Chapter 38 Substance Abuse and Eating Disorders

Substance Abuse

Introduction
° Variety of reasons for substance use
  o Depressed mood
  o Pain
  o Fear
  o Anxiety
  o Boredom
° Signs of problems when substance are abused:
  o Interferes with ability to function at work/home
  o Puts anyone in danger
  o Continues despite negative consequences

Delayed Diagnosis
° Denial
° Many do not seek treatment
° Attitude of health professionals related to substance abuse
  o Stigma against substance abuse
  o Hesitant to ask about substance use
° DSM-IV-TR diagnostic criteria - substance abuse [corresponds to Box 38-1]
° Alcohol
  o Effect of individual genetic makeup on resistance to alcoholism
    [corresponds to Box 38-2]
  o Blood alcohol concentration [corresponds to Table 38-1]
  o Cognitive symptoms
  o Comparison of commonly abused CNS depressants and stimulants
    [corresponds to Table 38-2]
  o Long-term physical effects [corresponds to Figure 28-3]
  o Manifestations of withdrawal:
    • Elevated VS, anxiety, tremors, diaphoresis, slurred speech, GI disturbances, ataxia, nystagmus, disorientation
    • Severest symptoms: hallucinations, seizures, and death
    • After years of alcoholism, person must drink almost constantly to avoid withdrawal symptoms
    • Alcohol withdrawal accompanied by seizures can be fatal, is medical emergency.
  o Treatment of withdrawal: benzodiazepine drugs for 4 days
  o Term: binge, Wernicke’s syndrome, Korsakoff’s syndrome, confabulation, myopathy
  o Long-term effects of alcohol abuse [corresponds to Figure 38-3]
    • Pancreatitis
    • Alcoholic hepatitis
    • Cirrhosis
    • Hepatic encephalopathy
• Cardiomyopathy
• Hemorrhagic stroke
• Hypertension
• Blackouts

Other CNS Depressants
  ° Patterns of substance use
    o Abstinence followed by relapse very common
  ° Effects of opiates and other CNS depressants
    o Physical dependence; withdrawal symptoms like alcohol
    o Manifestations: decreased libido, impotence, menstrual irregularities, infertility; pinpoint pupils; depressed respirations; seizures; coma
  ° Sedative, hypnotic, or anxiolytic-related disorders
    o Benzodiazepine, barbiturates (sleeping meds, antianxiety meds)
    o Overdose possible – additive effects of CNS depressants
    o Term: polysubstance abuse

CNS Stimulants - Amphetamines and Cocaine
  ° Correct use
    o Amphetamines for attention deficit disorders, occasional use for daytime sleepiness
    o Cocaine for vasoconstriction for surgery of mucous membranes
  ° Cocaine causes immediate euphoria
  ° Manifestations:
    o Intoxication: hyperactivity, talkativeness, grandiosity, anger, aggression, impaired judgment, possible hallucinations
    o Physical effects: elevated BP, nausea, chest pain, dilated pupils, confusion, cardiac dysrhythmias
    o Withdrawal symptoms: lethargy, depression; uncomfortable but not life threatening, lasting several days
  ° Treatment: for opiate overdose, naloxone hydrochloride (Narcan)

Hallucinogens [corresponds to Table 38-3]
  ° Common drugs LSD, mescaline, and phencyclidine (PCP)
  ° Hallucinogens plus stimulants: “designer” drugs (MDMA or Ecstasy)
  ° Effects unpredictable
  ° Manifestations: possible frightening psychotic episodes (especially prolonged in clients with schizophrenia); flashbacks; no withdrawal

Inhalants [corresponds to Table 38-3]
  ° Hydrocarbons (solvents, glue, aerosols) produce euphoria, loss of inhibition, altered sensations, hallucinations
    o Manifestations of overdose: cardiac or respiratory depression, renal injury, cardiac dysrhythmias, death
  ° Nitrites (amyl nitrite, butyl nitrite, nitrous oxide) cause prolonged penile erection, possible euphoria, perceptual alterations
    o Manifestations: panic, nausea, confusion, headache, hypotension

Cannabis (marijuana) [corresponds to Table 38-3]
  ° Chemical delta-9-tetrahydrocannabinol (THC) produced psychoactive effects
Manifestations: euphoria, sense of serenity, sensory perceptual changes
Has therapeutic use for anorexia, nausea, and vomiting

Caffeine and Nicotine [corresponds to Table 38-3]
Caffeine most commonly used stimulant, performance enhancer, prolongs work time, improve mental alertness, elevates mood [corresponds to Figure 38-5]
- Manifestations of overdose: increased anxiety, insomnia, irritability, diuresis, tremors, tachycardia
- Frequency of use determines tolerance and withdrawal
- Manifestations of withdrawal: headache, fatigue, irritability, nervousness
Nicotine most common substance dependence in US, produces increased performance, decreased appetite, reduced anxiety, increased alertness initially, followed by relaxation
- Manifestations associated with nicotine and substances in tobacco: cancer of the lungs, oral cavity, esophagus, pancreas, and prostate; COPD and emphysema; cardiovascular disease; accidents
- Manifestations among people exposed to second-hand smoke: respiratory diseases, asthma, COPD
- Manifestations of withdrawal: irritability, restlessness, drowsiness, anxiety, craving, transient increase in appetite
- Treatment: nicotine patches or nicotine gum to relieve symptoms

