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Running head: BULIMIA

Nursing's Role in the Identification
and Treatment of Bulimia

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Abstract

A review of the epidemiology, etiology, treatment and prevention of bulimia, a review of nursing process as it relates to bulimia, and the identification of a screening tool to assess bulimia is important to identify and destigmatize this life-threatening condition. An individual who has bulimia is defined by the American Psychological Association (1994) as an individual who exhibits recurrent episodes of binge eating, who engages in inappropriate behavior to avoid weight gain. The bulimic individual is commonly overly concerned with body shape and weight. The definitive etiology of bulimia is unknown, but is thought to be either psychological, familial, sociocultural, or biological. Nurses can have an important role in the identification and treatment of bulimia. Nursing Process is a valuable tool that can be used to identify and treat bulimia. Through education of individuals susceptible to bulimia, education of people in the best positions to identify bulimia early, and education of the general public, bulimia can be identified sooner with less permanent consequences to the individuals who suffer from bulimia. An integrated assessment tool, such as the tool attached, can be used to help identify individuals that are suspected to be bulimic. Above all, when assessing an individual who is suspected to be bulimic, a nonjudgmental attitude should be employed at all times by all nurses.

Nursing's Role in the Identification and Treatment of Bulimia

An individual who has bulimia, according to the American Psychological Association (1994), is an individual who exhibits recurrent episodes of binge eating and who engages in inappropriate behavior to avoid weight gain. The bulimic individual commonly is overly concerned with body shape and weight. Unlike the individuals who have anorexia nervosa, an individual with bulimia usually maintains a body weight at or above normal levels. To be diagnosed with bulimia, the following conditions must be present:

- A. Recurrent episodes of binge eating. An episode of binge eating is characterized by the following: (1) 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; (2) a sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for three months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of anorexia nervosa (American Psychological Association, 1994, pps. 549-550)

Bulimia, is further categorized by the American Psychological Association (1994) as being either the purging type or the nonpurging type by the following criteria:

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.

Nonpurging type: during the current episode of bulimia, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas (p. 550).

The condition of bulimia, however, is much more complicated than the mere bingeing and purging behaviors by which it is classified. There are many psychological and spiritual aspects of the bulimic individual so they cannot simply be categorized by their bingeing and purging

behaviors. There are various theories regarding the epidemiology, etiology, treatment, and prevention of bulimia. A review of these aspects of bulimia, a review of nursing process as it relates to bulimia, and the identification of a screening tool to assess bulimia will show the importance of identifying and destigmatizing this life-threatening condition. Without the identification and destigmatization of bulimic individuals, they will continue to exist in their worlds of shame and depression.

Epidemiology of Bulimia

According to American Psychological Association (1994) bulimic individuals can be found in most industrialized countries including Canada, Europe, Australia, Japan, New Zealand, and South Africa. The prevalence of bulimia differs according to a diversity of sources. The American Psychological Association (1994) stated that bulimia can be found in approximately one to three percent of adolescent and young adult females and that the rate in young males is approximately one-tenth that of young females. Johnson (1993) stated that the incidence of bulimia is much higher at five percent of young women and does not state any statistics for young males. Love and Seaton's (1991) statistical evidence places the prevalence of bulimia among high school and college students, both male and female, at as high as eight percent. The largest

percentage, and an alarming statistic, is stated by Keller (1986) to be as high as thirty percent of all college women. The reason for the discrepancy among statistical evaluations, stated Johnson (1993), is that accurately determining the prevalence of bulimia is particularly difficult since the social stigma attached to bulimia leads to the under-reporting of bingeing and purging activities which are carried out in secret.

Etiology of Bulimia

One of the most puzzling aspects of bulimia is that no one knows exactly what causes some individuals to develop bulimia while others do not. This puzzling disorder does, however, have characteristics that lead theorists to state that there are three realms of theory about the etiology of bulimia—psychological, familial, sociocultural, and biological (Palmer, 1990). In the follow section, under each subheading, will be a discussion of the various etiological theories by differing authors about bulimia.

Psychological Theory

From the psychological perspective, according to Bruch (1982), the behaviors of individuals who have bulimia are related to a lack of sense of self-identify and autonomy which leads to childlike behaviors and difficulty with decision-making and avoidance of responsibility. Because these individuals are unable to make mature decisions and take responsibility for their actions, they feel as if external forces control their

actions. According to Bruch (1982), these individuals strive to regain control of their bodily urges by employing purging which results in self-starvation. They employ this bulimic behavior because of mistaken beliefs that being slimmer they will make them more deserving of respect. Bruch (1982) stated that a crisis of loss, perceived or real, often precipitates the onset of bulimic behaviors. This loss may be a personal loss that can range from the loss of a family member, to the loss of a job, to the loss of familiar surroundings.

The addictive element of bulimia was discussed by Flood (1989). In her article, Flood (1989) described bulimic behaviors as the individual's attempt to relieve tension and to cope with stress because he or she does not have an adequate repertoire of coping skills to deal with daily minor and major stresses. The bulimic person often intensifies his or her stresses by denying that they exist until even a seemingly minor event surpasses the person's inadequate coping skills. Flood (1989) stated that the bulimic person uses bingeing and purging as a coping implement to compensate for their lack of coping skills. The use of bingeing and purging as a coping mechanism develops into a pleasurable addiction to diminish or suppress painful thoughts and feelings. The eating disorder becomes the "safe, strong, consistent source of gratification in one's life" (Flood, 1989, p. 47).

Meades' (1993) theory about the etiology of bulimia centers around the bulimic person's attempt to resolve an unhappy or imbalanced personal relationship by gaining a greater share of power over the person with whom the bulimic is in conflict. An example of this attempt to gain control and power was exemplified by Meades (1993) where he described a housewife's use of repeated bingeing and purging behaviors to communicate her feelings of helplessness and powerlessness to her spouse. She could not verbally communicate these same feelings; however, by bingeing and purging repeatedly, she coerced her spouse to also seek treatment. In this setting she found that she could communicate her messages to her spouse in a nonthreatening way.

Familial Theory

Palmer (1990), defined the development of the bulimic person according to the family-systems perspective. Ideally, parents are supposed to provide their young children and adolescents opportunities to develop as individuals by promoting independence and autonomy. Families of bulimic individuals, however, typically discourage the development of these traits, and instead leave their children feeling powerless and helpless. The typical family in which bulimic individuals are reared tends to consist of a controlling mother, a passive father, and an overly dependent child. Johnson (1993) defined the characteristics of

families of individuals with eating disorders as being enmeshment, overprotectiveness, and rigidity and conflict avoidance.

