13.4: Applying the Nursing Process to Eating Disorders

People with eating disorders may appear healthy even when they are very ill. Additionally, individuals with anorexia nervosa often do not view their behavior as a problem. They are typically only seen in health care settings due to concerned family or friends who encourage them to seek treatment. Conversely, individuals with bulimia nervosa or binge eating disorder may feel shame and sensitivity to the perceptions of others regarding their illness. Therefore, it is vital for the nurse to build a therapeutic nurse-patient relationship with clients with eating disorders and empathize with possible feelings of low self-esteem and lack of control over eating.[i]

This section will apply the nursing process to anorexia and bulimia nervosa.

Assessment

When assessing an individual with a potential or diagnosed eating disorder, it is vital to obtain their perception of the problem while assessing for signs and symptoms. Care planning that does not address their perspective will not be effective. As previously mentioned, clients with anorexia nervosa often do not perceive their behaviors as a problem, so specialized therapeutic techniques may be required. Review signs and symptoms associated with various eating disorders in the “Basic Concepts” section.

Subjective Assessment

A complete nursing assessment includes health history, psychosocial assessment, and screening for risk of suicide or self-harm. Nutritional patterns, fluid intake, and daily exercise should also be assessed. If the client has a binging or purging pattern, the amount of food eaten and/or the frequency of these behaviors should be assessed.
Objective Assessment

Objective assessments include routine weight monitoring and orthostatic vital signs. Common objective assessment findings for individuals with anorexia nervosa and bulimia nervosa are compared in Table 13.4a. Clients with binge eating disorder may have obesity and gastrointestinal symptoms but do not typically have other associated abnormal assessment findings.

Table 13.4a Comparison of Assessment Findings in Anorexia Nervosa and Bulimia Nervosa

<table>
<thead>
<tr>
<th>Anorexia Nervosa</th>
<th>Bulimia Nervosa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low weight</td>
<td>Normal to slightly low weight</td>
</tr>
<tr>
<td>Muscle weakening (from starvation and electrolyte imbalance)</td>
<td>Muscle weakening (from electrolyte imbalance)</td>
</tr>
<tr>
<td>Peripheral edema (from hypoalbuminemia)</td>
<td>Peripheral edema (from rebound fluids if diuretics are used)</td>
</tr>
<tr>
<td>Cardiovascular abnormalities (hypotension, bradycardia, heart failure from starvation, and dehydration)</td>
<td>Cardiovascular abnormalities (cardiomyopathy and cardiac dysrhythmias from electrolyte imbalances)</td>
</tr>
<tr>
<td>Abnormal lab results (hypokalemia and anemia from starvation)</td>
<td>Electrolyte imbalances (hypokalemia and hyponatremia from diuretics, laxatives, or vomiting)</td>
</tr>
<tr>
<td>Other signs:</td>
<td>Other signs:</td>
</tr>
<tr>
<td>Amenorrhea (lack of menstruation)</td>
<td>Tooth erosion or dental caries (from vomiting reflux over enamel)</td>
</tr>
<tr>
<td>Lanugo (growth of fine hair all over the body)</td>
<td>Parotid swelling (due to increased serum amylase levels)</td>
</tr>
<tr>
<td>Cold extremities</td>
<td>Calluses or scars on hand (from self-induced vomiting)</td>
</tr>
<tr>
<td>Constipation</td>
<td>Seizures (purging via self-induced vomiting lowers seizure threshold)</td>
</tr>
<tr>
<td>Impaired renal function</td>
<td></td>
</tr>
<tr>
<td>Decreased bone density</td>
<td></td>
</tr>
</tbody>
</table>

Diagnostic and Lab Work

Laboratory and diagnostic testing are typically performed to rule out thyroid imbalances and to evaluate for potential physiological complications resulting from starvation, dehydration, and electrolyte imbalances. Laboratory testing may include the following:[3]:

- Complete blood count
- Electrolyte levels
• Glucose level
• Thyroid function tests
• Erythrocyte sedimentation rate (ESR)
• Creatine phosphokinase (CPK)

Diagnostic testing may include these tests:

• Electrocardiogram (ECG)
• Dual energy X-ray absorptiometry (DEXA) to measure bone density

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Diagnoses

Common nursing diagnoses for individuals diagnosed with anorexia nervosa or bulimia nervosa include these diagnoses:

