalization:**

Hospitalization for bulimia is less frequent and usually occurs only in cases involving:

- significant medical complications,
- severe weight loss, or
- uncontrollable, constant binge–purging.

Some eating disorder programs may offer day treatment, rather than inpatient hospitalization.

Treatment (Cont..)

Yager (1985) recommended hospitalization if either of three conditions is met:

- Outpatient treatment fails and symptoms are health threatening,
- medication is being tried to control the symptoms, or
- the patient is suicidal.

Conclusion

Several types of treatment for bulimia are needed, although combining psychotherapy with antidepressants may be the most effective for overcoming the disorder.

Although most people with bulimia do recover, some find that symptoms don't go away entirely. Periods of bingeing and purging may come and go through the years, depending on your life circumstances, such as times of high stress.

Learning positive ways to cope, creating healthy relationships and managing stress can help prevent a relapse.

Famous Celebrities

- Princess Diana (British princess)
- Britney Spears (American singer)
- Lady Gaga (American singer)
- Kelly Clarkson (American singer, winner of American Idol season 1)

Sarah's Story

Sarah is on a liquid diet. "I'm going to stick with it," she tells herself. "I won't give in to the cravings this time." But as the day goes on, Sarah's willpower weakens. All she can think about is food. Finally, she decides to give in to the urge to binge. She can't control herself any longer. She grabs a bowl of cornflakes, inhaling it within a matter of minutes. Then it's on to anything else she can find in the kitchen. After 45 minutes of bingeing, she is so stuffed that her stomach feels like it's going to burst. She's disgusted with herself and terrified by the thousands of calories she's consumed. She runs to the bathroom to throw up. Afterwards, she steps on the scale to make sure she hasn't gained any weight. She vows to start her diet again tomorrow: Tomorrow, it will be different.