

CARE OF CLIENTS WITH MALADAPTIVE PATTERNS OF BEHAVIOR

NCMB317

Personality and Eating Disorders

PERSONALITY DISORDERS

- PERSONALITY (Pagkatao)
 - Refers to all attributes of an individual: behavioral, temperamental, emotional and mental that characterize a PERSON to be a unique human being
- PERSONALITY TRAITS
 - Are pattern of behaving, thinking, perceiving, and relating
- PERSONALITY DISORDERS
 - Personality disorders are not diagnosed until adulthood, that is, at age 18, when personality is more completely formed. Nevertheless, maladaptive behavioral patterns can often be traced to early childhood or adolescence.
 - Personality disorders are long-standing because personality characteristics do not change easily. Thus, clients with personality disorders continue to behave in their same familiar ways even when these behaviors cause them difficulties or distress.
- Diagnosis is made when the person exhibits enduring behavioral patterns that deviate from cultural expectations in two or more of the following areas:
 - **C**: Cognition
 - **I**: Interpersonal functioning
Impulse control
 - **A**: Affect
- The difficulties associated with personality disorders is stable and of long duration. They persist throughout young and middle adulthood but tend to diminish in the 40's - 50's
- Individual with personality disorder are not aware of their behavior (egosyntonic)
- It is often the major source of long term disability and frequently occur in conjunction with other psychiatric disorders
 - Major depression
 - Eating disorders
 - Panic disorders
 - Post Traumatic Stress Disorder
 - Somatization
 - Substance use disorder

EPIDEMIOLOGY

- 5% - 15% of the adult population has some form of personality disorders.
- People with personality disorders tend to come from younger age group
- Commonly seen in socially impaired environment
 - Urban areas with a high incidence of transient persons
 - Lower socioeconomic neighborhood
 - Prison/correctional
- Rate of PD in high social disintegration is three times as great as in more organized environment
- 9%- 28% of persons who complete suicide are diagnosed with PD

- About 1/3 of adolescents and young adults who complete suicide have PD
- Borderline personality disorder represents the most common diagnosis
- Recent study on personality disorders showed prevalence estimated as 4.3% (Cluster A), 2.7% (Cluster B), 4.6% (Cluster C) and 6.8% (any PD)

PSYCHOPATHOLOGY, ETIOLOGY, AND PSYCHODYNAMIC

- BIOLOGIC CORRELATES
 - *Genetic factor*
 - Personality develops in response to inherited characteristics (temperament). These are engrained by 2-3 years of age.
 - Cloninger temperament and character model describes how individuals respond to environmental stimuli based on their biological temperament
 - Harm avoidance
 - Novelty seeking
 - Reward dependence
 - Persistence

HARM AVOIDANCE (HA) Sensitivity to Punishment and Anxiety	NOVELTY SEEKING (NS) Sensitivity to Reward and Exploration
DEFINITION: Tendency to avoid harm, fear uncertainty, and be cautious	DEFINITION: Tendency to seek new experiences, excitement, and impulsivity.
HIGH HA: Anxious, pessimistic, shy, cautious, and easily stressed. Often avoids risks and new situations	HIGH NS: Curious, energetic, impulsive, and easily bored. Enjoys adventure and taking risks
LOW HA: Confident, optimistic, risk-taking, and less prone to anxiety.	LOW NS: Routine-oriented, reserved, and less impulsive. Prefers familiarity over novelty.
REWARD DEPENDENCE (RD) Sensitivity to Social Rewards and Approval	PERSISTENCE (P) Perseverance Despite Fatigue & Frustration
DEFINITION: Need for social attachment, approval, and emotional warmth.	DEFINITION: Ability to maintain effort despite difficulties or lack of immediate reward
HIGH RD: Warm, sociable, eager to please, and emotionally responsive. Seeks social reinforcement.	HIGH P: Hardworking, goal-driven, and determined. Does not give up easily
LOW RD: Independent, emotionally detached, and less influenced by social feedback. Prefers autonomy.	LOW P: Easily discouraged, may procrastinate or give up when faced with obstacles

- *Neurochemical Factors*
 - Imbalances of serotonin, norepinephrine and dopamine
- *Autonomic Nervous System*
 - Hypothalamus hypometabolism. According to Kerberg, pain activates the punishing center of the hypothalamus.
 - Ex: A child whose orientation to the world is based on hurting tend to cope by using greater amount of aggression.
 - It is this excessive aggressions that powers the development of borderline, passive-aggressive, histrionic and narcissistic personality disorders

- *Hormonal Therapy*
 - Aggressive behavior: increased levels of androgens
 - Impulsive behavior: increased level of estrogen and testosterone
 - Pleasure seeking individual: increased noradrenergic metabolites ex: gamblers
- BEHAVIORAL CORRELATES
 - Behaviors are learned. Children repeat actions that bring them rewards & avoid actions that incur punishments.
 - Behavior that has been consistently rewarded from infancy, before the development of understanding, cognition, and languages, is the most difficult to unlearn or modify.
 - Contradictory parental attitudes and inconsistent training
 - Serve as major factors in the development of passive-aggressive PD (Children may receive the kindness and support they crave, or they may be the recipient of hostility)
- PSYCHODYNAMIC CORRELATES
 - Personality develops in response to environmental influences (character).
 - Character consists of concepts about self and the external world
 - 3 Major character traits
 - Self-directedness
 - Cooperativeness
 - Self-transcendence
 - When fully developed, these character traits define a mature personality
 - Clients who developed personality disorders encounter difficulties at the separation-individual stage of development (18 months to 3 years)

