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A Comprehensive Review of Nursing Strategies for the Management of Eating Disorders in Adolescents: Exploring Perspectives and Best Practices for Holistic Care

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Abstract

Eating disorders (EDs) are complex mental health conditions that primarily affect adolescents, leading to significant physical, psychological, and social consequences. The management of EDs necessitates a multidisciplinary approach, with nursing strategies playing a crucial role in facilitating recovery and improving patient outcomes.This review employs a comprehensive analysis of the current literature surrounding nursing strategies for managing eating disorders in adolescents. Databases such as PubMed, Scopus, and CINAHL were searched for qualitative studies that explore the perspectives of patients, families, and healthcare professionals regarding ED treatment. Thematic synthesis was utilized to identify common themes across different stakeholder viewpoints.The findings reveal three primary themes: the struggle for autonomy, the perception of control, and the importance of holistic treatment approaches. Patients expressed a desire for autonomy while simultaneously feeling constrained by their eating disorders. Family members and healthcare professionals emphasized the need for a balanced focus on physical rehabilitation and psychological well-being. The review highlights the significance of individualized care that addresses the unique experiences and challenges faced by adolescents with EDs.Effective nursing strategies for managing eating disorders in adolescents must incorporate a comprehensive understanding of the patient's experience, promote family involvement, and foster collaborative relationships between healthcare providers and patients. The integration of psychological support with nutritional rehabilitation is essential for enhancing treatment adherence and facilitating long-term recovery. Future research should focus on developing tailored interventions that address the diverse needs of adolescents with eating disorders.

Keywords: *Eating Disorders, Nursing Strategies, Adolescents, Multidisciplinary Approach, Qualitative Research.*

Introduction

There are substantial social costs associated with eating disorders (EDs), which are severe mental illnesses that often have physical and psychological effects [1, 2]. An eating disorder may result in social issues and

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diminished quality of life for both the individual affected and their family. The onset often occurs during adolescence; nevertheless, recent years have seen a rise in new-onset eating disorders among adults [3-5]. The lifetime prevalence of eating disorders in Western nations is estimated at 1.89% [6]. Females are more often impacted than males. Earlier estimates indicated that around 90 percent of individuals impacted are women; however, recent research suggests that the male percentage may be around 20 percent [7]. Eating disorders often need multi-disciplinary intervention [8]. The majority of patients get outpatient treatment; however, more severe cases may need both daycare and inpatient clinical or mental care. Numerous inpatient facilities specialize in the treatment of people with eating disorders.

Cognitive behavioral therapy (CBT) is the preferred psychological treatment for adult patients, demonstrating the most robust empirical support for those with bulimia nervosa (BN) and binge eating disorders (BED), while also gaining growing endorsement for those with anorexia nervosa (AN) [8-10]. Family-based therapy is the preferred therapeutic approach for teenagers. The approach is primarily tailored for patients with anorexia nervosa or other restrictive disorders; however, it is also seen as beneficial for teenagers with bulimia nervosa [8, 9]. Approximately fifty percent of individuals with anorexia nervosa achieve complete recovery after therapy. At the ten-year follow-up, around 73 percent are in remission. The immediate impact of therapy is somewhat more favorable for other forms of eating disorders, yet there exists a considerable danger of recurrence. In a decade, there are somewhat more individuals recovering from bulimia nervosa compared to anorexia nervosa [11, 12].

Healthcare practitioners often characterize patients with an eating disorder as a problematic demographic, noting the difficulty in forming an effective therapeutic connection. Patients often express significant ambivalence and resistance, which complicates therapy and results in disputes with family and friends [13, 14]. A heightened collective understanding of eating disorders from the viewpoint of those afflicted, their relatives, and caregivers may enhance care and treatment for people grappling with eating disorders and alleviate the burden on their relationships [15-20]. In this context, the objective of the current research was to examine the realities of living with an eating disorder and the elements that promote or impede recovery, as seen by patients, their family members, and healthcare professionals.

