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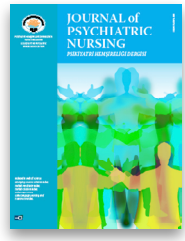

Case Report

A nursing care for a male anorexia nervosa case: A case report

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Abstract

Anorexia Nervosa is a serious mental disorder characterized by low body mass, excessive fear of weight gain and persistent behavior that prevents weight gain. This is a chronic disorder characterized by physical impairment, and has significant effects on the patient and their family. At the onset of the illness, trigger factors such as a criticism from friends, family members, or jokes about weight are common. This study presents a male patient diagnosed with "Anorexia Nervosa and Major Depression" at the age of 13, however it is not common in males. The family brought the patient to the hospital and he was admitted to the child psychiatry clinic after he was observed to have reluctance, intolerance and an unwillingness to eat. He was eating two tablespoons of food a day, drinking a half a glass of milk at school with a significant reduction of daily fluid and nutrient intake. A nursing care plan addressing the assessment of ineffective nourishment included the following; "eating less than required, fluid volume depletion, ineffective coping, body image distortion, discomfort in self-esteem, impairment in social interaction and constipation risk". The patient was observed to be quite reluctant and defensive during the interviews. Support from the patient's mother who was accompanying him was requested in order to implement the planned interventions effectively. It is suggested that studies on psychiatric care in adolescents with anorexia should be done to increase the knowledge on this subject and that the number of samples be more extensive.

Keywords: Anorexia nervosa; male patient; nursing care.

What is known on this subject?

- Anorexia nervosa is rarely seen in men and its etiology and progression differs from women.

What is the contribution of this paper?

- This study showed that a male adolescent anorexia nervosa patient, with a reluctant and defensive attitude, was able to restore healthy eating habits when presented with a motivational, therapeutic and empathic approach of a psychiatric nurse.

What is its contribution to the practice?

- The nursing diagnoses, expected outcomes and nursing interventions for the male adolescent, diagnosed with anorexia nervosa, can contribute to the practice.

The word anorexia comes from Greek and means lack of desire to eat. Anorexia Nervosa (AN), which first entered medical literature in the 1870s, is the first defined eating disorder.[1,2] AN is a mental disorder characterized by excessive fear of being overweight, a desire to have a slim body, constant behavior that makes weight gain difficult and a body image disorder. In addition, it has negative effects on the patient and the family.[3,4] One of the main pathologies of the disease is body image disorder. The weight perception of AN patients does not coincide with their actual weight because they perceive it as higher. The starting age of AN varies between 15–24 years and 10–30 years.[2] The lifetime prevalence is 0.9–2.2% in women and 0.3% in men and it often begins in adolescence.[3,4] AN is a disease with the highest mortality rate among psychiatric diseases. The death rate is between 2%–10%.[5]

Due to the clinical symptoms, AN is easy to identify.[6] This disease is characterized by compensatory behaviors such

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as severely restrictive eating, calorie counting, preference of low-calorie foods, excessive exercise, vomiting and use of laxatives and diuretics. Patients frequently weigh themselves and check their appearances in front of the mirror several times a day.[2] Physical indications such as osteoporosis, osteopenia and pathological fractures, fluid and electrolyte imbalances, arrhythmias, constipation, abdominal pain, hypotension, dry skin and reduced sexual desire can occur in AN.[7,2] A detailed medical examination of the AN patient is required prior to any treatment.[2] Depression is mostly comorbid with AN, but as the disease progresses, emotional lability appears to be more evident.[2] The primary goal in the treatment of an anorexic patient is to regulate the nutritional status and body weight. The secondary treatment goal is to reduce the weight loss behavior of the patient and to increase self-confidence, individuality and independence.

This study aims to collect data, to determine the NANDA nursing diagnoses and to plan, apply and evaluate nursing interventions in line with the nursing process steps for the patient diagnosed with AN. Consent was received from the patient and his mother.