SELF-DIRECTEDNESS (SD) Personal Responsibility and Goal-Oriented	COOPERATIVENESS (C) Social Harmony and Empathy	SELF-TRANSCENDENCE (ST) Spirituality and Connection to the Universe
DEFINITION: The ability to regulate behavior according to personal goals, values, and responsibility. It reflects self-confidence, discipline, and adaptability.	DEFINITION: The tendency to be socially tolerant, compassionate, and work well with others. It reflects agreeableness, empathy, and collaboration.	DEFINITION: The ability to feel connected to something beyond oneself (spirituality, nature, or the universe). It reflects mysticism, spirituality, and openness to experiences beyond logic.
HIGH SD: Independent, responsible, self-disciplined, and goal-oriented. Able to manage setbacks effectively.	HIGH C: Kind, helpful, forgiving, team-oriented, and values social harmony.	HIGH ST: Imaginative, spiritual, creative, open to mystical experiences, may feel interconnected with nature or the universe.
LOW SD: Blames others for failures, lacks direction, impulsive, struggles with self-control.	LOW C: Self-centered, critical, uncooperative, and may struggle with teamwork or empathy.	LOW ST: Practical, skeptical, rational, prefers concrete thinking, less interested in spiritual or existential matters

STATISTICS AND INCIDENCES

- Personality disorders are relatively common, occurring in 10% to 13% of the general population.
 - 15% of all psychiatric inpatients have a primary diagnosis of a personality disorder.
 - 40% to 45% of those with a primary diagnosis of major mental illness also have a coexisting personality disorder that significantly complicates the treatment.
 - In mental health outpatient settings, the incidence of personality disorder is 30% to 50%.
 - Clients with personality disorders have a higher death rate, especially as a result of suicide; they also have higher rates of suicide attempts, accidents, and emergency department visits and increased rates of separation, divorce, and involvement in legal proceedings regarding child custody.

TYPES OF PERSONALITY DISORDERS

- CLUSTER A
 - Clients are withdrawn, cold and engage eccentric behavior
 - Paranoid
 - Schizoid
 - Schizotypal
 - Low reward dependence and correspond to the categories of:
 - **C**: cognitive disturbance
 - **A**: affective dysregulation
 - **D**: detachment
- CLUSTER B
 - Clients seek attention and engage in erratic, dramatic and emotional behavior
 - Antisocial
 - Borderline
 - Narcissistic
 - Borderline
 - High novelty: attention seeking behavior and correspond to the categories of impulsiveness and aggression
- CLUSTER C
 - Client seek to avoid or minimize the experience of anxiety or fear
 - AVOIDANT
 - DEPENDENT
 - OBSESSIVE-COMPULSIVE
 - High harm avoidance and correspond to the categories of anxiety and depressive behavior

NURSING PROCESS

ASSESSMENT	<ul style="list-style-type: none"> • HISTORY TAKING <ul style="list-style-type: none"> ◦ Patient's general history/information <ul style="list-style-type: none"> ▪ Patient's initial information ◦ Presenting problems <ul style="list-style-type: none"> ▪ Chief complaint ◦ Present & past health history ◦ Patient's relevant family history ◦ Patient's relevant history • MENTAL STATUS EXAMINATION <ul style="list-style-type: none"> ◦ ATOMICS <ul style="list-style-type: none"> ◦ Many of these clients report disturbed early relationships with their parents that often begin at 18 to 30 months of age; 50% of these clients have experienced childhood sexual abuse; others have experienced physical and verbal abuse and parental alcoholism.
DIAGNOSIS	<ul style="list-style-type: none"> • Risk for suicide related to low frustration tolerance. • Risk for self-mutilation related to impulsive behavior. • Risk for other directed violence related to lack of feelings of remorse. • Ineffective coping related to failure to learn or change behavior based on past experience or punishment. • Social isolation related to ineffective interpersonal relationships. • Risk for self-harm related to emotional instability • Anxiety related to fear of abandonment
PLANNING AND GOALS	<ul style="list-style-type: none"> • The client will be safe and free of significant injury. • The client will not harm others or destroy property. • The client will demonstrate increased control of impulsive behavior. • The client will take appropriate steps to meet his or her own needs. • The client will demonstrate problem-solving skills. • The client will verbalize greater satisfaction with relationships.

EVALUATION	<ul style="list-style-type: none"> • The client will be safe and free of significant injury. • The client will not harm others or destroy property. • The client will demonstrate increased control of impulsive behavior. • The client will take appropriate steps to meet his or her own needs. • The client will demonstrate problem-solving skills. • The client will verbalize greater satisfaction with relationships.
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- ANTISOCIAL INDIVIDUALS
 - Chaotic home environment
 - Impulsive/aggressive parents
- OBSESSIVE-COMPULSIVE
 - Over controlling parents
 - Perfectionist parents
- PASSIVE-AGGRESSIVE
 - Contradictory parental attitudes and inconsistent training method
- PARANOID INDIVIDUALS
 - Often subject to parental antagonism
 - Serve as scapegoat to parental aggression
- SCHIZOID INDIVIDUALS
 - Have childhood that is bleak, cold, and unemphatic
 - Devoid of nurturance and support
- SCHIZOTYPAL INDIVIDUALS
 - Faulty family relationship thus social skills are not developed