Methods

A comprehensive review of scientific literature was conducted in 2023 across a variety of databases, such as Scopus, Cochrane Library (Cochrane Central Register of Controlled Trials), CINAHL, PsycINFO, PubMed (MEDLINE), as well as ENFISPO.

Results

The predominant evaluations were derived from investigations using just qualitative approaches; nonetheless, three reviews moreover included studies utilizing mixed methods [21-24]. The majority of the original research employed interviews as the main source of information, while some relied on focus group talks, survey answers, or behavioral observations. The majority of reviews used synthesis employing meta-ethnography [19, 25-33]. Alternative synthesis methodologies included topic assessment, interpretive meta-analysis, and several types of integrative synthesis techniques [20-24, 34, 35]. In the majority of evaluations, the Critical Appraisal Skills Program, or CASP, was used to evaluate the quality of the main research [19-21, 25-29, 31-34].

Thirteen systematic studies addressed patients' perspectives [19-23, 25, 27, 28, 30-34], five examined family members' viewpoints [24, 26, 29, 31, 32], and three concentrated on healthcare professionals' viewpoints [31, 32, 35]. The majority of studies encompassed both men and women with eating disorders, whereas just three evaluations focused only on women [19, 20, 33]. Most evaluations did not delineate age within the inclusion criteria; nonetheless, none contained trials with young children. Five evaluations focused on teenagers with eating disorders, however, they also included youngsters [23, 24, 30-32]. Nine papers focused only on AN [23, 25, 27, 28, 30-33, 35], while the other reviews included all EDs or lacked specificity regarding diagnosis in their inclusion criteria. One study focused only on nurses' perspectives via interviews

[35], while the other two included therapists, nurses, and treatment teams [31, 32]. The informants in the evaluations including family members were mostly caregivers, but siblings and friends were additionally included in some reviews [24, 26, 29, 31, 32].

The Viewpoint of Persons with Eating Disorders

Nine systematic studies detailing patients' opinions were included in the theme evaluation [23, 25, 27, 28, 30-34]. This approach included three themes: a solitary quest for control, a desire to be recognized as a whole individual, and the pursuit of rehabilitation strategies [23, 25, 27, 28, 30, 32-34]. Existence with an eating disorder was characterized by loneliness and isolation, accompanied by health issues and relational difficulties [28, 31, 33]. Low self-esteem, a negative body image, and perfectionistic self-expectations were identified as fundamental variables contributing to challenging adolescence and ambiguity over personal identity. Individuals with anorexia nervosa often see the condition as a fundamental aspect of their identity, instilling a dread of recovery due to concerns about losing their sense of self [28, 31, 33].

Coexisting with AN was characterized as a battle for autonomy while concurrently experiencing subjugation by the disorder. The favorable sensation of control fostered a sense of uniqueness and empowerment, particularly about their treatment, while the eating disorder was characterized as a "coping mechanism" that assisted them in managing challenging emotions and circumstances. For most patients, the contrasting experience was the challenge of loss or relinquishment of power, particularly while commencing therapy or feeling ensnared by their sickness and symptoms. The participants articulated that their whole lives centered on an obsessive preoccupation with calorie tracking and compensatory behaviors, leading to a solitary and secluded lifestyle [28, 31, 33].

Patients often had feelings of mistreatment and misunderstanding during general care, highlighting the need for access to specialized emergency department care. The patients often perceived that the healthcare system emphasized physical rehabilitation and the normalization of diet and weight excessively. This was seen as lacking empathy and led patients to believe that the psychologists did not comprehend the patients' actual issues. Patients recognized that normalizing weight and nutrition was a crucial aspect of therapy; yet, they saw an excessive emphasis on physical recovery as diminishing their identity to their illness [23, 27, 30, 32].

They underscored the need for dialogue about ideas and emotions, emphasizing that the treatment provided should include their broader living circumstances. It was deemed essential for the therapist to adjust and modify his/her approach during the therapy process. Initially, individuals may want a therapist who is proactive and assertive. Subsequently, when the patient is capable of assuming responsibility, the therapy should empower and motivate the patient to take charge of his/her own life.