An enmeshed family, stated Johnson (1993), is characterized by an extreme intensity in family interactions and communications which results in a lack of boundaries between the roles of the parents and the roles of the children. There are also unclear boundaries between individual family members. The lack of boundaries leads to a developmental delay of the child's self-identity. The enmeshed family speaks in terms of "we feel" and "we do" rather than developing individual identities. The eating disorder may be a desperate attempt of individuals reared in enmeshed families to separate themselves from these families in general and from their overly-dependent relationship with their mothers in particular (Johnson, 1993).

An overprotective family, according to Johnson (1993), is unusually concerned about the welfare of its members. The parents overprotect their children so frequently that their development of autonomous thinking, feeling, and acting is retarded. This parental overprotectiveness conveys to children a lack of trust when the parents do not allow their children to take appropriate risks. The children of overprotective families, therefore, do not learn to trust themselves and feel personally ineffective (Johnson, 1993).

Rigidity and conflict avoidance, stated Johnson (1993), refers to the low threshold that families with bulimic individuals have for conflict. These families, according to Johnson (1993) believe that their members are supposed to be perpetually happy and never have any problems. The families' superficially polite demeanors interfere with the children's need for self-expression. Because they are unable to express their feelings outwardly, they internalize their conflicts and become more obsessive and perfectionistic while searching for love, approval, recognition, and a reduction of their internal anxiety. Johnson (1993) further stated that, according to Erikson's psychodynamic theory, eating disorders are linked to conflicts in early childhood that have not been resolved. The lack of resolution further leads to the tasks of trust, autonomy, and separation/individuation being unfulfilled with the person remaining in a dependent position. The conflicts in early childhood come from lack of consistent parental responses to cues for emotional needs. Instead of identifying the child's feelings, the parents of these individuals can only perceive their own needs and feelings. Therefore, while physical needs may be met in these children, their emotional needs remain largely unaddressed. When these children strive for independence during their toddler years, their parents reward clinging dependent behavior, and do not reward assertiveness or independence.

The product of this parenting is an individual who lacks maturity and grows up to become an individual who is overly compliant with a strong need to please others. The self-esteem of these individuals comes from the approval of others rather than from their own sense of effectiveness and accomplishment. In the end, these individuals are unable to recognize their own impulses, feelings, and needs and try to establish their own identity by tyrannically controlling everything they eat and purge (Johnson 1993).

Sociocultural Theory

Perhaps the most simplistic and most widely accepted theory about the etiology of bulimia is the realm of the sociocultural theories. Palmer (1990) stated that from the sociocultural theoretical viewpoint, the society we live in views thinness as desirable and healthy. This idealization of thinness is portrayed in magazines, billboards, television, and movies throughout our country. Individuals in this country, through dieting, strive constantly to achieve and maintain the ideal thin body style that the media promotes. In addition, societal pressures for women to be successful, independent, and competitive while maintaining their traditional roles of wives, mothers, and homemakers creates an environment conducive to the development of eating disorders among those who are predisposed to eating disorders.

Johnson (1993) further stated that the lack of eating disorders in countries with inadequate food supplies supports the sociocultural theory of eating disorders. Our country, which has an abundant food supply and which has an unrealistic expectation of thinness, also has an overabundance of eating disorders. These simplistic sociocultural theories do not provide a viable explanation for why only some individuals, and not others, develop bulimia. If these theories are to be believed, every woman in every country with an abundant food supply, a media that promotes thinness, and women who strive to be wives, mothers, and career women would develop bulimia. In order to do justice to those individuals who develop eating disorders, more understanding about the underlying individual issues of these individuals needs to be stressed and the simplistic sociocultural theories need to be re-examined.

Biological Theory

The most controversial of all the theories surrounding bulimia is the biological theory of the etiology of bulimia. According to Palmer (1990), research is currently being performed to determine the relationship between endogenous endorphins and bulimia. Palmer (1990) stated that there is speculation that the kappa opioid receptor is stimulated in the brain of bulimic individuals causes them to experience binge/purge

cycles of eating. The use of naltrexone, a long-acting opiate antagonist, has been shown to stop the binge/purge cycles, leading to support of Palmer's theory.

A second biological theory has been studied since 1980. According to Pharmaceutical Information Associates, Ltd. (1994), research into the serotonin reuptake inhibiting drug, fluoxetine, noted a side effect of weight loss. Further research has noted that individuals with low levels of serotonin have higher rates of bulimia and vice versa. Again, it is not known which condition preceded the other—does the purging of bulimia cause low serotonin levels or does low serotonin levels predispose individuals to the development of bulimia?

As in the discussion of the sociocultural theory, the use of drugs may suppress the binge/purge cycles of bulimic individuals, but it does not deal with the underlying issues which cause some individuals to become bulimic while others do not. The positive aspect about the use of drugs, however, is that the cessation of the bingeing and purging can lead to an increased feeling of self-esteem by bulimic individuals. This increased self-esteem can have a positive effect on the depression which appears to co-exist with bulimia. It should be stressed, however, that bulimic individuals need psychotherapy in addition to pharmacotherapy

to determine the individual underlying etiological foundations of their bulimia.

Nursing Process

Nursing Process is the foundation of nursing actions that is based upon critical thinking. Wilkinson (1991) stated that this process begins with the assessment phase where both subjective and objective data are gathered about the individual. Following assessment, nursing diagnoses are developed to identify and prioritize client problems which fall within the scope of nursing practice. The nursing diagnoses are the foundation of the planning phase. In the planning phase, the nurse and client collaborate upon the development of client goals and nursing goals to address the problems which have been identified and prioritized. During implementation, the nurse performs nursing duties designed to address client goals. Evaluation is the process of measuring the client's outcome against the client goals to determine if the nursing duties have been effective in meeting the client goals (Wilkinson, 1991).

Assessment of the Bulimic Client

Whatever the etiology, bulimia is an illness that affects many individuals. Individuals are not, however, routinely assessed for bulimia in primary care settings. It is such a stigmatized disorder that nurses and primary care providers traditionally wait for individuals to seek help

because of the fear that the practitioner will inadvertently offend the individuals through misdiagnosis. When suspected in an individual, however, nurses should follow through with a complete assessment of that client. Because bulimia affects all dimensions of the individuals afflicted with it, these nursing assessments should include the physical, sociocultural, spiritual, and psychological dimensions. Included in the appendices of this thesis is a screening tool that nurses can use to help identify individuals that they suspect to have bulimia.