PSYCHOPHARMACOLOGY

- AGGRESSION/IMPULSIVITY
 - *Affective aggression*
 - Lithium
 - Anticonvulsant
 - Low dose antipsychotic
 - *Predatory (hostility/cruelty)*
 - Lithium
 - Antipsychotics
 - *Organic-like aggression*
 - Cholinergic agonist (Donepezil)
 - Antidepressant (imipramine-Tofranil)
 - *Ictal aggression (abnormal)*
 - Carbamazepine - tegretol
 - Diphenylhydantoin - dilantin
 - Benzodiazepines
- MOOD DYSREGULATION
 - *Emotional lability*
 - Lithium
 - Carbamazepine-tegretol
 - Antipsychotic
 - *Atypical depression/dysphoria*
 - MAOI
 - SSRI
 - Antipsychotic
 - *Emotional detachment*
 - SSRI
 - Atypical antipsychotics
- ANXIETY
 - *Chronic cognitive*
 - SSRI
 - MAOI
 - Benzodiazepines
 - *Chronic somatic*
 - MAOI
 - SSRI

- *Severe anxiety*
 - MAOI
 - Low dose antipsychotics
- PSYCHOTIC SYMPTOMS
 - Acute psychosis
 - Chronic and low level psychotic-like symptoms
 - Antipsychotic
 - Low dose antipsychotic

PHARMACOLOGIC MANAGEMENT

- Medications are in no way curative for any personality disorder; they should be viewed as an adjunct to psychotherapy so that the patient may productively engage in psychotherapy.
- ANTIDEPRESSANTS.
 - The selective serotonin reuptake inhibitors (SSRIs) and newer antidepressants are safe and reasonable effective; however, because the depression of most patients with personality disorders stems from their limited range of coping capacities, antidepressants are usually less effective than in patients with uncomplicated major depression.
- ANTIPSYCHOTICS
 - Response to antipsychotics in patients with a personality disorder is less dramatic than it is in true psychotic axis I disorders, but symptoms such as anxiety, hostility, and sensitivity to rejection may be reduced.

CLUSTER A

PARANOID PERSONALITY DISORDER

- Characterized by pervasive distrust and suspiciousness
- You suspect people. They are planning to harm you, to deceive you, they cannot be trusted. Even when people pretend to be neutral, they secretly have an agenda, and you are never going to forgive them for it. Just wait.. you will get revenge.
- DM: PROJECTION
 - **H**: hypervigilant
 - **A**: aloof and withdrawn
 - **R**: reluctant to confide in others
 - **M**: may perceive threat even in benign events
 - **S**: Suspicious (often feel attacked by others and may devise elaborate plans or fantasies for protection)

NURSING INTERVENTIONS

- Business like approach
 - Being on time
 - Keeping commitments
 - Being particularly straightforward
- Teach client to validate ideas before taking action
- Involve client in the treatment plan
- Provide health teaching on medications as part of the treatment plan
- "GET FACT"
 - **G**: Grudges held for long periods
 - **E**: Exploitation expected (without a sufficient basis)
 - **T**: Trustworthiness of others doubted
 - **F**: Fidelity of sexual partner questioned
 - **A**: Attacks on character are perceived
 - **C**: Confides in others rarely, if at all
 - **T**: Threatening meanings read into events

SCHIZOID PERSONALITY DISORDER

- Individuals may exhibit eccentric behavior, odd beliefs, social anxiety, and cognitive distortions.
- You are emotionally cold and the people you know describe you as completely detached but you do not notice them anyway, as your world is in your head. You are indifferent to life's activities
 - **M**: marked detachment, aloof and indifferent
 - **I**: indecisive
 - **L**: lack future goal (no real aspirations)
 - **E**: emotionally cold, uncaring, unfeeling
 - **S**: self absorbed/loner – sensory pleasure is absent (can't appreciate beautiful scenery)

NURSING INTERVENTIONS

- ENCOURAGE SOCIAL INTERACTION (GRADUALLY)
 - Allow the patient to participate in structured activities at their own pace.
 - Offer low-demand social situations, such as art therapy or journaling.
- RESPECT NEED FOR PRIVACY:
 - Avoid forcing interactions; provide space while ensuring safety.
 - Offer one-on-one interactions rather than group therapy.
- PROMOTE EFFECTIVE COMMUNICATION
 - Use simple, clear, and direct communication.
 - Accept their emotional detachment without pushing them to express feelings.
- ENHANCE COPING SKILLS:
 - Teach stress-reduction techniques such as mindfulness.
 - Encourage structured routines to provide a sense of control.
- MONITOR FOR DEPRESSION OR SUICIDAL THOUGHTS
 - Assess for co-occurring mood disorders, as social isolation may lead to depression.
- "SIR SAFE"
 - **S**: Solitary Lifestyle
 - **I**: Indifferent to praise or criticism
 - **R**: Relationships of no interest
 - **S**: Sexual experiences not of interest
 - **A**: Activities not enjoyed
 - **F**: Friends Lacking
 - **E**: Emotionally cold and detached

PSYCHOPHARMACOLOGY

- Antipsychotics
- Antidepressants
- Anxiolytics

SCHIZOTYPAL PERSONALITY DISORDER

- Pervasive pattern of social and interpersonal deficit, cognitive and perceptual distortions
- You are peculiar. The voices in your head tell you what to do, and it does not matter that your behavior seems odd to everyone else because you have a magical power that makes you very special indeed.
 - **P**: Paranoid ideation (believe that strangers cannot be trusted/avoid people they irrationally mistrust)
 - **O**: Odd appearance (disheveled, unkempt, ill-fitting clothes, do not match, stained or dirty)
 - Only has one significant relationship usually with a first degree relative

- **E**: Expression of feeling is often flat or inappropriate
- **M**: Magical thinking, superstitions
- **S**: speech sounds bizarre (use words incorrectly and often provide unsatisfactory answers to questions.
 - Ex: "Sleep is slow, REM's don't flow"

