Anorexia Nervosa In Children and Adolescents

Allison Slocum

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Professor JoAnn Davis

I, Allison Slocum, have neither given nor received help on this work, nor am I aware of any infraction of the honor code.

**Introduction**

 The profound deteriorating effects of anorexia nervosa have ranked the disease with “the highest mortality of any psychiatric disorder” (Morris, 2007, p. 894). The onset of this disease is most often presented in early adolescence and cases have been known to arise as early as 10 years of age (Perry, Hockenberry & Lowdermilk, Wilson, 2014, p.55). Patients are encompassed with a demented idea regarding their weight and the food they consume (Lewis, Dirksen, Heitkemper & Bucher, 2014, 903). Despite their factually underweight body mass index these patients are focused with “elaborate plans to reduce weight further” (Chaudhury, 2001, p.265). However, many barriers to research are present as it is “hard to engage patients with anorexia for treatments, let alone research” (Morris, 2007, p. 894).

**Etiology**

 There is no single identifiable trigger to the onset of anorexia nervosa but the eating disorder seems to have links to “genetic, neurochemical, psychodevelopmental, and sociocultural factors” (Perry, 2014, p.1036). Various forms of evidence suggest that patients with the condition are often “found in families with obsessive, perfectionist, and competitive traits” (Morris, 2007, p.895). Sociocultural factors that play a role in the development of the disorder are the patient’s influence by “peers, familial, and cultural pressures with respect to appearance” (Yager & Anderson, 2005, p. 1488). Adolescent girls are at the highest risk for developing the disorder as menarche and other stressful life changes are often precursors to anorexia nervosa’s development (Perry, 2014, p.1036).

**Disorder and Pathology**

 Anorexia nervosa is a disorder that encompasses a variety of factors such as “behavioral features and cognitions with mental and physical symptoms due to starvation” (Focker, Knoll & Hebebrand, 2013, p.2229). Many patients display phobias of weight gain, abstain from eating, diet excessively, experience binging and purging episodes, and are infatuated with exercising (Lewis, 2014, p.903). However, not all of these criteria are necessarily evident so another suggested measurement to be classified with this disorder is “persistent behavior that interferes with weight gain” (Focker, 2013, p.2231). This self-inflicted borderline starvation can lead to consequential symptoms such as “profound weight loss, intolerance to cold, amenorrhea, sinus bradycardia and lowered body temperature” (Perry, 2014, p.1036). Patients with severe anorexia have the ability to endure a high percentage of physical weight loss (Morris, 2007, p.894). It is suggested that the following aspects must be achieved in order for a definitive diagnosis to be made: body weight below 15% of normal, self-imposed weight loss, demented self-image, endocrine dysfunction, and affected sexual development (Morris, 2007, p. 895). In addition to these complications, “cardiac abnormalities occur in over 80% of patients and bradycardia leading to cardiac arrest is a common cause of death” (Chaudhury, 2001, p. 264).

**Health and Wellness**

 Common improvements regarding the physical despair of anorexia nervosa patient’s revolve around the management of the disorder through behavioral, nutritional, and pharmacotherapy techniques (Perry, 2014, p.1037). No single aspect alone is able to provide for a high rate of success as the care must “focus on reaching and maintaining a healthy weight, normal eating patterns, and perception of hunger and satiety” as a whole (Lewis, 2014, p. 903). It is necessary especially for children to include the patient’s family in the education, care planning, and support in order to provide for the best outcomes (Morris, 2007, p.896). As far as research has shown, “medication has little benefit in anorexia nervosa” as many harmful repercussions have a tendency to arise from the administration of such proposed drugs (Morris, 2007, p.897). It is also proven that treatment, that is put into effect earlier rather than later, has a profound effect on preventing long-term neurologic and cardiac effects of the disorder (Yager, 2005, p.1481). The barriers to developing the best plans of treatment include but are not limited to the lack of subjects willing to participate, the necessity for hospital admission, and the extensive length of time required for a patient to achieve remission status (Focker, 2013,p.2229).

**Interaction with Healthcare Team**

 The effectiveness of treatment for patients with anorexia nervosa is highest when multiple health care professionals from varying differences provide treatment in conjunction with one another (Perry, 2014, p.1037). It is critical that the health care team “decides on an approach and adheres to it” in conjunction with one another (Perry, 2014, p.1038). It is the responsibility of an individual’s primary care provider to report and document symptoms and suspicions of the developing or relapsing disorder; often times they will need the additional advice from a physician specializing in eating disorders (Morris, 2007, p.895). Studies have proven that individual sessions of therapy and plans of care are far more likely to achieve success than therapy that is carried out amongst multiple anorexia nervosa patients alongside one another (Morris, 2007, p.896). Also it is important that physicians “make a positive diagnosis of psychologically driven weight loss, rather than reach a diagnosis by exclusion” (Morris, 2007, p.898). Each patient’s weekly weight and daily caloric intake should be strictly monitored by his or her healthcare team (Yager, 2005, p. 1481). As far as a nursing personnel is concerned, “acute care involves careful monitoring of fluid and electrolyte imbalances and observation for signs of cardiac complications” (Perry, 2014, p.1038.). It is important to understand that long-term treatment is much more beneficial than acute care intervention as “hospital admission is still strongly correlated with poor outcome” (Morris, 2007. p. 896).

**Effects on Growth and Development**

 The effects of anorexia nervosa on the body are so profound that the disorder yields a “mortality rate of 5-10% at 10 years” (Chaudhury, 2001, p.265). The disease process can lead to low oxygen profusion levels as a result of anemia present in addition to muscle atrophy and kidney failure secondary to low levels of potassium sustained in the patients body (Lewis, 2014, p.903). If these hindering effects to growth and development fail to cease death is imminent, especially amongst patients who abuse substances or self-induce vomiting for weight loss (Morris, 2007, p. (895). Refeeding, which often consists of nasogastric tube feedings or parenteral nutrition therapy, is normally the initial intervention implemented to restore a normal growth and development pattern (Perry, 2014, p.1037). These feedings must be initiated gradually based on a patients “age, height, stage of puberty, premorbid weight, and previous growth charts” in order to prevent a potentially fatal complication known as refeeding syndrome (Perry, 2014, p.1037). In cases of full recovery there will be a return of a normal “cardiovascular function, immune function, fertility, and bone density” (Morris, 2007, p.898).

**Conclusion**

 Regarding the mortality rate of anorexia nervosa, “two thirds die of direct effect of the disorder, one-third from suicide” which emphasizes the importance that both the nutritional and psychological aspects of each affected patient must be researched, evaluated and treated for accordingly (Chaudhury, 2001, p. 265). It is important for health care professionals to be aware of the signs and symptoms, in addition to the average range of onset, which is most commonly reported between the ages of 10-25 years old (Perry, 2014, p.1035).

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