Physical Assessment

A comprehensive physical assessment is essential for the client whom either admits to bulimia or is suspected to have bulimia. The purging behaviors of bulimia, whether through laxative abuse or vomiting, can cause serious life-threatening complications such as fluid and electrolyte abnormalities. The American Psychological Association (1994) stated that the electrolytes most frequently out of balance, because of the purging behaviors, include potassium, sodium, and chlorine. The loss of stomach acid through vomiting can also lead to metabolic alkalosis while the loss of bicarbonate through laxative abuse can lead to metabolic acidosis (American Psychological Association, 1994).

The laboratory diagnostic work-up should include a complete blood count, sedimentation rate, electrolytes, urinalysis and culture, and

complete liver and renal function tests (Love & Seaton, 1991). In addition if any hibernation-like states are present, such as bradycardia, hypotension, hypothermia, an electrocardiogram and chest x-ray should also be performed (Love & Seaton, 1991). These additional tests are necessary to rule out cardiac involvement which can occur as a result of repeated bingeing and purging. While these diagnostic tests usually fall within the realm of the medical field, rather than the nursing field, nurses must be educated and knowledgeable about the normal parameters associated with these tests. There are also situations in which these diagnostic tests would fall within the realm of the standing orders of an institution which would preclude the physician having to order them each time an individual is suspected to have bulimia.

Certain objective physical traits may lead the nurse to believe that an individual is bulimic. These physical traits, according to Plehn (1990), include weight variations, a hoarse voice, hemoptysis, swollen but not tender parotid glands, and calluses or abrasions on the fingers, especially on the index and second fingers from forced vomiting. Additional objective physical symptoms includes conjunctival hemorrhages and small broken blood vessels on the cheeks as well as dental enamel erosion. Due to the poor overall nutrition of individuals with bulimia, additional physical symptoms of a sore tongue and a reddened

sore mouth may also be observed during physical assessment, along with hair loss, dry skin, slower reflex response, and cold intolerance (Plehn, 1990).

The subjective assessment of individuals suspected to have bulimia could be addressed through the use of the assessment tool which is attached. This tool allows the individuals to state in their own words how they feel about their body image, food ingestion, bingeing and purging behaviors, and self-esteem. In addition, the tool gives the practitioner information about the historical data regarding individual's development of bulimia and any other treatment modalities that the individual may have experienced to deal with their bulimia.

If bingeing and purging behaviors continue without detection, many life-threatening physical conditions can also develop which can lead to the necessity for critical care intervention. When nurses encounter individuals in critical care settings that they suspect of being bulimic, they should assess for the following signs and symptoms: "swelling of the hands and feet, abdominal fullness, fatigue, headache, nausea, weakness, feeling bloated, puffy cheeks, and dental problems" (Myer & O'Brien, 1993, p. 194).

Bulimia can also manifest as both menstrual problems and also activity, exercise, and sleep/rest pattern problems. Although most

bulimic patients are within normal weight ranges, Keller (1986) also stated that one key physical assessment that can identify an individual with bulimia is menstrual irregularity or amenorrhea. The etiology of this menstrual irregularity or amenorrhea is unknown, according to Keller (1986). Johnson (1993) stated that a complete physical assessment of bulimic individuals should also include information about the individual's activity, exercise, and sleep/rest patterns. Many bulimic individuals exercise compulsively, are restless, and frequently suffer from insomnia. Careful questioning into areas of sleep/rest cycles, exercise routines, and daily activities may elicit responses that can assist individuals to confront the reality of their disorder.

Whenever the above objective and subjective physical findings are assessed, further assessment into other dimensions of the individual are needed. such as sociocultural, spiritual, and psychological areas is necessary to determine what other areas of concern are contributing to the physical manifestation of bulimia.

Sociocultural Assessment

The amount of time dedicated to bingeing and purging behaviors and the shame associated with bulimia often cause many individuals with bulimia to lead structured, secluded, and desolate personal lives despite outwardly appearing successful in their educational and occupational

lives. Assessment into what activities that the individual pursues outside of their educational and occupational lives should therefore be carefully assessed. If it is ascertained that individuals are not able to socialize in settings outside of their educational and occupational lives where food is being served for fear of overeating, bulimia should be suspected and further assessment should be instituted to ascertain if, indeed, this problem does exist.

Also important under sociocultural assessment is evaluation of female individuals' attitudes and beliefs about the importance placed upon thinness and dieting by their culture. Assessment should be carefully conducted into individuals's eating habits for those individuals whose occupational and educational lives place significant importance on body size and structure such as gymnastics, wrestling, modeling, and acting. According to Love and Seaton (1991), not only should the client be questioned, but also their parents, coaches, instructors, families, and friends to ascertain if unreasonable pressures are being placed upon them to diet to maintain an unnatural body size.

Spiritual Assessment

Individuals who suffer from bulimia may be feeling spiritually depleted. As in other addictive disorders, such as alcoholism and gambling, the bulimic person typically feels unable to control their

behaviors. Overeaters anonymous (OA) offers a twelve step program designed to deal eating disorders in general and with the addictive behaviors associated with bulimia in specific. The OA program states that coming into touch with a higher power will give the individual the added strength they need to deal with their eating disorders. The higher power does not necessarily have to be belief in an organized religion. OA (1995) further stated that the higher power can be the strength of a group or the strength that comes from other people who have found a solution to the same problem that you have. A higher power can also come from inside the individual when they have found peace with the originating cause of their eating disorder (Overeaters Anonymous, 1995). Nurses can assess an individual's belief in a higher power by simply asking them if they believe in a higher power.

Psychological Assessment

Dankberg (1991) performed research into the occurrence of depression and its link to cognitive distortion in bulimic patients. Her hypothesis was that "as the overall degree of cognitive distortions increases, so does the level of depression" (p.334). The results of her research showed a positive correlation between depression and cognitive stigmata. As a side result of her research, Dankberg also found that sixty percent of bulimic patients she studied were in the moderately severe to

severe depression range. Particular attention should be focused upon assessing for "obsessionality, introversion, cognitive impairment, and depression" which can occur as a side effect of restrictive dieting. The psychological problems can cause the individual to present with symptoms such as "clinical depression, anxiety, panic-like states, obsessional thought content with ruminations, decreased concentration, vegetative symptoms, the presence of hyperactivity, disturbed sleep/wake cycle, and lethality toward self and others" (Love & Seaton, 1991, p. 683).