NURSING INTERVENTIONS

- ESTABLISH TRUST AND A THERAPEUTIC RELATIONSHIP
 - Approach the patient with patience and non-judgmental acceptance.
 - Maintain a calm and structured environment to reduce anxiety.
- ADDRESS PARANOIA AND SUSPICIOUSNESS
 - Do not argue about delusional beliefs;
 - Focus on reality-based interventions.
 - Validate feelings without reinforcing magical thinking or odd beliefs.
- ENCOURAGE SOCIAL SKILLS TRAINING
 - Support gradual exposure to social settings in a non-threatening manner.
 - Teach basic conversation techniques to improve interactions.
- HELP WITH REALITY TESTING
 - Use cognitive-behavioral strategies to help differentiate reality from distortions
 - Reinforce logical thinking without dismissing their perspective outright
- REDUCE ANXIETY AND ENHANCE COPING
 - Offer relaxation exercises and structured activities.
 - Provide support for managing daily tasks to reduce stress.
- MONITOR FOR PSYCHOTIC EPISODES
 - Assess for any worsening of symptoms that may indicate progression toward schizophrenia.
- "UFO AIDER"
 - **U**: Unusual perceptions
 - **F**: Friendless except for family
 - **O**: Odd beliefs, thinking, and speech
 - **A**: Affect – inappropriate, constricted
 - **I**: Ideas of reference
 - **D**: Doubts others
 - **E**: Eccentric – appearance/behavior
 - **R**: Reluctant in social situations, anxious

PSYCHOPHARMACOLOGY

- Low dose of atypical antipsychotics

CLUSTER B

ANTISOCIAL PERSONALITY DISORDER

- Characterized by pervasive disregard for and violation of the rights of others
- Everyone else is a tool for your pleasure. They have no rights, and You disregard their laws. You are aggressive when it suits you, you lie when it suits you, and your promises means nothing. You have no remorse.
 - **E**: exploit others without guilt (lacks empathy) egocentric
 - **V**: violate laws and rights of others
 - **I**: impulsive risky behavior
 - **L**: lack insight and almost never see their actions as the cause of their problems
 - **S**: Spouse or child abuse

NURSING INTERVENTIONS

- Limit setting
- Stating unacceptable behavior (don't's)
- Identifying consequences of behavior (effects)
- Identifying expected or desired behavior (do's)
- Confrontation
 - Use to manage manipulative or deceptive behavior
 - Nurse points out problematic behavior
 - Manage emotions of anger or frustration
- "CALLOUS MAN"
 - **C**: Conduct disorder before age 15y; Current age at least 18y
 - **A**: Antisocial acts; Commits acts that are grounds for arrest
 - **L**: Lies frequently
 - **L**: Lacunae – Lacks a superego
 - **O**: Obligations not honored
 - **U**: Unstable – can't plan ahead
 - **S**: Safety of self and others ignored
 - **M**: Money problems – spouse and children are not supported
 - **A**: Aggressive; Assaultive
 - **N**: Not occurring exclusively during schizophrenia or mania

PSYCHOPHARMACOLOGY

- Lithium, anticonvulsant, SSRI for aggression

BORDERLINE PERSONALITY DISORDER

- Pervasive pattern of unstable interpersonal relationships, self-image and affects
- SPLITTING: extreme idealization and devaluation
- You are unstable. Your relationships swing between intensely close and completely meaningless. Your sense of self changes dramatically, and the slightest impulse can send you on a destructive course of spending, over-eating, or drug abuse. Afterwards, you feel empty.
 - **C**: chronic feeling of emptiness (desperately seek relationships to avoid feeling of abandonment but they often drive others away because of their excessive demands)
 - **L**: lack self-control (frequently display temper, constant anger, recurrent physical fights)
 - **I**: impulsive behavior that are self damaging (spending, sex, substance abuse, reckless driving, binge eating)
 - **N**: neurosis-psychosis in between (ideas of reference)
 - **G**: get attention or maintain relationships through self-mutilation, suicidal

NURSING INTERVENTIONS

- PROMOTE SAFETY
 - *Help client to cope and control emotions*
 - Help client to identify their feelings and learn to tolerate them without exaggerated responses such as destruction of property or self-harm
 - *Cognitive restructuring techniques*
 - Thought stopping
 - Technique to alter the process of negative or self-critical thought patterns (shout "STOP")
 - *Decatastrophizing*
 - Techniques that involves learning to assess situations realistically rather than assuming a catastrophe will happen

- *Positive self-talk*
 - Therapeutic approach by reframing (-) thought to (+) thought
- STRUCTURE TIME
 - Making written schedule of activities such as appointments, shopping, reading a newspaper,
 - Making a list of solitary activities to combat boredom
- TEACH SOCIAL SKILLS
 - Realistic expectations of relationships
 - Maintaining personal boundaries because clients often have unrealistic expectations
- USE JOURNALING

PSYCHOPHARMACOLOGY

- SSRI
 - For anger and depression
- ANTICONVULSANT (Carbamazepine-Tegretol)
 - For lack of control and self-harm
- LOW DOSE ANTIPSYCHOTIC
 - For cognitive disturbance

NARCISSISTIC PERSONALITY DISORDER

- Characterized by pervasive pattern of grandiosity, need for admiration
- You are wonderful, and everyone needs to admire you. You think your talents and achievements are out of this world, although others don't find them quite so distinguished. You have little time for the lives of other people, which just aren't that noteworthy
 - **S**: sense of grandiose self-importance (exaggerate achievements and talents, expect to be recognized as superior without commensurate achievements)
 - **E**: excessive admiration to self and require others that she be treated special
 - **L**: lack empathy and arrogant
 - **F**: fantasies of unlimited power, beauty or brilliance