Collaborative Care
Substance dependency is chronic, progressive medical illness
- Characterized by remissions and relapses
- Fatal if untreated
Goal of substance dependency treatment:
- Abstain from substance use
- Develop effective coping mechanisms to replace substances as way to solve problems
Acute phase of treatment
- Focus on physiological safety; manage symptoms, prevent seizures, stabilize VS, minimize effects of CNS stimulation
- Detoxification begins in the acute phase
- Medications (benzodiazepine and vitamin B₁ for alcohol; naltrexone (ReVia) for opiate overdose)
- Clients who use drugs or alcohol regularly are at risk for withdrawal.
- Clients who have used drugs or alcohol recently are at risk for additive effects with prescribed drugs.
- Client with tolerance to CNS depressants may require more anesthesia than average person.
- Term: cross-tolerance, detoxification
Rehabilitation phase of treatment – supportive treatment; continues indefinitely
- Medications to prevent relapse
  - Disulfiram (Antabuse) and naltrexone (ReVia) for alcohol
  - Methadone for heroin
• Clonidine (Catapres) as antihypertensive for opium drugs
  o Cognitive-behavior therapy helps client:
    • Stay sober
    • Develop new coping skills
    • Make a plan for relapse prevention
    • Live life fully, accepting responsibilities, joys, and frustrations
  o Support groups [  
    • Alcoholics Anonymous [corresponds to Box 38-3], Al-Anon, Ala-
      Teen
  ° Dual diagnosis
    o Clients who have both a substance abuse disorder and a serious mental
      disorder

Substance Dependency among Nurses
  ° Manifestations suggesting drug use:
    o Mood changes, irritability, forgetfulness, isolation, inappropriate behavior
    o Altered work performance: multiple medication errors, missed deadlines, 
      sloppy charting, absenteeism, wasting of narcotics
    o Red eyes, ataxia, restlessness, anxiety, slurred speech, hyperactivity, 
      tremors, runny nose, alcohol on breath or heavy use of mouth
      fresheners
  ° Term: impaired nursing
  ° Treatment: possible nurse-monitoring or treatment program; state board of 
    nursing will be notified
  ° Client safety is primary responsibility.

Nursing care for clients with substance abuse:
  ° Assess clients for substance abuse [corresponds to Boxes 38-4 and 38-5]
  ° Encourage positive coping mechanisms
  ° Help clients identify triggers for substance use and strategies for avoiding 
    them.
  ° Note client progress and give positive reinforcement for insights.
  ° Establish atmosphere of trust.
  ° Encourage clients to stop blaming others and to take responsibility for own 
    life.

Eating Disorders
  ° Nurses must start by being aware of their own attitudes about food and 
    body size.
    o Assess your own eating habits
    o How do you feel when you have a big holiday meal with your family?
    o What do you eat when you are under stress?
  ° Reasons to check your attitude regarding eating disorders:
    o Attitude brought to work can affect client care:
      • Ability to care for client objectively
      • Ability to care for client professionally
      • Ability to empathize with client’s needs

Anorexia Nervosa
  ° Diagnostic criteria and manifestations:
- Intense fear of weight gain even when emaciated
- Disturbance in the way one’s body weight or shape is perceived
- Refusal to keep body weight at or above 85% of norm
- Difficulty trusting others
- 90% of individuals who have anorexia nervosa are female.
- Multi-system effects [corresponds to Figure 38-7]
- Term: purging

**Bulimia Nervosa**
- **Diagnostic criteria and manifestations:**
  - Episodes of binge eating with or without purging, commonly at least twice a week for at least several months
  - Body shape and weight are the most important factors in determining self-esteem.
  - Tend to be normal weight or slightly overweight
  - Depression, anxiety, disgust about body and physical size
  - Difficulty trusting others

**Binge Eating Disorder**
- **Diagnostic criteria and manifestations:**
  - Episodes of binge eating without the compensatory behaviors used in bulimia
  - Episodes at least twice a week for 6 months
  - Tend to be overweight
  - Difficulty trusting others

**Males with Eating Disorders**
- **Diagnostic criteria same as for women**
  - Difficulty trusting others

**Causes of Eating Disorders**
- Biological factors – genetic influence, reduced serotonin levels
- Environmental factors – association with sexual abuse, behavior problems
- Control issues
  - Often have controlling parent
  - Difficult challenge for nurses [corresponds to Box 38-6]
  - Eating patterns
  - Terms: catastrophize, dichotomous thinking
- Cognitive distortions: attitudes and coping mechanisms are seen as part of self so behavior is difficult to change.

**Collaborative Care**
- Medications – often antidepressants helpful
- Cognitive behavioral therapy – often successful with binge eating/purging

**Obesity**
- Risks of overweight and obesity may soon match cigarette smoking in being cause of disease.
- Causes: improper nutrition and inadequate exercise
- Metabolic syndrome, a group of major risk factors in overweight/obese people:
  - Abdominal obesity
- Abnormal serum lipids (high level of LDLs, low level of HDLs)
- Elevated BP
- Insulin resistance
- Increased clotting of the blood

Collaborative care:
- Set realistic goals.
- Plan a change in eating patterns.
- Develop support system.
- Structure meal plans.
- Record food intake.
- Encourage moderate physical activity on most if not all days.

Nursing Care for Clients with Eating Disorders:
- Help client focus on health lifestyle.
- Encourage openness; discourage secretive behavior.
- Encourage clients to seek insights into their behaviors.
- Support positive coping mechanisms.
- Provide a role model and acknowledge the difficulty of the challenge.
- Support hope.

Nursing Process Care Plan: Client with Obesity

Critical Thinking Care Map: Caring for a Client with Substance Dependency