Flood (1989) stated that control is a recurring theme that is discovered when assessing eating disordered individuals. They most fear having to be spontaneous and set up rules and regulations for everything they do in an attempt to control all situations that they encounter. When a loss of control is perceived by individuals with bulimia, they binge and purge in an attempt to feel a false sense of control over their unpredictable environments. During psychological assessment, if an individual is perceived to value control to an inordinate degree, a complete assessment for bulimia should be conducted.

With all of the above psychological abnormalities common in individuals with bulimia, when assessing the psychological dimension particular attention should be paid to individuals that state they have problems with esteem, control, stress, and personal relationships.

Because of the high rate of suicide attached to bulimia, a comprehensive suicide assessment should be performed on all individuals suspected to have bulimia as soon as possible. The beliefs that an individual holds about suicide can have an impact upon their intent to commit suicide. While some persons may find it abhorrent to commit suicide because of their beliefs, others may find that it is an acceptable end to the depression, shame, and stigma of bulimia. The nurse, through assessment and crisis intervention, may be able to preclude an individual from committing suicide (Johnson, 1993).

Because of the stigma attached to bulimia, and the feelings of shame associated with bulimia, maintaining a nonjudgmental attitude when assessing the psychological dimension of clients is extremely important. If the nurse, after examining her own beliefs, is unable to be nonjudgmental about bulimic clients, he or she should seek out another nurse to perform the assessment.

Nursing Diagnosis Associated with Bulimia

Following assessment the following list of prioritized nursing diagnoses, quoted from her text, may be developed according to Johnson (1993):

- Altered nutrition: less than body requirements related to refusal to ingest or retain ingested food, physical exertion in excess of caloric intake.
- Self-esteem disturbance related to unrealistic expectations from self and/or others, lack of positive feedback, striving to please others to gain acceptance.
- Ineffective individual coping related to unmet developmental tasks (trust, autonomy), dysfunctional family system.
- Altered family processes related to enmeshed family system, ineffective communication patterns, denial of problems and conflicts, unresolved issues of control, inability to manage conflict.
- Fluid volume deficit related to diuretic or laxative abuse, vomiting, inability to concentrate urine.
- Altered bowel elimination: constipation or diarrhea related to refusal to ingest or retain ingested food, chronic laxative abuse.
- Altered oral mucous membranes related to deficient nutritional status and frequent vomiting.
- Powerlessness related to deficiency in learning that one's actions can cause desired outcomes.

- Social isolation related to fear of rejection, impaired age-appropriate social skills, preoccupation with obsessive thoughts and compulsive behaviors.
- Altered sexuality patterns related to impaired nutritional status, social isolation, low self-esteem.
- Altered cardiac output: decreased, related to hypokalemia, decreased blood volume.
- High risk for injury related to excessive exercise and deficient nutritional status.
- Altered thought process related to all-or-none thinking, intellectualization, obsessions, over-generalization, malnutrition (p. 565).

Following the development of nursing diagnoses, nurses then enter the planning phase of the Nursing Process.

Nursing Planning for Bulimia

In the planning stage of nursing process, nurses prioritize the nursing diagnoses they develop and, with client collaboration, determine goals to address the problems. Outcome criteria to measure whether or not the goals are met are developed next. For each of the top five nursing diagnoses, a list of goals outcome criteria will be developed to determine if the client goals are being met. The goals and outcome criteria used all

come from Linda Juall Carpenito's *Nursing Diagnosis: Application to Clinical Practice* (1997).

For the nursing diagnosis of altered nutrition: less than body requirements related to refusal to ingest or retain ingested food and physical exertion in excess of caloric intake the client goals with accompanying outcome criteria would be:

Goal: client will ingest and retain, without excess physical exertion, sufficient calories to meet bodily requirements.

Outcome Criteria: (1) client will increase oral intake as evidenced by a total daily caloric intake sufficient to meet bodily requirements - 1600 to 3000 calories to be determined based upon physical activity, emotional state, body size, age, and individual metabolism. (2) client will describe causative factors of inability to ingest and retain food. (3) client will describe rational and procedure for treatments to ensure adequate ingestion and retention of food.

For the nursing diagnosis of self-esteem disturbance related to unrealistic expectations from self and/or others, lack of positive feedback, and striving to please other to gain acceptance the client goals and accompanying outcome criteria would be:

Goal (1): client will develop realistic expectations from self and/or others

Outcome Criteria: (1) client will identify positive aspects of self; (2) client will analyze behavior and resulting consequences; (3) client will modify excessive and unrealistic self-expectations

Goal (2): client will develop methods to realistically evaluate feedback from others.

Outcome Criteria: (1) client will accept positive feedback from others; (2) client will not exaggerate negative feedback from others.

Goal (3): client will cease striving to please others to gain acceptance.

Outcome Criteria: (1) client will not seek approval excessively from other; (2) client will begin to take verbal and behavioral risks without thinking about reactions from other individuals.

For the nursing diagnosis of ineffective individual coping related to unmet developmental tasks (trust, autonomy) and dysfunctional family system the client goals with accompanying outcome criteria would be:

Goal (1): client will meet developmental tasks of trust and autonomy.

Outcome Criteria: (1) client will identify coping patterns and consequences of the behavior that results; (2) client will identify personal strengths and accept support through the nursing relationship; (3) client will make decisions and follow through with appropriate actions to change provocative situations in personal environment.

For the nursing diagnosis of altered family processes related to enmeshed family system, ineffective communication patterns, denial of problems and conflicts, unresolved issues of control, and inability to manage conflict the client goals with accompanying outcome criteria would be:

Goal (1): client and family will develop effective communication patterns.

Outcome Criteria: (1) client and family will verbalize feelings to nurse; (2) client and family will verbalize feelings to each other.

Goal (2): client and family will accept problems and conflicts as they arise.

Outcome Criteria: (1) client and family will correctly identify and cope with problems and conflicts.

For the nursing diagnosis of fluid volume deficit related to diuretic or laxative abuse, vomiting, and inability to concentrate urine the client goals with accompanying outcome criteria would be:

Goal: client will maintain fluid volume balance.