NURSING INTERVENTIONS

- Matter of fact approach
- Set limits on rude or verbally abusive behavior and explain what is expected of him/her
- Teach client any needed self-care skills
- Learn to consider feelings of others
- Gain cooperation with needed treatment
- Therapy: insight-oriented psychotherapy
- "A FAME GAME"
 - **A**: Admiration required in excessive amounts
 - **F**: Fantasizes about unlimited success, brilliance, etc.
 - **A**: Arrogant
 - **M**: Manipulative
 - **E**: Envious of others
 - **G**: Grandiose sense of importance
 - **A**: Associates with special people
 - **M**: Me first attitude
 - **E**: Empathy lacking for others

HISTRIONIC PERSONALITY DISORDER

- Pervasive & excessive emotionality and attention seeking behavior
- You need attention. You behave inappropriately provocative and seductive towards others in order to draw attention to yourself. Your theatrical language makes everything sound a bazillion times more exciting than it really is

- **K**: keep self the center of attention
- **S**: self dramatization and exaggerated expressions of feeling
- **P**: pose seduction or intimacy/considers relationships to be more intimate than they actually are

NURSING INTERVENTIONS

- Teach client social skills
- Provide a factual feedback about behavior
- Nurse gives client feedback about their social interactions with others, manner of dressing and non-verbal behavior
- Feedback should focus on appropriate alternatives not criticism
- “I CRAVE SIN”
 - **I**: Inappropriate behavior – seductive or provocative
 - **C**: Center of attention
 - **R**: Relationships are seen as closer than they really are
 - **A**: Appearance is most important
 - **V**: Vulnerable to others’ suggestions
 - **E**: Emotional expression is exaggerated
 - **S**: Shifting emotions; Shallow
 - **I**: Impressionistic manner of speaking (lacks detail)
 - **N**: Novelty is craved

PSYCHOPHARMACOLOGY

- Antidepressant as needed

CLUSTER C

AVOIDANT PERSONALITY DISORDER

- Characterized by pervasive pattern of social inhibitions with feelings of inadequacy & hypersensitivity to negative evaluation
- You have an extreme fear of the potential, negative opinions of other people and that leads you to avoid social situations altogether. You feel inferior to other people and expect them to reject you. The worst thing that could possibly happen is being embarrassed in front of all of your friends.
 - **F**: fear criticism and rejection
 - **E**: escape intimate relationship
 - **A**: avoidance of social events and any new activities because they may prove embarrassing
 - **R**: reluctant to engage in new activities

NURSING INTERVENTIONS

- Provide support
- Help client to explore (+) self- aspects, (+) responses from others and possible reason for self-criticism
- Cognitive restructuring techniques
- Help client to practice self-affirmation and (+) self talk
- Promote self-esteem
- Desensitization
- “RIDICULE”
 - **R**: Restrained within relationships
 - **I**: Inhibited in interpersonal situations
 - **D**: Disapproval expected at work
 - **I**: Inadequate (view of self)
 - **C**: Criticism is expected in social situations
 - **U**: Unwilling to get involved
 - **L**: Longs for attachment to others
 - **E**: Embarrassment is the feared emotion

PSYCHOPHARMACOLOGY

- Antidepressant (MAOI)
- Anxiolytics

AVOIDANT PERSONALITY DISORDER

- Characterized by pervasive & excessive need for being taken care of.
- You need to be taken care of. You can't make even small decisions without consulting someone else first, and letting them take responsibility for the consequences. If a close relationship ends, you urgently seek another, because how can you take care of yourself alone? You will volunteer to do the most horrible tasks just to show how grateful you are to your close friends for being there for you
 - **M**: marked dependency
 - needs others to assume responsibility for most major areas of life
 - feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for self
 - **A**: abilities are devalued
 - **D**: difficulty making decisions

NURSING INTERVENTIONS

- SUPPORTIVE THERAPY
- FOSTER CLIENT'S SELF RELIANCE AND AUTONOMY
 - Help clients identify their strengths and needs
- TEACH PROBLEM-SOLVING SKILLS
 - Help clients explore problems, serve as a sounding board for discussion of alternatives
- DECISION MAKING SKILLS
 - Provide support and positive feedback for effort in this area
- Cognitive restructuring techniques
- Positive reframing
- Decatastrophizing
- “DARN HURT”
 - **D**: Disagreement is difficult to express
 - **A**: Advice – needs excessive input
 - **R**: Responsibility for major areas delegated to others
 - **N**: Nurturance – seeks excessive degree from others
 - **H**: Helpless when alone
 - **U**: Unrealistically preoccupied with being left to care for self
 - **R**: Relationships are desperately sought (when an established one ends)
 - **T**: Tasks – difficulty initiating projects

OBSESSIVE-COMPULSIVE PERSONALITY DO

- Characterize by pervasive preoccupation with fears with orderliness, cleanliness and perfectionism
- Everything must be ordered and controlled, even if it takes a lot of time and effort. You spend so long taking care of the schedule and making sure that the rules are upheld, that the point of any activity is lost. You won't complete a project until it is exactly perfect, and you prefer not to work with others because they just don't do things in the right way.
 - **C**: consistently late for appointments
 - **R**: rigid to rules (moralistic)
 - **O**: organize and orderly
 - **P**: perfectionist

NURSING INTERVENTIONS

- Assist client to make timely decision and complete work
- Help clients to accept/tolerate less than perfect work or decision made on time
- Cognitive restructuring techniques
- Positive reframing (gain insight of their behavior)