Family-centered therapy was prevalent among adolescent patients. These patients often had significant guilt towards their parents and siblings, noting that a beneficial component of family therapy was its capacity to enhance the overall well-being of the family, foster unity, and promote communication. Nonetheless, patients reported feeling unable to discuss all matters significant to them during family therapy. This jeopardized the treatment's depth, emphasizing surface behavioral modifications rather than addressing the fundamental roots of the disorder. The young patients deemed it essential to integrate family treatment with individual therapy. Individual counseling was seen as a crucial platform for inspiring, involving, and instilling hope in patients. Patients recognized the need to address relational dynamics both inside and outside the family and emphasized the importance of being seen as distinct individuals rather than only as individuals with AN [23, 27, 30, 32].

In research centered on AN, patients frequently characterized recovery as an experience that transcends the simple absence of an eating disorder diagnosis. The sensation of health did not emerge spontaneously with the normalization of weight and dietary habits. Patients characterized recovery as a journey of self-discovery and the courageous acknowledgment that the illusion of control provided by the eating disorder had exerted influence over them. Recovery included the capacity to adhere to good habits despite challenges [23, 25, 27, 33]. Four factors were identified as pivotal to recovery: regaining control and autonomy over one's life, transforming the anorexic identity and discovering self-acceptance beyond the illness; connecting with authentic emotions, and recognizing the disease's impact on oneself, thus confronting anorexic thoughts.

The comprehensive review examining recovery in individuals with an eating disorder revealed that patients saw the word "healthy" as including emotional, social, and psychological well-being. It included ways for addressing challenges encountered in life and fostering a sense of identity or seeing life as meaningful. Recovery was characterized as a staged process that sometimes-encountered difficulties. Recovery was enhanced by supportive connections, including those with friends and relatives. Trusting connections with friends and family may have a dual effect, encouraging the unwell individual to get treatment and offering support during the healing process. Trusting connections with healthcare experts were deemed essential for both the desire to pursue and adhere to therapy, as well as for the healing process itself.

The Healthcare Viewpoint

Three systematic evaluations included the observations of healthcare personnel [31, 32, 35], with all three primarily concentrating on AN. Two studies [31, 32] analyzed the similarities and variations in perspectives of anorexia nervosa and its treatment amongst staff, patients, and families. The third overview [35] examined the knowledge, attitudes, and perceived obstacles faced by healthcare providers. The healthcare viewpoint identified three themes: a struggle for control, the need for physical rehabilitation, and gaining access to an individual's reality. The healthcare personnel saw control as a fundamental element of anorexia nervosa (AN), seeing that, in addition to the need to regulate their bodies, patients also had a want to exert control over their families via eating disorders (ED) [32]. The staff saw that the need for control transformed into an external force, superseding the patient's autonomous decision-making, resulting in the ED exerting control over the patient. The staff believed it necessary to assume authority from the young individual by implementing explicit structure and regulations about therapy [32, 35]. This was deemed necessary to provide security for the youth and to provide them the option to relinquish control. In one research, nurses emphasized the significance of knowledge and comprehension of the condition, noting that insufficient understanding might result in staff using control measures in a restrictive and punitive manner, thereby fostering resentment [35].

Physiological Recuperation

The healthcare personnel used a biological paradigm to comprehend AN [31, 32]. Anorexia nervosa was seen as a condition requiring treatment. This indicated that personnel prioritized weight rehabilitation and modifications in other discernible eating disorder symptoms as crucial components of therapy. The personnel indicated a deficiency in understanding about symptoms of ED and evaluation, as well as inadequate abilities to address patients' issues [35]. This resulted in feelings of frustration and insecurity while interacting with the patients. Enhanced understanding was deemed crucial for ameliorating staff attitudes towards individuals with eating disorders.