Case Report

Medical History: The case is a thirteen-year-old male patient (M.A.) attending 8th grade. The medical history was received through an interview with the patient and the patient's mother. Two years before in 2014, during the summer break of 6th grade, the patients' grandmother was checking her blood sugar and decided to check M.A.'s blood sugar. His blood sugar was elevated (M.A. does not remember the value). His mother said that M.A. was 75–80 kilograms (kg) then, was often ridiculed by school mates and that he was thinking a lot about these issues. During this time, M.A. started to prefer wheat bread with his meals, stopped eating any kinds of snacks and sugar and started to do exercises on his own. This continued for about a year and the patient's weight dropped to 64 kg. After that M.A. experienced a severe burn on his leg from hot tea near the end of the 7th grade (June 2017). M.A. had to stay in bed for about 15 days from this injury and because he was not able to watch what he was eating, he stated he had gained weight. His mother said to him "M.A. your little belly is growing". The mother stated that he became very sad and started to be cautious about what he was eating again. The mother stated in her interview that her son had been distant towards her since this summer break. The mother noted the weight of the patient was 64 kg in August 2017. His mother said that he experienced weakness, loss of motivation, introversion, and reluctance towards eating. He would only eat two spoons of food during meals, drink only a half of glass of milk at school and that he reduced his liquid and food intake significantly. This continued for about one and a half months (patient's weight: 48 kg). After that the family brought the patient to a pediatrician in a provincial hospital where he was prescribed medication. His mother stated M.A. only used the proton pump-inhibiting drugs for two days. After that he hid them and she found the medication in his bag, pencil case or the trash. When asked why he did not take the medication he said: "If my stomach gets better, I will eat again and gain wait". Therefore, he hid the drugs. After the family took M.A. to the same doctor again, he referred him to the child and adolescent psychiatry department in a hospital in Denizli, Turkey because he thought that the problem of M.A. was psychological. The family took M.A. to the child and adolescent psychiatry department and he was admitted to the clinic. The patient weighed 47 kg on admission and his Body Mass Index (BMI) was calculated as 18.82 kg/m^2. The preliminary diagnosis was "Anorexia Nervosa and Major Depression". Drug treatment was started with one antidepressant (Fluoksetin 20 mg/day) and an antipsychotic (Aripiprazol 2.5 mg/day).

The Relationship of the Patient with Family Members: M.A. stated that there was no problem in the relationship with his father and that it was a normal father-son relationship. The mother is a housewife. While M.A stated that his relationship with his mother is normal he also said that she is extremely caring, protective and controlling. M.A. said he has a ten-year old sister, to whom he has a normal brother-sister relationship and that they would sometimes play and study together and also fight from time to time.

Mental Examination: It was observed that the patient's interest in himself and his care had decreased. He was very weak, exhausted and exhibited slow movements. His head was tilted forward and his shoulders were slumped. He had a stagnant, frozen and unhappy facial expression. During the healthcare professional interaction, he did not establish eye contact. He used calm, short and clear phrases with a low voice. His insight regarding his disease was limited (he said that he was not ill and that there was not a major problem). He thought that he was overweight, that he would gain weight and that he could not stop it and that he must stay thin. The patient's mood was observed as depressed. Perception, memory, orientation, intelligence and abstract thinking ability were within normal limits. His self-concept was negative. At first the patient did not answer the question about self-concept. He used the transient response: "Ask my mother". When he was then asked to rate himself between 1 and 10, he gave himself a 4–5 out of 10 regarding self-concept (which happened indecisively and unwillingly). Within the clinic, he only established a limited communication with other patients and clinical staff.

