Anorexia Nervosa

Which course of treatment provides the best outcomes for adolescents with anorexia nervosa and is the outcome influenced by provision of services specialised in treating eating disorders?

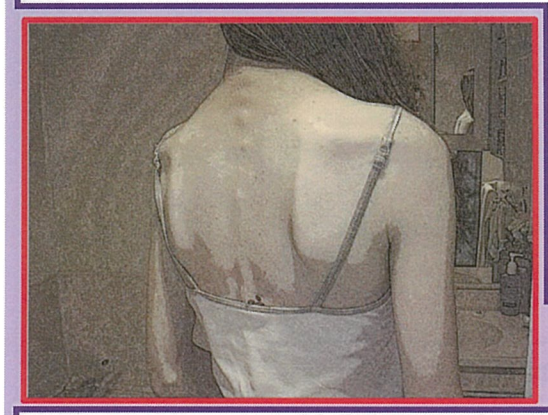
Anorexia nervosa (AN) is a severe psychiatric illness with an average mortality rate of 5%. It is the third most common chronic illness affecting adolescent females with an average duration of 5-7 years. It is characterised by a relentless pursuit of emaciation and a pathological obsession with self-starvation creating potentially fatal consequences

The unique ego-syntonic nature of AN drives strong resistance to treatment. Patients view their behaviours as desirable rather than destructive and believe their illness is an integral part of who they are. Essentially, the elements of treatment drive profound anxiety and result in deceitful behaviours in a desperate attempt to retain their identity.

Treatment Priorities

Medical Stabilisation

The priority of treatment is nutritional rehabilitation in order to prevent death and maximise the effectiveness of therapy. Starvation and re-feeding can cause life-threatening complications thus inpatient treatment is crucial for those who are medically unstable. Once stable, adolescents should receive outpatient care to avoid the detrimental effects of prolonged hospitalisation (Marzola et al., 2013).



Family-Based Therapy

The Maudsley Family-Based Therapy model, currently the only evidence-based treatment for adolescents, supports parents to play an active role in their child's recovery. Parents learn to externalise AN as a separate entity which has gripped their child, and thus initially need to assert full control and intensive supervision of all meals and exercise until the child is well enough to manage independently. The child and family must then be supported to establish a healthy adolescent identity without AN (Hay et al., 2014).

Effective Nursing Care

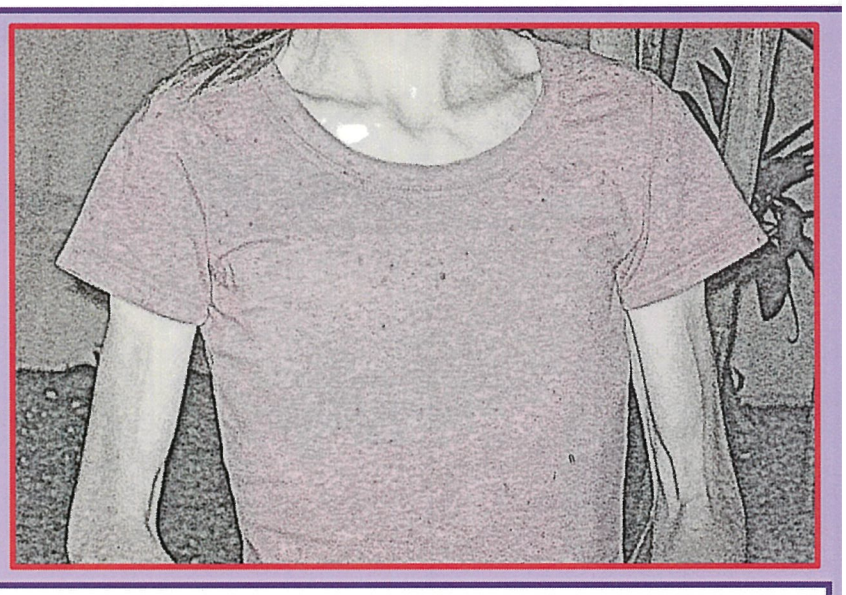
Nurses must be able to provide non-judgemental support in a safe, recovery-focused environment. Nurses have a highly influential role and drive motivation to change by re-establishing hope and a will to live. Specialised units are able to address the challenging nature of the disorder and accommodate the extensive needs of children with eating disorders. In contrast, nurses working in paediatric medical wards were found to believe that children with AN were less deserving of care than those with physical illnesses. Patients were described as manipulative and deceitful; creating mutual distrust and a battle of wills. Nurses were pessimistic of a full recovery and believed treatment was a waste of time (Zugai et al., 2013).

Conclusion

Medical stabilisation followed by adequate psychological support in the community under specialised, competent care promotes cost-effective, clinically acceptable outcomes for children with anorexia nervosa.

Recommendations

- Increased funding for specialised eating disorder services in NZ
- Adequate education of eating disorders for health professionals



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Emma Lloyd

Rationale

I choose to present my findings as a poster in order to create a visually appealing resource which can be viewed by many people and will enable me to achieve my aims of this project. Firstly, I hope to create awareness amongst our communities to aid understanding of the complex nature of anorexia nervosa. Secondly, I aim to educate current and future health professionals to hopefully expose the need for increased provision of appropriate services for adolescents with anorexia. By creating a poster, I have been able to present information in a succinct manner with key messages laid out. I have used colour to attract the viewers alongside somewhat confronting images to draw attention to the severity of this particular illness and convey emotion (Rowe & Ilic, 2009).

PECOT	Information	Explanation
Population	*Inclusion* Adolescents aged 10-19 diagnosed with anorexia nervosa (DSM-IV/DSM-V) *Exclusion:* Adults aged 20+*;* those with serious co-morbidities	The most likely group to receive treatment and the least likely cohort to have serious co-morbidities which often require long-term hospitalisation
Exposure	Those receiving a course of treatment specialised for patients with anorexia nervosa	Professionals working in specialised areas are more attuned to the unique nature of the disorder
Comparison	Those receiving generalised medical or mental health treatment	In New Zealand, very few of these specialised settings exist therefore children are required to undergo community-based generalised outpatient clinics or medical hospitalisations
Outcome	Weight Restoration (>95% EBW) + Eating attitudes (scored using an approved self-report questionnaire (EDE-Q, SIAB-EX, EDI-2, MROAS)) within one standard deviation of norms.	'Recovery' from anorexia is complex, and the goal for patients is medical stabilisation plus absence of thoughts and behaviours which significantly impair ability to function in daily activities.
Time	One year	Patients with inadequate treatment usually relapse within the first year, I want to look at what treatments allow maintenance of wellbeing for at least a year, therefore increasing chances of a full recovery and enhancing quality of life

EBW – Expected Body Weight; EDE-Q – Eating Disorders Examination Questionnaire; EDI-2 – Eating Disorder Inventory 2; MROAS – Morgan-Russel Outcome Assessment Schedule; SIAB-EX – Structured Inventory for Anorexic and Bulimic Eating Disorders.

References

Rowe, N. & Ilic, D. (2009). What impact do posters have on academic knowledge transfer? A pilot survey on author attitudes and experiences. *BMC Medical Education, 9*, 71.

Emma Lloyd
ID: 1000001490