- “LOW MIRTH”
 - **L**: Leisure activity is minimal
 - **O**: Organizational focus
 - **W**: Work and productivity predominate
 - **M**: Miserly spending habits
 - **I**: Inflexible around morals, values, etc
 - **R**: Rigidity and stubbornness
 - **T**: Task completion impaired (by perfectionism)
 - **H**: Hoards items – cannot discard them

PSYCHOPHARMACOLOGY

- TCA (Clomipramine – Anafranil)
- SSRI (Fluoxetine – Prozac)

DIFFERENCE BETWEEN OCD AND OCPD	
OCD	OCPD
Obsessive-compulsive disorder	Obsessive-compulsive personality disorder
Anxiety disorder/Obsessive-compulsive and other related disorders	Personality disorder
Ego dystonic	Ego syntonic
Rituals is done due to obsession and compulsion	Rituals is done to make things done perfect
Rituals reduces anxiety	Perfectionism increases anxiety
Seeks treatment because of the psychological stress	Seeks treatment because of some conflicts it caused in his/her relationship
Allowing the patient to do the ritual	Manage time and meet deadlines
Provide distraction or diversionary activities	Provide support – assure patient that tasks are accepted even less perfect done on time

PASSIVE-AGGRESSIVE PERSONALITY DO

- Characterized by a pervasive pattern of depressive cognitions and behaviors in various contexts.
- It occurs equally in men and women and more often in people with relatives who have major depressive disorders.
- People with depressive personality disorders often seek treatment for their distress and generally have a favorable response to antidepressant medications (APA, 2000).
- PASSIVE BEHAVIOR (VALE)
 - **V**: View future negatively (believe that nothing good ever last)
 - **A**: Ambivalent and indecisive
 - **L**: Low self-confidence despite the bravado
 - **E**: Excessive dependence
- AGGRESSIVE BEHAVIOR (FRAMES)
 - **F**: Fault finder
 - **R**: Report feeling cheated, victimized, exploited misunderstood or unappreciated
 - **A**: Anticipate difficulties and disappointments where none exist
 - **M**: May blame others for their own feelings and misfortune
 - **E**: Easily upset and offended
 - **S**: Shows resistance through procrastination and stubbornness

NURSING INTERVENTIONS

- Help client to identify feelings and express them directly
- Assertiveness Training
- Role play

DEPRESSIVE PERSONALITY DISORDER

- Depressive Personality Disorder (DPD) is not included as a formal diagnosis in the DSM-5.
- It was previously considered in DSM-III-R (Revised version of DSM-III) as a proposed personality disorder, characterized by chronic depressive traits, pessimism, low self-esteem, and self-criticism.
- However, it was removed in DSM-IV due to overlap with other conditions, particularly Persistent Depressive Disorder (Dysthymia) and Major Depressive Disorder (MDD).
- Instead of a separate personality disorder, depressive traits are now considered part of Persistent Depressive Disorder (Dysthymia)
- People with chronic depressive personality features may be diagnosed with Persistent Depressive Disorder (PDD) or a co-occurring personality disorder
 - Ex: Avoidant or Borderline Personality Disorder) if criteria are met
- Characterized by a pervasive pattern of depressive cognitions and behaviors in various contexts.
- Symptoms is the same with major depression but is less severe and has shorter duration
- It occurs equally in men and women and more often in people with relatives who have major depressive disorders.
- People with depressive personality disorders often seek treatment for their distress and generally have a favorable response to antidepressant medications (APA, 2000).

NURSING INTERVENTIONS

- Assess self-harm risk
- Institute suicidal precautions
- Promote self-esteem
- Increase involvement in activities

IMPULSE CONTROL DISORDER

- DSM 5 – Disruptive, Impulse-Control and Conduct Disorders
- A group of disorders that are characterized by problems with self-control of emotions and behaviors.
- Behaviors or actions are considered a threat primarily to others’ safety and/or to societal norms.
- Some examples of these issues include fighting, destroying property, defiance, stealing, lying, and rule breaking.
 - Oppositional defiant disorder
 - Intermittent explosive disorder
 - Conduct disorder
 - Pyromania: intense drive to set fire
 - Kleptomania: intense drive to steal
- A: intense drive
- DM: displacement

PSYCHODYNAMIC

- A cry for help
- Need to release anger
- Need attention & love
- Learned theory

OTHER SPECIFIED DISRUPTIVE DO

MEGALOMANIA

- Intense drive to acquire power

TRICHOTILLOMANIA

- Intense drive to pull one’s hair

DERMATOLOMANIA/SKIN-PICKING DO/EXCORIATION

- Intense drive to pick one’s skin

ONYCOPHAGIA

- Intense drive bite one’s nails

GAMBLING DISORDER

- In the Substance-Related and Addictive Disorders section)

PATHOLOGICAL GAMBLING

- Intense drive to gamble not to win money but because of the aroused and euphoric state that the individual experience during the betting

NURSING INTERVENTIONS

- **U:** Use empathy, not sympathy
- **S:** - Set limit on patient’s unacceptable behavior
- **E:** - Encourage participation in social activities (Diversional therapy)
- **R:** Reduce anxiety
Redirect client’s attention away fromself

EATING DISORDERS

- Eating disorder is characterized by alteration in eating pattern and disturbance in body image that interferes with relationship and occupational functioning.