Nursing Care Plan

Eight meetings were carried out with M.A. from 14.11.2017–05.12.2017 for 30 minutes two times a week. It was observed that M.A. was reluctant and cooperate during the first meetings, so the patient was reminded about the meeting times and the subject. Due to M.A.'s attitude, the nurse started to experience feelings of anxiety and helplessness. During the meetings, M.A. was uneasy and restless, which created a concern with the nurse that the meetings would be cut short. The nurse thought

his attitude stemmed from the fact that he thought he was not ill and did not need any treatment. At the start of the meetings topics were chosen that the patient would find fun and interesting, which increased his compliance with the meetings. The healthcare personnel exhibited a patient, sincere and empathic communication approach since the patient was an adolescent. After the third meeting, it was observed that the patient started to comply with the meeting time and was waiting beforehand at the place of the meeting. Interviews with the individual on a therapeutic basis suggested that he developed a feeling of trust in the treatment team and in the nurse. After this process, it was observed that M.A. had an increased awareness of the disease and showed cooperation regarding medical treatment and nursing interventions. In order to implement the planned interventions effectively, help from the mother, who accompanied the patient, was requested.

Nursing Diagnosis 1: Nutritional Imbalance: "Eating less than required"

Etiological Factor: Due to the patient's deteriorated perception of the body.

Expected Outcome: The individual will eat and maintain a balanced diet.

Nursing Interventions

- Realistic, necessary and sufficient caloric requirement of the individual will be defined in cooperation with a doctor, a dietician and the individual.
- The issues regarding the patients' desire to be thin and the thoughts preventing him from eating will be discussed.
- Laboratory results, daily intake and output and daily weight will be monitored.
- Behaviors of M.A. such as destroying food and exaggerating his own weight will be monitored.
- The environment will be set up for the meals (ventilated room).
- While the patient is eating, someone will sit with him and the eating time will be limited to 30 minutes.
- After meals, the patient will be monitored for at least one hour, he will be accompanied to the bathroom and he must be given positive feedback about his eating.

Evaluation: The weight of M.A. during the first weeks was 47.45 kg (BMI=19.007 kg/m^2). During the nursing interventions, it was observed that his irrelevant and angry thoughts and attitudes continued regarding issues about eating. He did not finish his meals completely (he ate 100 cc soup and drank 200 cc buttermilk). Nursing approaches were continued with the knowledge that the food-related behavior of the patient would not change anytime soon. It was observed that the patient sat for one hour in the room with a reluctant attitude. Additionally, M.A. was very angry about the nurse documenting what he ate. After he calmed down, his emotions about this issue was discussed. He said that he doesn't like it when his food intake is being written down and calculated. During the third week, his weight was 51.75 kg (BMI=20.733 kg/m^2). It was observed that the patient willingly took out cheese and olives from the refrigerator for breakfast. During the fourth week, his weight was 51.95 (BMI=20.813 kg/m^2). He ate cheese, milk, marmalade, honey and two slices of bread for breakfast. M.A. ate things such as yoghurt, fruit and juice for snacks. During the fifth week, his weight was 53.50 (BMI=21.434 kg/m^2). M.A. eats three meals and one snack per day. This increased the motivation of the nurse.

Nursing Diagnosis 2: Liquid Volume Deficiency

Etiological Factor: The patient presented with excessive weight loss due to vomiting.

Expected Outcome: The fluid-electrolyte balance of the individual will be maintained.

Nursing Interventions

- Foods that M.A. likes and does not like will be evaluated and he will be assured that he will have liquids he prefers. Two liters of fluid intake will be given daily.
- The patient and his family will be given an explanation for the need to maintain adequate hydration and the methods of providing the needed amount of fluids.
- The patient will be observed for signs of dehydration.
- Weight, vital signs and fluid intake-output will be monitored.
- The patient and family will be educated about fluids that are effective diuretics such as coffee and tea.

Evaluation: It was observed that M.A. only listened without establishing any eye contact during the planned interventions in the meetings. M.A.'s pulse was 82/min and blood pressure was 90/60 mmHg. He stated that he could only drink water and milk because he only liked those liquids. The intake-output was monitored as 2300 cc liquid intake and output was four urinations and one-time vomiting.

Nursing Diagnosis 3: Ineffective Coping

Etiological Factors: The patient presented with loss of control due to feelings.

Expected Outcome: M.A. will make necessary decisions to change the negative situation around him and to take appropriate actions in accordance with his decisions.

