Miscellaneous Disorders Part Two Worksheet:

Miscellaneous Disorders	Answer	Matching Options
Pica		A. This involves the repeated regurgitation of food that may be re-chewed, re-swallowed, or spit out. This regurgitation typically occurs soon after eating and is not due to an associated gastrointestinal or other medical condition.
Rumination Syndrome		B. Characterized by restricted food intake leading to significantly low body weight, an intense fear of gaining weight, and a distorted body image. Individuals may severely restrict the amount of food they eat and view themselves as overweight, even when they are underweight.
Avoidant/restrictive Food Intake Disorder		C. Characterized by excessive nighttime food consumption, which is not simply a nocturnal eating habit, but rather involves consuming more than 25% of the daily caloric intake after the evening meal and often awakening from sleep to eat.
Anorexia Nervosa		D. A disorder marked by a lack of interest in eating or food, or avoidance based on the sensory characteristics of food, leading to significant nutritional deficiency and/or dependence on enteral feeding or oral supplements.
Binge Eating Disorder		E. This disorder is characterized by frequent episodes of eating large quantities of food (often very quickly and to the point of discomfort); a feeling of a loss of control during the binge; experiencing shame, distress or guilt afterwards; and not regularly using unhealthy compensatory measures (e.g., purging) to counter the binge eating.
Bulimia Nervosa		F. A psychological condition characterized by a significant discomfort or distress due to a discrepancy between one's experienced or expressed gender and one's assigned gender at birth. Symptoms often include persistent feelings of identification with the opposite gender, strong desires to be treated as the experienced gender, and a profound sense of unease with one’s primary and secondary sex characteristics.
Purging Disorder		G. In this disorder, individuals engage in purging behaviors, such as vomiting, excessive use of laxatives, or diuretics, to influence weight or shape in the absence of binge eating episodes.
Diabulimia		H. An obsession with eating foods that one considers healthy. They will be fixated on defining and maintaining the perfect diet, and this fixation on proper nutrition can interfere with their daily life.
Night Eating Syndrome		I. A condition characterized by the persistent eating of non-nutritive, non-food substances for at least one month, such as dirt, clay, or hair, which is inappropriate to the developmental level of the individual.
Orthorexia Nervosa		J. This term is often used to describe the deliberate manipulation of insulin by individuals with type 1 diabetes to control weight. Underuse of insulin leads to poor glucose control and body weight loss but increases the risk of severe diabetes-related complications.
Gender Dysphoria		K. A behavioral syndrome marked by an abnormality in motor activity and responsiveness. It can manifest as either a significant reduction in voluntary movement or excessive and peculiar motor activity. Common signs include mutism, stupor, maintaining a rigid posture, resistance to movement, and mimicking another’s speech or movements.
Medication-induced Movement Disorders		L. A collection of psychiatric and somatic symptoms that are considered to be a recognizable disease only within a specific society or culture. These disorders often manifest as combinations of psychological and physical symptoms linked to cultural beliefs and practices. Symptoms and expressions of the disorder vary widely, being heavily influenced by the local cultural context.

Catatonia			M. A group of disorders caused by the adverse effects, primarily from psychiatric drugs, that lead to involuntary movements. Symptoms can include tremors, muscle rigidity, restless movements, involuntary facial movements, and difficulty with voluntary movements, which typically occur after prolonged use of neuroleptic medications.
Culture-bound Syndrome			N. A condition marked by cycles of binge eating followed by behaviors such as self-induced vomiting to prevent weight gain. These episodes are accompanied by feelings of loss of control, and self-esteem is heavily influenced by perceptions of body shape and weight.

Case Study Exercises

Case Study 1

Emily is a 32-year-old software developer who has been using laxatives excessively and engaging in self-induced vomiting after meals for several months. Despite a normal weight, she is preoccupied with her body image and fears gaining weight. She often feels a loss of control during eating and is overwhelmed by guilt after eating meals, regardless of the portion size. Emily's behaviors are secretive, and she feels embarrassed about her habits. Her electrolyte imbalances have led to multiple hospital visits.