POTENTIAL SIGNS OF AN EATING DISORDER

- Excessive exercise
- Preoccupation with feeling fat
- Abnormal electrolyte levels
- Intense fear of gaining weight
- Unusually large intake of food
- Anxiety around or avoidance of eating

TYPES OF EATING DISORDERS

- Anorexia Nervosa
- Bumilia Nervosa
- Other related disorders

NURSING PROCESS

ASSESSMENT	
ANOREXIA	BULIMIA
HISTORY TAKING	
<ul style="list-style-type: none"> • Perfectionist with above average intelligence • Goal oriented • Dependable • Seeking approval • Parents describe client as being “good” and “causing no trouble” 	<ul style="list-style-type: none"> • Pleasing to others and avoiding conflicts • Has history of impulsive behavior such as substance abuse and shiplifting • History of anxiety, depression and personality disorders
GENERAL APPEARANCE AND BEHAVIOR	
<ul style="list-style-type: none"> • Appears slow, fatigues and emancipated • Slow to respond to questions • Often wear loose fitting clothes regardless of wether to keep them warm and to hide body weight 	<ul style="list-style-type: none"> • With normal or near normal body weight • Normal physical appearance • Appears open and willing to talk
MOOD AND AFFECT	
<ul style="list-style-type: none"> • Usually sad, anxious and worried • Seldom smile and serious most of the time 	<ul style="list-style-type: none"> • Normal mood and affect • May express intense guilt, shame, and embarrassment when discussing bingeing and purging

THOUGHT PROCESS AND CONTENT	
ANOREXIA	BULIMIA
<ul style="list-style-type: none"> • Have paranoid ideas about their family, friends, and health care professionals 	<ul style="list-style-type: none"> • Preoccupied with dieting, food and food related behavior • Body image disturbance
ROLES AND RELATIONSHIPS	
<ul style="list-style-type: none"> • Withdraw from peers and pay little attention to friendship • Failure at school which is in contrast to previously successful academic achievements 	<ul style="list-style-type: none"> • Feels great shame about their bingeing and purging behaviors • Time spent buying and eating food and purging interfere clients’ role performance

NURSING DIAGNOSIS (BIOLOGICAL DOMAIN)

- Imbalance nutrition: less/more than body requirement
- Planning: Client will establish adequate nutritional eating patterns

NURSING INTERVENTIONS FOR BIOLOGIC DOMAIN

- Establish nutritional eating pattern
 - Set specific time for meals
 - Sit with the client during meals and snacks
 - Observe client ff. meals and snacks (1-2 hours)
 - Weight client daily in uniform clothing and time
 - Provide positive reinforcement
 - Offer liquid protein supplement if unable to complete required calories
- Adhere to treatment program guidelines regarding restrictions
 - No food substitutions
 - No energy drinks
 - Prevent hoarding, hiding, or discarding foods
 - Refrain exercise

NURSING DIAGNOSIS (PSYCHOSOCIAL DOMAIN)

- Anxiety, Disturbed body image, Ineffective coping, Chronic low self-esteem
- Planning:
 - Client will demonstrate reduced anxiety
 - Client will verbalize acceptance of body image with stable body weight
 - Client will demonstrate non-food related coping mechanism
 - Increase self-esteem

NURSING INTERVENTION FOR PSYCHOSOCIAL DOMAIN

- Help client identify emotions and develop a non-food related coping strategies
 - Help client identify and express feeling.
 - Alexithymia difficulty expressing feeling
 - Self-monitoring using a journal to raise clients' awareness about behavior and help them regain a sense of control
 - Manage emotions through relaxation and distraction techniques
- Help client deal with body image issues
 - Recognize benefits of a normal or near normal body weight
 - Identify personal strength, interest and talents to broadened clients' perception of themselves
 - Increased self-esteem
- Provide health education
 - Client:
 - Basic nutritional needs
 - Harmful effects of restrictive dieting and purging
 - Benefits of normal body weight.
 - Acceptance of healthy body images

- Family and Friends
 - Provide emotional support
 - Become informed about eating disorders
 - Express concern about client's health
 - Avoid talking about weight, food intake and calories
 - Encourage client to seek professional help.

EVALUATION

- Demonstrate alternative methods of dealing with stress
- Demonstrate more satisfying relationships
- Develop a positive self-concept
- Find new ways of effective coping
- Acceptance of a healthy body image
- Maintain a normal body weight

TREATMENT

ANOREXIA	BULIMIA
1. MEDICAL MANAGEMENT <ul style="list-style-type: none"> • focuses on weight restoration, nutritional rehabilitation rehydration and correction of electrolyte imbalances. 2. PSYCHOPHARMACOLOGY <ul style="list-style-type: none"> • Cyproheptadine (Periactin) • Amitriptyline (Elavil) • Olanzapine (Zyprexa) • Flouxetine (Prozac) 3. PSYCHOTHERAPY <ul style="list-style-type: none"> • Family therapy • Individual therapy 	1. COGNITIVE-BEHAVIORAL THERAPY <ul style="list-style-type: none"> • strategies designed to change the client's thinking (cognition) and action (behavior) 2. PSYCHOPHARMACOLOGY <ul style="list-style-type: none"> • TCA - Desipramine (Norpramin) Imipramine (Tofranil) • SSRI - Fluoxetine (Prozac) Sertraline (Zoloft)

ANOREXIA NERVOSA

- Anorexia is a life-threatening eating disorder characterized by body weight that is 85% or less of that expected for their age and height

SIGNS AND SYMPTOMS

- **A:** Amenorrhea for at least 3 consecutive cycles
- **N:** No organic factor accounts for weight loss
- **O:** Obviously thin but feels fat
- **R:** Refusal to maintain body weight
- **E:** Emotional expression is restrained
- **X:** Symptoms of depression and social withdrawal are present
- **I:** Intense fear of gaining weight
- **A:** Always think of food and food related activities