• *Imbalanced Nutrition: Less Than Body Requirements*
• *Risk for Electrolyte Imbalance*
• *Risk for Imbalanced Fluid Volume*
• *Impaired Body Image*
• *Ineffective Coping*
• *Interrupted Family Processes*
• *Chronic Low Self-Esteem*
• *Powerlessness*
• *Risk for Spiritual Distress*

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Outcome Identification

These are the typical overall treatment goals for individuals with eating disorders:

• Restoring adequate nutrition
• Bringing weight to a healthy level
• Reducing excessive exercise
• Stopping binge-purge and binge eating behaviors

SMART expected outcomes are individualized for each client based on their established nursing diagnoses and current status. (SMART is an acronym for Specific, Measurable, Attainable/Actionable, Relevant, and Timely.) An example of a SMART expected outcome for an individual hospitalized with anorexia nervosa who is experiencing electrolyte imbalances is:

• The client will maintain a normal sinus heart rhythm with a regular rate during their hospitalization.
Planning Interventions

Planning depends on the acuity of the client’s situation. As previously discussed, clients are hospitalized for stabilization. Common criteria for hospitalization include extreme electrolyte imbalance, weight below 75% of healthy body weight, arrhythmias, hypotension, temperature less than 98 degrees Fahrenheit, or risk for suicide. After a client is medically stable, the treatment plan includes a combination of psychotherapy, medications, and nutritional counseling. Review the “Treatment for Eating Disorders” section for more details.

Implementation

Nurses individualize interventions based on the client’s current clinical status and their phase of treatment. Interventions can be categorized based on the American Psychiatric Nursing Association (APNA) standard for Implementation that includes the Coordination of Care; Health Teaching and Health Promotion; Pharmacological, Biological, and Integrative Therapies; Milieu Therapy; and Therapeutic Relationship and Counseling. (Review information about these subcategories in the “Application of the Nursing Process in Mental Health Care” chapter.) Read nursing interventions for clients with eating disorders categorized by APNA categories in Table 13.4b.

Table 13.4b Examples of Nursing Interventions by APNA Subcategories

<table>
<thead>
<tr>
<th>Subcategory of the APNA Standard of Implementation</th>
<th>The nurse will …</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordination of Care</td>
<td>Communicate client trends with interprofessional team members, such as risk for suicide and target weight. A target weight and daily caloric intake are set in collaboration with the dietician and the provider.</td>
<td>All team members providing care must be aware of the client’s suicide risk to maintain a safe environment. A combination of treatments is used to achieve the client’s goal weight and promote recovery.</td>
</tr>
<tr>
<td></td>
<td>Refer to community resources and outpatient treatment.</td>
<td></td>
</tr>
<tr>
<td>Health Teaching and Health Promotion</td>
<td>Promote health by teaching adaptive coping strategies such as journaling. Support basic skills such as learning how to create meal plans, shopping at the grocery store, and navigating family or social eating situations.</td>
<td>Nurses encourage resilience by promoting healthy coping strategies, communication, and problem-solving skills.</td>
</tr>
<tr>
<td>Pharmacological, Biological, and Integrative</td>
<td>Deliver patient education about antidepressants or other medications with expected time</td>
<td>Client understanding of their medications and potential side effects can increase medication adherence.</td>
</tr>
</tbody>
</table>
Therapies

frames for improvement.

Provide a pleasant, calm atmosphere at mealtimes. Emphasize the social nature of eating. Encourage conversations during mealtimes that do not involve the topics of eating or exercise.

Milieu Therapy

Observe clients during meals to prevent hiding or throwing away food and at least one hour after eating to prevent purging.

Encourage the client to make their own menu choices as they approach their goal weight.

The milieu of an eating disorder specialty unit is purposefully organized to assist the client in establishing healthy eating patterns and normalization of eating. The highly structured environment provides precise mealtimes, adherence to the meal plan, close observation of bathroom trips, and monitoring potential access to laxatives or diuretics. Mealtimes can cause episodes of high anxiety. The client should feel accepted and safe from judgmental evaluations in the milieu with a focus on eating behaviors and underlying feelings of anxiety, dysphoria, low self-esteem, and a lack of control.¹⁰

Therapeutic Relationship and Counseling

Provide 1:1 therapeutic communication to encourage the client to develop adaptive coping strategies, use stress management techniques, develop supportive relationships, and seek spiritual resources.

Acknowledge the emotional and physical difficulty the client is experiencing.

Use motivational interviewing and contract with the client to increase their ownership of treatment goals.

Effective therapeutic techniques for clients with depression can promote hope and positive self-esteem.