This is an example of which disorder: _____

What is your treatment plan: _____

Case Study 2

Mark, a 19-year-old college student, has been avoiding multiple food groups for the past two years. He expresses a severe aversion to textures like those of fruits and creamy foods, which he says make him feel nauseous. His restrictive eating habits have led to significant weight loss and nutritional deficiencies, requiring him to take various supplements. Mark's diet is limited to very specific foods, which he believes won't trigger his aversion, severely impacting his social life and academic performance.

This is an example of which disorder: _____

What is your treatment plan: _____

Case Study 3

Linda, a 28-year-old nurse, is diagnosed with type 1 diabetes but has been manipulating her insulin doses for the past year in an effort to lose weight. She frequently skips insulin after meals, leading to periods of high blood sugar levels followed by significant drops. Her weight has fluctuated, and she has experienced several episodes of diabetic ketoacidosis. Linda's medical team is concerned about the long-term complications of diabetes management, including potential for renal damage and neuropathy.

This is an example of which disorder: _____

What is your treatment plan: _____

Case Study 4

Sarah, a 45-year-old graphic designer, has been consuming large amounts of food during the night for several months. She reports that her eating episodes disrupt her sleep, and she feels unable to control these behaviors. More than half of her daily calorie intake occurs after her evening meal. Despite feeling full, Sarah is compelled to eat during these nocturnal awakenings, which leaves her feeling depressed and fatigued during the day.

This is an example of which disorder: _____

What is your treatment plan: _____

Case Study 5

John, a 24-year-old fitness instructor, has developed a fixation on eating only what he considers "pure" foods, avoiding anything processed or containing artificial ingredients. His diet has become increasingly restricted, focusing on small groups of foods he deems healthy. John spends several hours planning his meals and researching food sources, which has started to interfere with his professional responsibilities and social interactions. His obsession with healthy eating has also led to significant weight loss and nutritional deficiencies.

This is an example of which disorder: _____

What is your treatment plan: _____

Case Study 6

Lisa, a 16-year-old high school student, repeatedly eats inedible objects such as paper, soap, and cloth. This behavior has persisted for more than a year and is not appropriate for her developmental level. Her parents initially thought she was just experimenting, but the continued behavior has led to several gastrointestinal issues. Lisa hides these activities from her family and friends, who have noticed her unusual eating habits and expressed concern.

This is an example of which disorder: _____

What is your treatment plan: _____

Case Study 7

Anna, a 22-year-old university student, suffers from episodes where she consumes excessively large amounts of food in one sitting, at least once a week. These binges are often planned and involve foods she otherwise avoids. Afterward, Anna feels intense shame and distress about her

lack of control, which affects her self-esteem deeply. She has not engaged in compensatory behaviors such as purging, but her weight has been increasing steadily, adding to her distress.

This is an example of which disorder: _____

What is your treatment plan: _____

Case Study 8

Roger, a 30-year-old journalist, has been regurgitating his meals soon after eating. He re-chews and then either re-swallows or discards the food. This occurs almost daily, and Roger has been experiencing weight loss and dental issues as a result. He feels embarrassed by his condition and avoids eating in public. His social life has suffered, and he feels isolated because of his eating behaviors.

This is an example of which disorder: _____

What is your treatment plan: _____

Case Study 9

Paula, a 25-year-old dance instructor, restricts her calorie intake severely, fearing any weight gain could end her career. Her perception of her body size and shape is distorted, viewing herself as overweight when, in fact, she is significantly underweight. She is obsessed with maintaining a calorie deficit, often exercising for hours to ensure this. Her physical health has declined, showing signs of amenorrhea and osteopenia.

This is an example of which disorder: _____

What is your treatment plan: _____

Case Study 10

Karen, a 29-year-old marketing specialist, has developed a habit of forcing herself to vomit several times a week, even after eating only small meals. She does not overeat before engaging in this behavior and describes it as a compulsion driven by an intense fear of gaining weight and a need to control her figure. Despite her weight being within a normal range, Karen is deeply anxious about her appearance. The frequent episodes of vomiting have led to dental erosion and a persistent sore throat. She has kept these habits hidden from friends and family out of embarrassment. Karen decided to seek help after realizing the negative impact on her health and acknowledging that her methods of controlling her body weight were harmful and ineffective.