The medical perspective on the ED was seen as beneficial by staff since it was believed to alleviate feelings of guilt among patients and their families. Healthcare practitioners found it beneficial to see the illness as a phenomenon apart from the person. The staff used this "externalization" to differentiate between sickness and patient as a therapeutic approach [31, 32]. The objective was to alleviate the patient's guilt and enhance their motivation. Within this topic, a review by Salzman et al. [35] also highlighted the other perspective, indicating that although weight rehabilitation is significant, an exclusive focus on physical concerns may impede the patient connection.

An effective relationship between patient and therapist was deemed crucial [31, 32, 35]. Integrity, comprehension, esteem, and a non-judgmental, empathic disposition were essential for establishing a partnership. The staff said that patients with eating disorders are a complex and demanding demographic, making it difficult to establish rapport, since they often exhibit skepticism and distrust towards their caregivers. Staff experienced frustration with patients' ambivalence or hesitance to participate in therapy and sometimes saw patients as manipulative. A systematic study investigated the experiences of healthcare professionals in interacting with family, namely parents of individuals with an eating disorder [32]. The team underscored the need to foster a constructive partnership with the parents and include them in the therapy process. This was deemed a necessary prerequisite for the efficient treatment of young patients with anorexia nervosa. Five systematic studies addressed the viewpoints of family members [24, 26, 29, 31, 32]. All of them concentrated mostly or solely on AN. Similar to the other two viewpoints, the viewpoint of family members also unveiled three themes: the equilibrium between control and trust, a want for a more comprehensive treatment strategy, and a desire for a collaborative partnership including the whole family.

The family members believed that the whole family was adversely impacted by the sickness of the affected individual [24, 26, 29, 31, 32]. The family members characterized the eating disorder as a voluntary decision that the individual, at least at some stage of the illness, might have avoided [29]. The family members saw that managing food and weight had become a coping mechanism for the sick individual in an otherwise unpredictable existence; nonetheless, they believed that the eating disorder had usurped control over their loved one, altering her personality and behavior. Family dynamics and traditional roles changed, resulting in communication among family members being characterized by conflict, distrust, and ambiguity. The individual with the eating disorder may be seen as having regressed, prompting parents to adopt a more restrictive approach. Conversely, siblings sometimes assumed a more adult position, acting as "mediators" within the family and shouldering more responsibility.

Family members articulated a challenging equilibrium between accommodating the sick individual, such as modifying the family's dietary practices and activities and imposing more demands. The family members tried to strike a balance between exerting control and imposing expectations on the unwell individual while simultaneously praising and encouraging good actions and demonstrating confidence in him/her. They believed it was essential to modify the family's social events and mealtimes by, for example, excluding particular foods from the household. Consequently, this sometimes led to people "walking on eggshells" and tolerating behaviors that were detrimental in the long run. Siblings often criticized the parents' approaches, believing they were too accommodating. A prevalent technique to manage this delicate balance was differentiating the sickness from the person and interpreting certain behaviors as manifestations of "the disease speaking." This enabled family members to maintain a supportive demeanor, even when they saw the individual with the eating disorder as misbehaving [24, 26, 29, 31, 32].

Observing an individual with an eating disorder was distressing, eliciting feelings of fear, irritation, and guilt among family members. Their daily lives were impacted, both socially and practically. Numerous sources said that the family grew more secluded and ceased social interactions with others. Multiple systematic evaluations indicated that family members no longer had time for activities and that their professional lives were impacted [24, 29]. In this context, family members emphasized the necessity for expedited access to specialized care provided by experienced and dedicated personnel capable of offering comprehensive information and support to the entire family, including siblings, while facilitating connections to external support networks for those facing similar circumstances. [24, 26, 29, 31, 32].

Parents often saw the health care concept as too biomedical, concentrating mostly on bodily symptoms like malnutrition. They recognized that the distinct individual behind every individual was overlooked [24, 29, 32]. The biological explanatory paradigm may alleviate parental guilt, although it also presents a pessimistic outlook on the patient's recovery prospects [29]. The family members underscored the need for the therapist to see the patient as a person, ensuring that the treatment not only addressed the eating disorder symptoms but also included other significant aspects pertinent to the patient [24, 29, 32].