Outcome Criteria: (1) client will maintain adequate intake of fluid and electrolyte volume as evidenced by moist mucous membranes, nonsunken eyeballs, electrolyte levels within normal limits, specific gravity within normal limits, and electrocardiogram within normal limits; (2) client will not abuse laxatives, diuretics, or enemas; (3) client will not intentionally vomit after eating.

While other nursing diagnoses are also extremely important, for the sake of brevity, only the top five nursing diagnoses associated with bulimia have had goals with accompanying outcome criteria developed for them.

Implementation

The first implementation that nurses undertake is the identification of individuals that have bulimia. The screening tool that found in the appendices addresses the client goals and outcome criteria necessary to identify individuals suspected to have bulimia. This screening tool has questions that have been drawn from the following sources: Johnson

(1993); Kozier, Erb, Blais and Wilkinson (1995); and Seidel, Ball, Dains, and Benedict (1995). This screening tool does not have official validity or reliability since it has never actually been tested. If, through use of this screening tool or other methods, an individual is ascertained to have bulimia, the remainder of nursing implementations in this section are then appropriate.

Nursing implementations for individuals with bulimia can take place in either outpatient or inpatient settings. The physical and mental state of bulimic individuals will determine whether the individuals can be treated in the outpatient setting or if they require more intensive inpatient care. Conrad, Sloan, and Jedwabny (1993) stated that rationale for inpatient treatment is based upon the need for monitoring and interruption of the potentially life-threatening behaviors of purging and restricting food.

The following list of criteria, according to Palmer (1990), indicates that there is a definitive need for inpatient treatment:

- a rapid weight loss of greater than 15 percent of body mass, persistent bradycardia of less than or equal to 50 beats per minute, hypotension with a systolic reading of less than 90, or hypothermia with a core body temperature of less than or equal to 97 degrees Fahrenheit;

- medical complications ensue;
- suicidal ideation is present;
- there is persistent sabotage or disruption of outpatient treatment by either the patient or family members; or
- there is complete denial of need for any help whatsoever (Palmer, 1990, p. 16).

Nursing implementations, both outpatient and inpatient, because bulimia is defined as a mental disorder with nutritional complications, are usually performed collaboratively with psychologists, psychiatrists, physicians, and dietitians. Nursing implementations are developed with input from the client to ensure that the client's goals are met. In the case of bulimia, where family interactions are important to the outcome of the patient, the family should also be included when developing some interventions. Nurses perform implementations to help individuals and families attempt to regain homeostasis in areas disturbed because of bulimic behaviors or that contribute to the development of bulimic behaviors.

Outpatient Nursing Interventions

Outpatient nursing interventions are determined by the model of treatment that is being used by the therapy team and are also determined by the level of preparation of the nurse involved. Muscari

(1993), a nurse practitioner stated that the role of the nurse practitioner in caring for bulimic patients in the outpatient setting is one of working with a team that includes a therapist and a nutritionist. Because the primary care practitioner is often the first person to identify a bulimic client, being supportive of the client and encouraging the client to accept assistance is particularly important. Although the care boundaries must be established for each team member, some aspects of care will necessarily overlap, such as "self-esteem development and coping and cognitive behavioral training" (Muscari, 1993, p. 259). Muscari (1993) sees one of the primary roles of the nurse practitioner, when treating an individual with bulimia, as supporting and caring for the client and family while reinforcing the need to maintain the treatment protocol. It is particularly important, when the client is an adolescent, to recognize that the client's family may conspire to cover and hide family problems that could be contributing to the behaviors of the bulimic client. Encouraging family members to verbalize their own frustrations about the bulimic client's behaviors is also important for the primary practitioner. Often the family will have additional financial problems as well as emotional problems associated with large food expenditures and treatment costs that are not covered by medical insurance. Including the family in the client's treatment plan will allow them to vent their own frustrations that could

inadvertently be hindering the client's progress as well as allowing them to assist in the client's recovery (Muscari, 1993).

Muscari (1993) also stated that the role of the nurse practitioner intervening with bulimic individuals involves the difficult area of trust building. Because there is a negative stigma associated with bulimia, which leads to a significant amount of shame and denial, the development and maintenance of a trusting relationship is extremely difficult and requires continuous effort. Without the achievement of trust, however, the treatment of the underlying issues of the etiology of bulimia, such as low self-esteem, feelings of inadequacy, and alterations in sexuality, cannot be accomplished (Muscari, 1993).

Meades (1993) described the role of the registered nurse with psychiatric training in dealing with bulimic individuals in the community setting. The need to control or the feeling of loss of control is a common factor identified by individuals who suffer from bulimia. The nurse working with the bulimic clients, must recognize this need and, with the clients, develop ways to alter their distorted cognitions about control into more realistic perceptions about control issues. These distortions can best be dealt with by a combination of cognitive and behavioral treatment approaches. The cognitive approach involves successfully challenging and disproving faulty cognitions about bingeing and purging by examining

the guilt and self-revulsion felt by the client following a binge and purging session. The nurse can further help clients by informing clients about the physical harm caused by repeated vomiting, and by exploring possible interpersonal relationship stressors that have triggered binge and purging episodes. The behavioral treatment approach involves positive reinforcements for practicing healthy behaviors rather than binge and purging behaviors in response to stressors that have been identified (Meades, 1993).

Meades (1993) has also identified conflictual, non-cohesive, chaotic families of individuals with bulimia which also benefit from nursing interventions. These families, with unclear issues of responsibility and inconsistent of love and affection, appear to contribute to the uncontrolled binge eating and purging behavior of bulimic individuals. Although nurses cannot reunite separated families, they can be instrumental in helping individuals to realize that they also cannot feel responsible for reuniting their families in cases of separation. Nurses can also help families that communicate dysfunctionally, whether separated or not, to develop more functional channels of communication that does not employ "emotional blackmail" and can freely and sincerely express emotions and love. The ultimate result desired is to have the individuals

and their families develop the ability to channel their conflicts into less destructive behaviors when they cannot be resolved.