This is an example of which disorder: _____

What is your treatment plan: _____

Case Study 11

A 24-year-old individual presents to the clinic expressing a profound and persistent unease with their physical appearance and sex characteristics. Since adolescence, they have felt a strong inclination towards the opposite sex, frequently dressing in clothes typical of that gender and requesting friends and family to refer to them by a different name. They report significant distress in social situations and a persistent desire to undergo medical procedures to alter their body. Despite understanding societal norms, the individual feels trapped in a body that does not reflect their true identity, leading to anxiety and depression.

This is an example of which disorder: _____

What is your treatment plan: _____

Case Study 12

A 34-year-old woman has been brought to the emergency room by her family after they observed her exhibiting unusual behaviors. She has not spoken in days, occasionally erupting into fits of uncontrollable mimicry of the voices around her. She maintains unusual postures for hours and shows little reaction to external stimuli, including attempts at communication. Her family is extremely concerned, as these symptoms appeared suddenly and have disrupted her ability to function independently.

This is an example of which disorder: _____

What is your treatment plan: _____

Case Study 13

A 28-year-old patient presents with symptoms that are perplexing to medical professionals unfamiliar with his cultural background. He reports episodes of intense fear that he attributes to the spirit of an ancestor manifesting within him, as per the beliefs of his community. During these episodes, he exhibits convulsions and periods of trance-like states where he speaks in a language that he does not know when in his normal state. Local healers have been unable to alleviate his symptoms, which have progressively isolated him from his community.

This is an example of which disorder: _____

What is your treatment plan: _____

Case Study 14

A 60-year-old man, who has been treated with antipsychotic medication for schizophrenia for several years, has developed peculiar side effects. His family notes that he has been exhibiting uncontrollable jerky movements, especially around his mouth and feet. He reports feeling unable to remain still, frequently pacing around the room. These symptoms seem to worsen with higher doses of his medication. His psychiatrist notes these movements were not present before the medication regimen started.

This is an example of which disorder: _____

What is your treatment plan: _____

Answers

Matching
I
A
D
B
E
N
G
J
C
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F
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K
L

Case Study 1: Bulimia Nervosa

Emily's symptoms include binge eating followed by purging behaviors such as self-induced vomiting and the use of laxatives, alongside a preoccupation with body image and fear of weight gain, which are characteristic of bulimia nervosa.

- **Pharmacological**: Antidepressants, particularly selective serotonin reuptake inhibitors (SSRIs) like fluoxetine, are commonly prescribed to reduce binge-purge cycles.
- **Nonpharmacological**: Cognitive-behavioral therapy (CBT) is the first-line psychological treatment. It helps address dysfunctional thoughts related to eating, body shape, and weight. Nutritional counseling and interpersonal psychotherapy are also beneficial.

Case Study 2: Avoidant/Restrictive Food Intake Disorder

Mark's severe aversion to certain textures and restrictive eating leading to nutritional deficiencies are key features of Avoidant/Restrictive Food Intake Disorder (ARFID), which focuses on the sensory characteristics of food and lack of interest in eating.

- **Pharmacological**: There are no FDA-approved medications specifically for ARFID, but medications might be used to treat comorbid conditions such as anxiety or depression if present.
- **Nonpharmacological**: Nutritional counseling to ensure dietary needs are met and exposure therapy to gradually introduce new foods in a structured and supportive environment.

Case Study 3: Diabulimia

Linda is manipulating her insulin to control weight, a behavior seen in individuals with type 1 diabetes who are attempting to lose weight through poor management of their insulin, known colloquially as diabulimia.

- **Pharmacological**: Insulin therapy must be managed and adjusted correctly, possibly in combination with medications for comorbid conditions such as depression or anxiety.
- **Nonpharmacological**: Psychoeducation about diabetes management and the consequences of insulin manipulation, CBT for addressing underlying emotional and behavioral issues, and potentially inpatient treatment programs specializing in diabetes and eating disorders.

Case Study 4: Night Eating Syndrome

Sarah's pattern of consuming a significant portion of her daily calories during nighttime, along with disrupted sleep due to eating, aligns with night eating syndrome.