The parents often held themselves accountable for their child's eating disorder and examined its potential familial roots and the child's upbringing. The siblings experienced significant distress due to the scenario, a sentiment echoed by their parents [24, 26, 29, 32]. Siblings experienced anxiety and often assumed substantial accountability for both the affected sibling as well as their parents. Simultaneously, kids often experience anger towards their ailing sibling and sometimes jealousy over the increased time and attention their parents devoted to them. The healthy siblings occasionally experienced a conflict of loyalties and felt obligated to intervene between the affected sibling and the parents.

Family members often encounter insufficient help from the healthcare system, particularly during the first stages of the disease [24, 26, 29, 31, 32]. Obtaining an accurate diagnosis and appropriate assistance proved challenging, necessitating that family members advocate vigorously for the proper care of the afflicted individual. Family members often perceived exclusion from care and thought that healthcare personnel did not provide assistance or heed their concerns. This exclusion was frequently ascribed to regulations or principles about secrecy or law. Family members felt that they got contradictory guidance and recommendations from the healthcare provider or that their concerns were not regarded with seriousness [29].

The first theme related to the patient's desire for autonomy, seen by family members and healthcare professionals as an illusory control, whereby the individual was, in reality, constrained and restricted by the eating disorder. The second topic included the equilibrium between physical healing and psychological requirements, with the biological model being seen separately from every one of the three viewpoints. Healthcare professionals believed that, when utilized with appropriate knowledge and expertise, the model provided essential support for identifying target symptoms and recovery objectives. Conversely, patients as well as their families contended that the model overly emphasized the somatic dimensions of the disorder, neglecting psychological distress. The third element emphasized the need to establish trustworthy connections to achieve an effective therapeutic partnership that acknowledges the whole person rather than only the illness, while also including family members.

Consequences for Healthcare Systems

The eating disorder inflicts significant distress on both the individual and their family, with both parties underscoring the need to obtain appropriate treatment. Our synthesis indicates a discrepancy between eating disorder individuals and their family members, on one side, and healthcare workers, on the other, about the understanding and treatment of eating disorders. Healthcare personnel often include a biological explanatory paradigm; however, emergency department patients and their families see this model as inadequate. The various approaches are not inherently contradictory; however, they may complicate alliance formation and lead to divergent treatment paths, with professionals prioritizing symptom alleviation and weight restoration, while patients and their families advocate for a more comprehensive treatment and recovery strategy. This conflict, along with recommendations for its avoidance, was also highlighted in a study involving healthcare personnel [35]. Patients, family members, and healthcare personnel mostly recommended enhancing knowledge as a means to attain a holistic approach while addressing the patient's physical requirements. The significance of having access to professionals who have expertise in comprehending the condition, addressing the patient's physical requirements, and recognizing their psychological challenges, while engaging with the patient respectfully, cannot be overstated.

Contemporary health care and policymakers are increasingly emphasizing the use of manual-based therapies and the assessment of treatment results. Significant focus is put on inquiries about which therapy modality has the most robust scientific backing, and how to ensure that therapists use the approach by the handbook [36]. These are, indeed, significant inquiries that need attention. It is essential to recognize that these elements seem to be completely missing from patients' and families' accounts of what is deficient or significant in therapy. Conversely, individuals with an eating disorder need therapy that is more adaptable and personalized, emphasizing their unique circumstances [37]. None of the systematic reviews in this research indicated that patients or families requested any particular treatment modality; rather, they advocated for a more holistic and personalized approach to therapy. Given that a substantial percentage of ED patients terminate treatment prematurely, often due to a lack of motivation, healthcare providers must enhance their understanding of patients' and family members' perceptions of the care delivered, as well as the factors that would encourage patients to remain in treatment.