Flood (1989) also formulated an outpatient treatment plan based upon the establishment of trust. Where her treatment plan deviates from Meades, however, is in the role of the nurse involved in the treatment. Flood (1989) stated that one of the most important, but often overlooked, nursing intervention tools is role modeling. Nurses must be comfortable with their own body images to deal effectively with bulimic patients, because these individuals quickly perceive when the individuals attempting to help them deal with their own body image issues have, in actuality, unresolved feelings about their own bodies. Flood (1989) also described a treatment plan that she entitled "face, embrace, and erase." This plan helps individuals to identify, manifest, and relinquish feelings identified by them to have triggered bulimic episodes in the past. With this treatment plan, the individuals' need for excessive control can be dealt with and lessened. Without the need for excessive control, the achievement of a state of peace can become a practiced and accomplished skill. Flood's (1989) final nursing intervention involves the identification of feelings before, during, and after a bingeing and purging episode. The individuals must then recreate that same emotion that they each previously felt in their own imagination followed by the creation of a

sense of peace. If performed correctly, the individuals' minds should not be able to distinguish the difference between reality and simulation and will respond by pacifying the painful emotions that are simulated. The outcome expected from this intervention is that the individuals will experience a sense of calm and a reduction in the necessity to repress emotions and purge pain. The overall goal, similar to Meade's intervention goals, is the feeling of self-control that results in increased self-esteem (Flood, 1989).

Inpatient Treatment

If the client manifests the physical and emotional symptomology previously described and requires inpatient treatment, there are interventions that are unique to that situation. Inpatient treatment can be either in a hospital for critical care, in a psychiatric facility that specializes in bulimic care, or in a general psychiatric facility.

Myer and O'Brien (1993) summarize the multisystem complications that can occur as a result of bulimia and the resulting interventions which are necessary to ensure that permanent physical consequences can be either avoided or lessened. The vomiting or abuse of laxatives can lead to significant fluid losses resulting in dehydration. If such dehydration is assessed, nursing interventions relating to this dehydration consist of: (1) monitoring the infusing solution for correct composition and rate; (2)

monitoring the output amounts and relating laboratory values for adequate renal function; (3) monitoring the abdomen and lower extremities for third-spacing of fluids; (4) monitoring skin condition and providing resulting necessary oral hygiene and skin care to prevent complications; (5) monitoring central venous pressure for values less than 5-10 cm, arterial pressure for values less than 90 mm Hg., urine output less than 30 ml/hr; and (6) monitoring for all other signs and symptoms of dehydration.

The vomiting and laxative abuse can also lead to serious electrolyte imbalances of potassium (hypokalemia) and sodium (hyponatremia) which, if untreated, can also lead to serious metabolic acidosis and alkalosis (Myer & O'Brien, 1993). Nursing interventions to reduce the incidence of hypokalemia include observing the individuals' cardiac monitors for dysrhythmias such as "depressed ST segment, flattened, inverted T waves, increased amplitude of P wave, prolonged P-R interval, widened QRS complex, and U waves if the serum K+ [potassium] levels fall lower than 3.0 meq/L" which manifest as skipped beats or palpitations (Myer & O'Brien, 1993, p. 197). Additional nursing interventions to decrease the incidence of hypokalemia include: "assessing and monitoring all vital signs; level of consciousness; muscle strength, movement, and sensation; characteristics of the abdomen

including bowel sounds; intake and output, and laboratory values" (Myer & O'Brien, 1993, p. 197). If hypokalemia has been assessed, nursing interventions to help resolve this problem are aimed at correcting the low serum potassium and also at eliminating the cause of the low serum potassium. These interventions include peripheral infusion of intravenous potassium and discontinuing the vomiting and laxative abuse that precipitated the hypokalemic problem (Myer & O'Brien, 1993). Nursing interventions to reduce the incidence of low serum sodium, hyponatremia, which can be life-threatening, include correctly assessing individuals for signs and symptoms of sodium depletion by identifying changes in levels of consciousness and central nervous system functions. If suspected, hyponatremia can be confirmed by checking "urine sodium, osmolarity, and specific gravity" (Myer & O'Brien, 1993, p. 199). If confirmed, hyponatremia can be treated by peripheral infusion of a hypertonic solution if individuals are experiencing "neurological symptoms such as seizures and peripheral paresthesias" (Myer & O'Brien, 1993, p. 199).

Equally important to correct assessment and treatment of physical problems is the assessment and prevention of self-mutilating and self-destructive behaviors. If, during assessment, a risk of suicide is determined, safety precautions, such as visually checking the patient

every fifteen minutes, must be instituted by the nurse to protect individuals from self-inflicted injury. Appropriate collaborative interventions in this situation include consultation with a psychiatric nurse specialist to ensure that interventions are included in care plans to address each individual client's needs, consultation with an adolescent specialist if the patient is in that age group, and consultation with an eating disorder expert.

If the client is not critically ill, but is unable to control life-threatening bulimic behaviors during outpatient treatment, inpatient treatment in either a facility specifically designed for eating disorders or in a general psychiatric unit is indicated. Conrad, Sloan, and Jedwabny (1992) explored nursing interventions that are necessary to deal with the characteristic maladaptive behaviors, such as denial, minimization, splitting, and projection, common to eating disordered individuals in general and bulimic individuals in particular. If individuals come from a dysfunctional family, they tend to attempt to replicate that same conflict within the treatment unit (Conrad, Sloan, & Jedwabny, 1992).

Research was instituted into possible treatments for this acting-out behavior. Results of the research showed that the better the nurse-client relationship, the less the client used acting-out behavior and vice-versa. Therefore, the nursing staff determined that guidelines for a consistent approach were needed to "clarify boundaries for managing client care,

since the process among staff members often mirrored the struggle that these individuals experienced during the treatment process" (Conrad, Sloan, & Jedwabny, 1992, p. 14). An additional nursing intervention that was considered important was the weekly meetings to examine client care and the therapeutic approaches that were being used. It was concluded, during these meetings, that effective nursing interventions involved two tracks. Track number one related to issues of weight, bingeing, and strenuous dieting. Track number two related to issues of psychological factors underlying family dysfunction and personality development. Under this therapeutic/administrative model, autonomous nursing interventions were determined to be "teaching the client proper nutrition or how to delay acting out behaviors" while the psychiatrist's domain was determined to be the administrative responsibilities, the psychological problems, and therapeutic responsibilities (Conrad, Sloan & Jedwabny, 1992, p. 15).

Under the therapeutic/administrative model, nursing interventions are designed according to client goals decided upon in weekly meetings with each individual. Upon the agreement of client goals, a care plan is developed which will be followed by all nurses caring for the client. This nursing care plan ensures the consistent care that is necessary to meet client needs. The individuals' progress from the medical phase, which

strives to attain a stable medical condition for the individuals, to the restoration phase, which has increased levels of client responsibility, to the maintenance phase, which assists the clients toward regaining control of their lives.