- **Pharmacological**: SSRIs have been shown to be effective. Melatonin might also be considered to help regulate sleep patterns.
- **Nonpharmacological**: Cognitive-behavioral therapy focusing on altering the behavioral pattern of night eating and addressing the underlying causes, along with sleep hygiene practices.

Case Study 5: Orthorexia Nervosa

John's obsession with consuming only "pure" or "healthy" foods and the significant impact this has on his life are indicative of orthorexia nervosa, where the focus is on eating foods that are considered healthy to an extreme extent.

- **Pharmacological**: There are no specific medications for orthorexia, but antidepressants may be used if there are comorbid conditions like anxiety or depression.
- **Nonpharmacological**: Psychotherapy, particularly CBT, to address obsessive thoughts about healthy eating and to broaden dietary variety. Nutritional counseling is essential to restore balanced eating habits.

Case Study 6: Pica

Lisa's ingestion of non-food items such as paper and soap over an extended period, which is developmentally inappropriate, fits the definition of pica, a disorder characterized by eating things that are not typically considered food.

- **Pharmacological:** Nutritional deficiencies, particularly in iron and zinc, should be addressed with appropriate supplements once identified. For patients with intellectual disabilities, behavioral and aversion therapies could be effective, and strategies like differential reinforcement can be utilized to redirect pica behaviors toward healthier activities. Although no medications are specifically approved to treat pica, anecdotal evidence suggests that antipsychotics such as risperidone (Risperdal) or olanzapine (Zyprexa) may help reduce pica behaviors. However, these medications come with side effects, including constipation, that could exacerbate the condition. Beyond removing the offending substances from the individual's surroundings, it's essential to understand and address the cultural traditions and beliefs that may contribute to pica behavior.
- **Non-pharmacological:** Primary prevention plays a crucial role in identifying individuals at risk of pica, such as children living in old homes with lead-based paint and pregnant women. Screening these groups can help detect the condition early. To minimize exposure to the non-food substances that individuals with pica crave, measures like reducing access to these substances or providing safe substitutes with similar textures should be employed. Behavioral interventions, including aversion therapy and reinforcement techniques to modify behavior. Environmental modification to reduce access to non-food items is also important.

Case Study 7: Binge Eating Disorder

Anna's episodes of consuming large amounts of food without subsequent compensatory behaviors (like purging), feelings of loss of control during these episodes, and emotional distress afterwards are classic signs of binge eating disorder.

- **Pharmacological:** Lisdexamfetamine dimesylate (Vyvanse), commonly used to treat attention-deficit/hyperactivity disorder (ADHD), is also the first medication approved by the U.S. Food and Drug Administration to specifically target moderate to severe binge-eating disorder in adults. As a stimulant, it carries the potential for habit formation and misuse. Users often report side effects like dry mouth and sleep disturbances, while more serious side effects are also possible. Other types of medications that might help alleviate symptoms of binge-eating disorder include certain anticonvulsants, like topiramate (Topamax), and antidepressants, such as fluoxetine (Prozac), which can offer symptom relief through their mood-stabilizing and appetite-suppressing effects.
- **Non-pharmacological:** Cognitive behavioral therapy (CBT) may assist in managing triggers for binge eating, such as negative body image or depressive moods. It can also enhance your control overeating habits and encourage healthier patterns. Enhanced CBT (CBT-E), a specialized form of CBT, is specifically tailored to treat eating disorders. Integrative cognitive-affective therapy (ICAT) is another therapeutic approach that can benefit adults struggling with binge-eating disorder. It focuses on modifying the emotional responses and behaviors that precipitate binge eating. Dialectical behavior therapy (DBT) emphasizes learning behavioral skills that help with stress management, emotional regulation, and interpersonal relationships. By improving these skills, individuals can mitigate the impulses that lead to binge eating.

Case Study 8: Rumination Syndrome

Roger's repeated regurgitation of food, which is then re-chewed, re-swallowed, or spit out, occurring soon after eating and not due to a medical condition, is characteristic of rumination syndrome.