Treatment manuals are a collection of concepts intended for application to each unique patient. When administered adeptly and with flexibility, individualized care need not clash with the use of treatment manuals [38, 39]. Nonetheless, some physicians see treatment manuals as restrictive to their practice and inhibiting the customization of therapies [39]. In light of this context and the study's findings indicating that patients and relatives advocate for a more holistic and individualized approach to treatment, it appears that eating disorder (ED) treatment encounters a significant challenge in synthesizing theory, research, clinical expertise, and the crucial viewpoints of patients and their families to enhance and tailor ED treatment. To achieve success, it has been proposed that we broaden the area of treatment research and enhance diversity within eating disorder therapy and research [40].

Conclusions

The compilation recognizes significant similarities and differences among the perspectives of the three informants, with healthcare professionals deeming the biomedical model beneficial, whereas patients and family members considered it inadequate and neglectful of their psychological distress. Perceiving these viewpoints as complementary instead of contradictory may enhance the comprehension of the intricacies involved in treating eating disorders. Recognizing experiences from other viewpoints may ultimately result in modifications in health care that might enhance treatment adherence and recovery rates for persons with eating disorders. Our research highlights a need for scientifically rigorous qualitative systematic evaluations on eating disorders, with a precisely defined population for age, sex, and description. There is a specific need for comprehensive studies on experiences related to BN and BED.

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مراجعة شاملة لاستراتيجيات التمريض في إدارة اضطرابات الأكل لدى المراهقين: استكشاف وجهات النظر وأفضل الممارسات للرعاية الشاملة

الملخص

الخلفية :تُعد اضطرابات الأكل (EDs) من الحالات الصحية العقلية المعقدة التي تؤثر بشكل رئيسي على المراهقين، مما يؤدي إلى عواقب جسدية ونفسية واجتماعية كبيرة. يتطلب التعامل مع اضطرابات الأكل نهجًا متعدد التخصصات، حيث تلعب استراتيجيات التمريض دورًا محوريًا في تسهيل عملية التعافي وتحسين نتائج المرضى.

المنهجية :تعتمد هذه المراجعة على تحليل شامل للأدبيات الحالية المتعلقة باستراتيجيات التمريض لإدارة اضطرابات الأكل لدى المراهقين. تم البحث في قواعد البيانات مثل PubMed و Scopusو CINAHLعن دراسات نوعية تستكشف وجهات نظر المرضى وأسرهم والمهنيين الصحيين بشأن علاج اضطرابات الأكل. تم استخدام التحليل الموضوعي لتحديد الأنماط المشتركة بين وجهات النظر المختلفة لأصحاب المصلحة.

النتائج :كشفت النتائج عن ثلاثة مواضيع رئيسية: الصراع من أجل الاستقلالية، وإدراك السيطرة، وأهمية النهج العلاجي الشامل. عبّر المرضى عن رغبتهم في الاستقلالية مع شعورهم في الوقت ذاته بأنهم مقيدون باضطرابات الأكل لديهم. أكد أفراد الأسرة والمهنيون الصحيون على ضرورة تحقيق توازن بين إعادة التأهيل الجسدي والصحة النفسية. كما سلطت المراجعة الضوء على أهمية الرعاية الفردية التي تأخذ في الاعتبار التجارب والتحديات الفريدة التي يواجهها المراهقون المصابون باضطرابات الأكل.

الاستنتاج :يجب أن تتضمن استراتيجيات التمريض الفعالة لإدارة اضطرابات الأكل لدى المراهقين فهمًا شاملاً لتجربة المريض، وتعزيز مشاركة الأسرة، وتعزيز العلاقات التعاونية بين مقدمي الرعاية الصحية والمرضى. يعد دمج الدعم النفسي مع إعادة التأهيل الغذائي أمرًا ضروريًا لتعزيز الالتزام بالعلاج وتحقيق التعافي على المدى الطويل. ينبغي أن تركز الأبحاث المستقبلية على تطوير تدخلات مخصصة تلبي الاحتياجات المتنوعة للمراهقين المصابين باضطرابات الأكل.

الكلمات المفتاحية :اضطرابات الأكل، استراتيجيات التمريض، المراهقون، النهج متعدد التخصصات، البحث النوعي.