The first priority is to establish a therapeutic relationship. The client’s feelings of extreme fatigue can be used to engage cooperation in the treatment plan.

Motivational interviewing is a collaborative, goal-oriented style of communication. It is designed to strengthen personal motivation and commitment to specific goals by eliciting and exploring the person’s reasons for change within an atmosphere of acceptance and compassion.¹¹

Accurate weight taking and monitoring are vital. The client may try to control and sabotage the weight monitoring. The client is typically expected to gain 0.5 pound on a specific schedule. However, weight gain of more than five pounds in one week can cause pulmonary edema. The particulars of how patients should be weighed (i.e., open vs. blind weighed) is a point of debate in the field. Because viewing the scale can cause anxiety, blind weighing is typically used during the acute stage of treatment, whereas open

¹⁰

¹¹
Be empathetic with the client’s struggle to give up control of their eating and weight as they are expected to regain weight. Encourage the clients to verbalize or use a journal to record their feelings surrounding eating disorder behaviors. Confront irrational thoughts and beliefs to promote healthy eating behaviors. Monitor physical activity and individualize the client’s plans for exercise.

Focus on the client’s strengths, including their work on normalizing weight and eating behaviors. Reinforce the knowledge and skills gained from individual, family, and group therapy sessions.

weighing may be suitable at later stages of recovery.\textsuperscript{[12]}

Oral or enteral supplements may be prescribed based on the client’s status. However, be alert for refeeding syndrome in severely malnourished clients.

External control is required initially to promote good nutrition and a healthy weight. Cognitive and behavioral changes will occur gradually.

The client often experiences a strong drive to exercise. Nurses can assist in planning a reasonable amount of exercise.

Acknowledge milestones and encourage other sources of gratification other than eating.

Inpatient Care

If the client is exhibiting risk for suicide, a safety plan should be immediately implemented. Review nursing care for clients with risk for suicide in the “Application of the Nursing Process in Mental Health Care” chapter.

Severely malnourished clients may require therapeutic enteral nutrition. Any client with negligible food intake for more than five days is at risk of developing a potentially fatal complication called refeeding syndrome. The hallmark feature of refeeding syndrome is hypophosphatemia but may also involve serious sodium and fluid imbalances; changes in glucose, protein, and fat metabolism; thiamine deficiency; hypokalemia; and hypomagnesaemia. To avoid this syndrome, a thorough nutritional assessment must be performed followed by the slow reintroduction of nutrients and fluids according to evidence-based guidelines.\textsuperscript{[13]}

After resolving acute symptoms, clients with anorexia begin a weight restoration program for incremental weight gain with a treatment goal set for 90% of ideal body weight. Specially trained dieticians assist in developing daily meal plans and caloric intake, and clients are generally weighed two or three times a week to gauge progress.\textsuperscript{[14]}

Nurses should be aware that clients with bulimia nervosa typically establish a therapeutic nurse-client relationship more quickly than clients with anorexia nervosa. As previously discussed in this chapter, clients with anorexia nervosa often
do not view their condition as a disorder and value their obsessive-compulsive behaviors with eating as a way to feel safe and secure and avoid negative feelings. Conversely, clients with bulimia nervosa view their behaviors as problematic and desire help.[16]

Outpatient Care

Outpatient partial hospitalization is an option for clients who have been medically stabilized. In this setting, clients are in a clinical setting during the day and then go home to practice skills in the afternoon. Outpatient treatment continues if the client maintains a contracted weight, vital signs are within a normal range, and there is an absence of disordered eating behaviors.[16]

A significant part of the recovery process includes rebuilding relationships with family. Family members or significant others often feel frustrated, powerless, and hopeless because the strategies they previously attempted, such as forcing the client to eat or begging the client to eat, were not successful. The nurse helps with this recovery process by providing education to the client and their loved ones about the illness, treatment, and meal planning. Adaptive coping skills to address disordered thoughts should be reinforced.[17]

Review information about coping strategies in the “Stress, Coping, and Crisis Intervention” chapter.

Resources

Nurses refer clients and their loved ones to resources as part of discharge planning. Review examples of community resources in the following box.

Resources for Individuals With Eating Disorders

- National Eating Disorders Association (NEDA): Support, resources, and treatment options
- Eating Disorders Resource Group: Resources including treatment apps
- ANAD: Eating disorder peer support groups

Evaluation

Evaluation is a continuous process of reviewing a client’s progress towards their individualized goals and SMART outcomes. Interventions are continually evaluated and modified based on their success in meeting these short-term goals.