- **Pharmacological:** Typically, no medications are prescribed as first-line treatment. Individuals with rumination syndrome might find relief through medication that helps relax the stomach following meals. In cases where frequent regurgitation leads to damage of the esophagus, proton pump inhibitors like esomeprazole (Nexium) or omeprazole (Prilosec) may be recommended. These medications work by protecting the esophageal lining, providing a safeguard while behavior therapy helps to reduce the frequency and intensity of the regurgitation.
- **Non-pharmacological:** Behavioral treatments, such as diaphragmatic breathing and habit reversal training, are effective. Psychological counseling may also help in managing stress, which can contribute to the condition.

Case Study 9: Anorexia Nervosa

Paula's severe restriction of calorie intake, fear of gaining weight, distorted body image, and significant health issues such as amenorrhea and osteopenia align with anorexia nervosa.

- **Pharmacological:** No medications specifically treat anorexia, but drugs may be used to manage symptoms of anxiety and depression, or to address specific health issues arising from malnutrition. Atypical antipsychotics, such as olanzapine (Zyprexa), quetiapine (Seroquel), and risperidone (Risperdal), have demonstrated some effectiveness in treating anorexia nervosa. Their benefits are believed to stem from their ability to alleviate depression, anxiety, and the core psychopathology associated with eating disorders.
- **Non-pharmacological:** Many forms of individual and group psychotherapies can be used to treat anorexia. Family-based therapy (FBT) is particularly effective for adolescents. Nutritional rehabilitation to restore weight and eating habits, along with individual psychotherapy, is crucial.

Case Study 10: Purging Disorder

Karen, a 29-year-old marketing specialist, exhibits symptoms consistent with purging disorder. She regularly engages in self-induced vomiting several times a week, notably without preceding binge eating. Driven by a profound fear of weight gain and a desire to control her body shape, her behavior is accompanied by significant anxiety about her appearance. The physical repercussions of her actions include dental erosion and a chronic sore throat, indicative of the damage caused by frequent vomiting. Embarrassed by her actions, Karen has kept this behavior hidden from friends and family. Ultimately, recognizing the harmful and unsustainable nature of her habits, she decided to seek professional help. This case underscores the essential

characteristics of purging disorder: compulsive vomiting to control weight, absent of binge eating, and the psychological distress it entails.

- **Pharmacological:** While there isn't a specific treatment regimen for purging disorder, it often shares similarities with anorexia and bulimia, leading healthcare providers to use similar approaches. SSRIs, such as fluoxetine (Prozac) or sertraline (Zoloft), can be beneficial.
- **Non-pharmacological:** Treatment typically combines medication with nutritional counseling and various therapeutic techniques, including CBT, mindfulness practices, guided imagery, family therapy, and group sculpting, to address both the psychological and nutritional aspects of the disorder.

Case Study 11: Gender Dysphoria

The individual's experience of significant distress related to their gender identity, their desire to be treated and recognized as the opposite sex, and their discomfort with their physical characteristics align with the symptoms of gender dysphoria. This diagnosis is supported by their ongoing discomfort with their assigned gender at birth and their desire for medical intervention to align their physical body with their gender identity.

- **Pharmacological:** Hormone Replacement Therapy (HRT) is commonly used to align an individual's physical characteristics with their gender identity. This includes estrogen and anti-androgens for transgender women, and testosterone for transgender men.
- **Nonpharmacological:** Psychological counseling, including individual therapy and support groups, is crucial. This helps address mental health issues like depression and anxiety, and provides support for navigating social transitions. Gender-affirming procedures, such as surgery and voice therapy, may also be considered based on individual needs.

Case Study 12: Catatonia

The patient’s lack of response to external stimuli, maintenance of rigid postures, mutism, and episodes of mimicking behaviors are classic signs of catatonia. This neuropsychiatric condition involves a significant disturbance in motor behavior and responsiveness, often requiring immediate medical attention.