PREOCCUPATION WITH FOOD

- Preoccupied with food-related activities
 - Grocery shopping
 - Collecting recipes or cookbooks
 - Counting calories
 - Creating fat-free meals
 - Cooking family meals
- Unusual ritualistic food behaviors
 - Refusing to eat around others
 - Cutting food into small pieces
 - Not allowing food to touch their lips

SUBTYPES OF ANOREXIA NERVOSA

- RESTRICTIVE SUBTYPE
 - Attain weight loss through fasting, dieting and excessive exercise
- BINGE-PURGING SUBTYPE
 - Attain weight loss through induce vomiting, use of laxatives, diuretics and enema

BULIMIA NERVOSA

- Bulimia is an eating disorder characterized by recurrent episodes of binge eating at least twice a week for 3 months

SIGNS AND SYMPTOMS

- **B:** Binge eating
- **U:** Under strict dieting or vigorous exercise
- **L:** Lack control over eating
- **I:** Induced vomiting
- **M:** Moth-eaten appearance teeth
- **I:** Increase and persistent concern of body
- **A:** Abuse of diuretics and laxatives

ANOREXIA NERVOSA	BULIMIA NERVOSA
Ego syntonic	Ego dystonic
Do not recognize the eating behavior as a problem	Recognize her altered eating pattern
Early age of onset: 16-17 year old or younger	Later age of onset: 18-19 year old or older
Below normal body weight	Near normal or normal body weight
Less worried	Worried of the opinion of others
Starve	Binge then purge
Amenorrhea	Absence of amenorrhea

MEDICAL COMPLICATON R/T WEIGHT LOSS

CARDIAC

- Bradycardia, hypotension, loss of cardiac muscle, cardiac arrhythmias

DERMATOLOGIC

- Dry, cracking skin due to dehydration, lanugo, edema and acrocyanosis (blue hands and feet)

HEMATOLOGIC

- Leukopenia, anemia, thrombocytopenia, hypercholesterolemia, and hypercarotenemia

METABOLIC

- Hypothyroidism (lack of energy, weakness, intolerance to cold, and bradycardia)
- Hypoglycemia

MUSCULOSKELETAL

- Loss of muscle mass, loss of fat, osteoporosis, and pathologic features

GASTROINTESTINAL

- Delayed gastric emptying, bloating, constipation, abdominal pain, gas, and diarrhea

REPRODUCTIVE

- Amenorrhea

NEUROPSYCHIATRIC

- sleep disturbances, depression, mild organic mental symptoms, and sleep disturbances

OTHERS

- Electrolyte imbalances
- Elevated BUN
- Hypertrophy of salivary gland

MEDICAL COMPLICATION R/T PURGING

DENTAL

- Erosion of dental enamel (perimyolysis), particularly front teeth

GASTROINTESTINAL

- Salivary gland and pancreas inflammation and enlargement, esophageal and gastric erosion or rupture, dysfunctional bowel, and superior mesenteric artery syndrome

METABOLIC

- Electrolyte abnormalities
 - Hypokalemia
 - Metabolic alkalosis
 - Hypochloremic alkalosis
 - Hypomagnesemia
 - Elevated BUN

NEUROPSYCHIATRIC

- Seizures (r/t large fluids shifts and electrolyte disturbances), mild neuropathy, fatigue, weakness, and mild organic mental symptoms

BINGE EATING DISORDERS

- BED is a severe, life-threatening but treatable eating disorder characterized by recurrent episodes of eating large quantities of food often very quickly and to the point of discomfort.
- BED is one of the newest eating disorders formally recognized in the DSM-5
- It is the most common eating disorder in the United States.

RUMINATION DISORDERS

- Rumination syndrome is a condition in which people repeatedly and unintentionally spit up (regurgitate) undigested or partially digested food from the stomach, re-chew it, and then either re-swallow it or spit it out
- It can occur in children, teens and adults. Rumination syndrome is more likely to occur in people with anxiety, depression or other psychiatric disorders.

AVOIDANT RESTRICTIVE EATING DISORDER

- Also known as Avoidant Restrictive Food Intake Disorder (ARFID) and is previously known as feeding disorder
- It is a serious mental health condition that causes the individual to restrict food intake by volume and/or variety
- This avoidance may be based on appearance, smell, taste, texture, brand, presentation, fear of adverse consequences, lack of interest in food, or a past negative experience with the food, to a point that may lead to nutritional deficiencies, failure to thrive, or other negative health outcomes
- The fixation is not caused by a concern for body appearance or in an attempt to lose weight.

PICA

- Characterized by ingestion of non-nutritive substance or objects.
- Includes sand, paper, crayons, leaves, etc.
- Result to malnutrition
- Complications: intestinal obstruction and infections, lead poisoning
 - ORTHOREXIA: involves an unhealthy obsession with healthy eating, mostly revolves around food quality, not quantity
 - BIGOREXIA: when someone, usually a man, worries that their body is too small and weak and tries to eat only foods that they believe will build bigger muscles
 - DIABULIMIA: eating disorder in a person with type I diabetes, wherein the person purposefully restricts insulin in order to lose weight.

OTHER SPECIFIED FEEDING/EATING DO (OSFED)

- OSFED was previously known as Eating Disorder Not Otherwise Specified (EDNOS)
- OSFED is a serious, life-threatening but treatable eating disorder.
- The category was developed to encompass those individuals who did not meet strict diagnostic criteria for anorexia nervosa or bulimia nervosa but still had a significant eating disorder.