Pharmaceutical Therapy

Depending upon the psychiatrist or medical physician ordering the medications there are two schools of thought about the use of pharmacotherapy in the treatment of bulimia. While one group of practitioners believe that pharmacotherapy alone can "cure" bulimia, the other group believes that a balance of pharmacotherapy and psychotherapy are necessary to help the individual to heal. The best possible outcomes have been accomplished with a combination of the two therapies (Mickley, 1989). The medications help the client to deal with the binging and purging while the psychotherapy helps the client to deal with the underlying issues which precipitated the bulimia.

In some clinical studies, at least 50% of bulimic individuals have been able to control their binges after beginning pharmacotherapy (Mickley, 1989). When considered against the 86% relapse rate following the conventional behavioral therapy, this is a significant improvement (Fairburn, Norman, & Welch, 1995). There are two classes of antidepressants that have been found to successfully treat bulimic

behaviors--tricyclic antidepressants and selective serotonin reuptake inhibiting agents. Because of the strong link between depression and bulimia, the first class of drugs to be tried as a treatment for bulimia was the tricyclic antidepressants.

While tricyclic antidepressants showed some success with bulimia, there was significantly more success with the selective serotonin uptake inhibitor Prozac (fluoxetine HCl). With 20-60 milligram dosage, Prozac diminishes depression, carbohydrate craving, and pathological eating habits. Only a few women dropped out of the study because of adverse side effects of Prozac (Fluoxetine Bulimia Nervosa Collaborative Study, 1992).

In addition to antidepressants, Naltrexone, a drug used against heroin addiction, has shown promise in the battle against bulimia. In a study of a small group of nineteen individuals with bulimia who took Naltrexone and also underwent psychotherapy, all but one client responded positively to the treatment (Marazzi, 1995).

Therefore, with the statistics that support the benefit of pharmacotherapy, not only is the nurse's responsibility the accurate administration of such drugs in inpatient settings, but also to advocate for bulimic individuals with their medical providers. Nurses also need to educate individuals about the benefits and side-effects that are

associated with such pharmacotherapy while encouraging additional psychotherapy.

Evaluation

Evaluation of the effectiveness or ineffectiveness of nursing interventions in relationship to bulimia must be done by returning to the outcome criteria of the client goals. If the outcome criteria have been met then, accordingly, the individuals' goals should also have been met.

While meeting the individuals' goals will not ameliorate the bulimia altogether, it will at least ensure that the client's physical health status will have improved and they will have been given the information with which to deal with the psychological, spiritual, and sociocultural dimensions of their lives. If the client goals have not been met, reevaluation and revising of the client goals and nursing goals must then be performed.

Prevention

If there were a physical cause of bulimia and an antidote could be discovered, individuals would not have to deal with the shame and guilt associated with bulimia that comes from the misinformation that is disseminated to the public. This shame and guilt comes from hearing other people talk about bulimic individuals as if they were weak and should be able to control their bulimic behaviors or as if they actually enjoyed their bulimic behaviors. If, indeed, there were definitive proof

that low serotonin levels cause the onset of bulimia rather than bulimic behaviors causing low serotonin levels, a blood test to check serotonin levels could be predictive of the onset of bulimia. At the present time, however, the etiology of bulimia is still not definitively known; therefore, the prevention of bulimia must be based upon educating the population most susceptible to the development of bulimia, those individuals in the best position to identify bulimia in its early stages, and the general public about the realities of bulimia.

The education of the public most vulnerable to the development of eating disorders, adolescents to young adults, needs to begin in the schools (Connolly & Corbett-Dick, 1990). School nurses are in an ideal location to perform this education and should begin this education at the elementary level before the students reach adolescence. When teaching about bulimia, nurses should be extremely careful not to glamorize the development of eating disorders. If students at this age are told that the smart, pretty, popular students develop bulimia, they may view the development of bulimia as a desirable behavior. Rather, education about bulimia should be age appropriate and focus upon the nutritional, biological, psychological, and social components of maturation that can influence the development of bulimia. Because of the strong link between low self-esteem and the development of bulimia, particular emphasis

should be placed upon enhancing the self-esteem of children (Connolly & Corbett-Dick, 1990).

In addition to educating children, individuals who are in the best positions to identify bulimia early should also be educated about the early warning signs and symptoms of bulimia which are:

- a noticeable weight loss or gain
- excessive concern about weight
- bathroom visits after meals
- depressive moods
- strict dieting followed by eating binges
- increasing criticism of one's body (Wilfley & Grilo, 1994, p. 41).

The individuals in the school system in the best positions to detect bulimia during its early stages are, teachers, coaches, school nurses, psychologists, counselors, and coaches (Connolly & Corbett-Dick, 1990).

Because they are the individuals who clean the bathrooms where the purging behavior takes place, the janitorial staff should also be alerted to detecting the physical evidence left in the bathrooms following purging behaviors. The primary reason to educate these individuals about the detection of bingeing and purging behaviors in individuals during the early

stages is that the longer the behaviors continue before detection, the harder the compulsion is to stop (Rock & Zerbe, 1995).

The final group of individuals who need education about bulimia is the general public. At the present time, many bulimic individuals do not come forward to receive the help that they need to overcome this disorder due to the stigma and shame that are attached to the diagnosis of bulimia. If nurses in general, and school nurses in particular, begin to educate the public about the fact that bulimia is truly an illness and that early detection can lead to earlier treatments, there would be less permanent physical and psychological consequences and fewer suicides because of bulimia.

Summary

Bulimia is an eating disorder that should never be taken lightly. The physical and psychological damage that can be done by bulimia can never be completely repaired. If society placed less blame upon bulimic individuals for the bingeing and purging behaviors and offered more understanding, perhaps more individuals that suffer from bulimia would be willing to come forth to receive the help that they desperately need. This author can only hope and pray that the two statements that drove her deeper into her own eating disorder are never again spoken in her presence, that being: (1) how can individuals with bulimia stand to throw

up, its so disgusting; and (2) why do they bother to eat in the first place if they are just going to throw it back up. Individuals will not, however, discontinue to say such things until they are educated about the true nature of bulimia.

References

American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders (4th ed.). Washington, D.C.: American Psychiatric Association.

Bruch, H. (1982). Anorexia nervosa, therapy and theory. The American Journal of Psychiatry, 139, 1531-1538.