- **Pharmacological:** Medications that may be used in the treatment of patients suffering from catatonia include benzodiazepines like diazepam (Valium) and lorazepam (Ativan), which are often the first line of treatment due to their rapid efficacy in reducing catatonic symptoms. Carbamazepine (Tegretol), an anticonvulsant, may be considered in some cases, particularly if catatonia is associated with seizure activity. Zolpidem (Ambien), a sedative-hypnotic, has shown efficacy in some cases where other treatments have failed. Tricyclic antidepressants (TCAs) such as amitriptyline (Elavil) and nortriptyline (Pamelor) may be used if there is a significant depressive component. Muscle relaxants

like baclofen (Lioresal) can be used if severe muscle rigidity or spasticity is present. Amobarbital (Amytal Sodium), a barbiturate, may be used in certain cases, often administered intravenously in a hospital setting. Reserpine (Serpasil), an older antihypertensive, has been used historically for catatonia but is less common in modern practice due to side effects. Levothyroxine (Synthroid), a thyroid hormone, may be used if hypothyroidism is contributing to catatonic symptoms. Lithium carbonate (Lithobid), a mood stabilizer, can be used if there is an underlying bipolar disorder. Bromocriptine (Parlodel), a dopamine agonist, can be beneficial in some cases, particularly if neuroleptic malignant syndrome is suspected. Neuroleptics, such as risperidone (Risperdal) or olanzapine (Zyprexa), might be used cautiously, particularly if catatonia is associated with an underlying psychotic disorder. Each medication is chosen based on the individual's specific clinical presentation and underlying condition, with close monitoring essential during treatment.

- **Non-pharmacological:** Electroconvulsive therapy (ECT) may be considered. Monitoring in a medical setting to ensure patient safety is critical. Supportive care, including hydration and nutrition, may be necessary. Psychotherapy may be helpful post-crisis for underlying psychiatric conditions.

Case Study 13: Culture-bound Syndrome

The patient's symptoms, including convulsions, trance-like states, and speaking in unknown languages, coupled with the cultural interpretation of these as manifestations of an ancestral spirit, point to a culture-bound syndrome. These syndromes are specific to certain cultures or societies and may not be widely recognized or diagnosed outside of those cultural settings.

- **Pharmacological:** The use of medication is less typical unless treating an underlying clinically recognized psychiatric disorder such as anxiety or depression, in which case standard pharmacotherapy for these conditions would be applied.
- **Nonpharmacological:** Incorporating culturally sensitive approaches is essential. Collaboration with cultural healers and integration of community practices may improve patient engagement and outcomes. Psychoeducation for both the patient and their family about the nature of the illness and its cultural significance can also be beneficial.

Case Study 14: Medication-Induced Movement Disorders

The symptoms of involuntary movements, particularly after the initiation and dose escalation of antipsychotic medication, indicate a medication-induced movement disorder. This condition often arises as a side effect of long-term use of neuroleptic drugs, commonly presenting as motor disturbances like tremors and involuntary jerking movements.

- **Pharmacological:** For medication-induced movement disorders, pharmacological interventions may include adjusting the dosage of the causative medication or switching to a different antipsychotic with a lower risk of movement disorders. For instance, if a patient is on haloperidol (Haldol), they might be switched to an atypical antipsychotic

like quetiapine (Seroquel) or clozapine (Clozaril), which have a lower risk of inducing movement disorders. Additionally, specific medications may be prescribed to alleviate symptoms. Benzodiazepines like clonazepam (Klonopin) or lorazepam (Ativan) can help with tremors and muscle stiffness. Beta-blockers such as propranolol (Inderal) may be used to manage tremors, and anticholinergics like benztropine (Cogentin) can help reduce rigidity and tremors associated with movement disorders. These interventions aim to address the adverse effects of the primary medication while maintaining the therapeutic benefits.

    - Tetrabenazine (Xenazine) is the only FDA-approved drug specifically for the treatment of movement disorder symptoms, primarily used in conditions like Huntington's disease. It works by reducing the amount of dopamine in the brain, which can help lessen involuntary movements.
    - Botulinum toxin injections (Botox®) can also be used in some cases, especially when dystonia or abnormal muscle contractions are present. These injections temporarily block nerve signals, providing relief from involuntary muscle movements for several months.

- **Non-pharmacological:** Physical therapy can help manage symptoms and improve motor function. Education on self-monitoring for signs of worsening movement symptoms is also beneficial for patient self-care. Deep brain stimulation is another option for managing movement disorders. It involves implanting a device that delivers electrical signals to specific areas of the brain to block abnormal nerve signals that cause involuntary movements. This technique is used primarily in severe cases where medications are ineffective or not well-tolerated.