Carpenito, L. (1997). Nursing diagnosis: Application to clinical practice (5th ed.). Philadelphia: J.B. Lippincott Company.

Connolly, C. & Corbett-Dick, P. (1990). Eating disorders: A framework for school nursing initiatives. Journal of School Health, 60(8), 401-405.

Conrad, N., Sloan, S., & Jedwabny, J. (1992). Resolving the control struggle on an eating disorders unit. Perspectives in Psychiatric Care, 28(3), 13-18.

Dankberg, G. (1991). Degree of cognitive distortions and level of depression in bulimic patients. Issues in Mental Health Nursing, 12, 333-342.

Fairburn, C., Norman, P., & Welch, S. (1995). A prospective study of outcome in bulimia nervosa and the long-term effects of three psychological treatments. Archives of General Psychiatry, 52, 304-312.

Flood, M. (1989). Addictive eating disorders. Nursing Clinics of North America, 24(1), 45-53.

Fluoxetine Bulimia Nervosa Collaborative Study Group (1992). Clinical trials for bulimia: Fluoxetine, fluvoxamine. Archives of General Psychiatry, 49, 139-147.

Johnson, B. (1993). Adaptation and growth: Psychiatric-mental health nursing (3rd ed.). Philadelphia: J.B. Lippincott Company.

Keller, O. (1986). Bulimia: Primary care approach and intervention. Nurse Practitioner, 11(8), 42-51.

Kozier, B., Erb, G., Blais, K., & Wilkinson, J. (1995). Fundamentals of nursing: Concepts, process, and practice. (5th ed.). Redwood City: Addison-Wesley Nursing.

Love, C., & Seaton, H. (1991). Eating disorders: Highlights of nursing assessment and therapeutics. Nursing Clinics of North America, 26(3), 677-695.

Marrazzi, M. (1995). Breaking the dieting habit. Psychology Today, 28(2), 12-22.

Meades, S. (1993). Suggested community psychiatric nursing interventions with clients suffering from anorexia nervosa and bulimia nervosa. Journal of Advanced Nursing, 18, 364-370.

Mickley, D. (1989). Evaluating common eating disorders: 10 questions to ask your patient. Physician Assistant, 146-160.

Muscari, M. (1993). The role of the nurse practitioner in the diagnosis and management of bulimia nervosa, part 3: Psychosocial management. Journal of the American Academy of Nurse Practitioners, 5(6), 259-263.

Myer, S., & O'Brien, A. (1993). Multisystem complications of bulimia: A critical care case. Dimensions of Critical Care Nursing, 12(4), 194-203.

Overeaters Anonymous (1995). To the newcomer. Rio Rancho, NM: Overeaters Anonymous.

Palmer, T. (1990). Anorexia nervosa, bulimia nervosa: Causal theories and treatment. Nurse Practitioner, 15(4), 13-21.

Pharmaceutical Information Associates, Ltd. (1994). Serotonin and eating disorders. Medical Sciences Bulletin, (1-4). (Downloaded from the Internet)

Plehn, K. (1990). Anorexia nervosa and bulimia: Incidence and diagnosis. Nurse Practitioner, 15(4), 22-31.

Rock, C. & Zerbe, K (1995). Keeping eating disorders at bay. Patient Care, 29(18), 78-80.

Seidel, H., Ball, J., Dains, J., & Benedict, G. (1995). Mosby's guide to physical examination. (3rd ed.). St. Louis: Mosby.

Wilfley, D., & Grilo, C. (1994). Eating disorders: A women's health problem in primary care. Nurse Practitioner Forum, 5(1), 34-45.

Wilkinson, J. (1991). Nursing Process in action: A critical thinking approach. Redwood City: Addison-Wesley Nursing.

Appendix A

Screening Tool for Individuals Suspected of Being Bulimic

Physical Assessment

Subjective Data - History; Objective Data - Nursing Assessment

Vitals: BP _____, Temp _____, Pulse _____, Resp _____

General Symptoms - fever, chills, malaise, fatigability, night sweats, weight (Average, preferred, present, change)

S: _____

O: _____

Diet - appetite, likes, dislikes, restrictions, diet history, food diary for past week

S: _____

O: _____

Skin, Hair, & Nails - dryness, brittleness, pigmentation or texture changes, swelling of hands & feet

S: _____

O: _____

Head & Neck - Changes in voice, sore throats, bleeding or swollen gums, loss of tooth enamel, swollen parotid glands, conjunctival hemorrhages, broken blood vessels in cheeks, sore tongue, reddened mouth, puffy cheeks

S: _____

O: _____

Menstrual History - amenorrhea or irregularity

S: _____

O: _____

Hematological - anemia,

S: _____

O: _____

Gastrointestinal - heartburn, nausea, vomiting, hematemesis, constipation, diarrhea, hemorrhoids, abdominal fullness

S: _____

O: _____

Concluding Question - Anything else that is important for the nurse to know _____

Appendix B
Psychological Assessment

Self assessment:

1. Do you like your body's image? ___ yes ___ no
 Comments _____
2. Do you like your personal appearance? ___ yes ___ no
 Comments _____
3. Do other people remark negatively about your personal appearance?
 ___ yes ___ no Comments _____
4. Do you like yourself as a person? ___ yes ___ no
 Comments _____
5. Can you say no when you want to say no? ___ yes ___ no
 Comments _____
6. Do you ever feel generally inadequate with other people?
 ___ yes ___ no Comments _____
7. Do you feel liked by your peers and coworkers? ___ yes ___ no
 Comments _____
8. Do you feel like you are under a lot of stress? ___ yes ___ no
 Comments _____
9. Do you feel that your life is a positive experience? ___ yes ___ no
 Comments _____
10. Have you ever thought about committing suicide? ___ yes ___ no
 Comments _____

Family Assessment:

1. Do you feel that your family is too close? ___ yes ___ no
 Comments _____
2. Do you do social activities with people other than your family?
 ___ yes ___ no Comments _____
3. Are you proud of your family members? ___ yes ___ no
 Comments _____
4. Do you think your family is proud of you? ___ yes ___ no
 Comments _____

Spiritual Assessment

1. Are there any particular religious practices that are important to you?
 ___ yes ___ no Comments _____
2. Do you feel your faith is helpful to you? ___ yes ___ no
 Comments _____
3. Do you believe that God loves you and cares about you?
 ___ yes ___ no Comments _____
4. Do you believe that God contributes to your sense of well-being?
 ___ yes ___ no Comments _____