Nursing Interventions

- Assist M.A. in recognizing the consequences of his own personal coping style and behavior (such as disruption in social interactions).
- Define the beginning of emotions and symptoms and their relationship with events and life changes. The patient will be evaluated if he hurts himself or not.
- Increase environmental support with the inclusion of the family in treatment.

- Present M.A. with alternative perspectives that are more promising but not detached from reality.
- Discuss coping with thoughts that prevent him from eating. These include stopping negative thoughts about food and giving homework to the patient that automatically reveals his thoughts about eating and replace them with rational thoughts.
- Encourage M.A. to evaluate his behaviors (Did this behavior help you in any way?).

Evaluation: The patient stated that he would try to express his feelings and thoughts and he would not be alone when encountering a problem. He said: "I will look more hopeful into the future". But during the meeting he avoided the basic problems (eating, weight gaining thoughts) and got angry with topics about food. Consequently, the nurse felt the patient was not cooperating and was not going to be successful. With the progression of the treatment and care M.A. stopped being angry when the topic of eating and weight gain was discussed by week three.

Nursing Diagnosis 4: Disturbance in Body Image

Etiological Factors: The patient presented with a decrease in self-esteem secondary to Anorexia Nervosa.

Expected Outcome: M.A. will exhibit behaviors that show his acceptance of his appearance (self-care and eating patterns).

Nursing Interventions

- Assist M.A. in expressing his thoughts and concerns about himself, body image, size/weight, eating, bodily functions and physical requirements.
- Teach M.A how to verbalize confirmative and realistic thoughts about his body.
- Encourage M.A. to create his own expressions and repeat them throughout the day.
- Encourage M.A. to communicate with his peers and family (phone calls, visitations).
- Encourage M.A. to talk about stressful thoughts such as being thin, being overweight, being perfect and his appearance.

Evaluation: He was reluctant to talk while discussing the interventions. Consequently, the meetings started with topics such as his hobbies, computer games he liked and books he had read. The nurse said that she liked the same book when she was M.A.'s age, which made M.A. very happy. After that M.A. stated that he said the phrase "I am not fat" five times throughout the day. He also said that he looked in the mirror three times a day. It was observed that his self-care was very good.

Nursing Diagnosis 5: Disturbance in Self-Esteem

Etiological Factors: The patient presented with a sense of inadequacy and worthlessness.

Expected Outcome: M.A. will express his own positive aspects.

Nursing Interventions

- Encourage M.A. to express his feelings, especially feelings about himself.
- Encourage M.A. to ask questions. He will be provided with valid and reliable information.
- Assist M.A. to get positive feedback and support from friends by encouraging him to join activities.
- Give M.A. some responsibilities to increase his sense of trust.
- Discuss with M.A the importance of speaking comfortably, being at peace and making eye contact.
- Teach M.A. effective communication techniques such as "I" language (I will be hurt if you say this).
- Educate M.A. in assertiveness techniques. He will be given an explanation about the differences between passive, determined and aggressive behaviors. Assert that he understands the importance of protecting one's own fundamental rights but also to respect the rights of others.
- Encourage M.A. to recognize negative unplanned thoughts and extreme generalizations.

Evaluation: M.A. said that he is a hardworking, organized and tidy person. He stated that he wanted to become a mathematics teacher and that he loves the subject mathematics. When he was asked to evaluate himself from 1 to 10, he gave himself six points without hesitation (during his first meeting he gave himself four to five points). This improvement increased the professional satisfaction of the nurse.

Nursing Diagnosis 6: Distortion in Social Interaction

Etiologic Factors: The patient presented as not being able to relate to or trust others.

Expected Outcome: M.A. will report an increase in satisfaction with socialization.

Nursing Interventions

- Encourage M.A. to try new social behaviors. Daily activities will be planned.
- Affirm role models for certain behaviors accepted by society such as greeting, thanking, and congratulating others.
- Encourage M.A. to be active during sports hours and activity hours and to communicate with other patients.
- Encourage family members to understand and support the patient.
- Observe M.A. establishing eye contact while communicating.

Evaluation: While his participation at the activity and sports hours and sweet Tuesday activities were short, he started to increase his participation in the following weeks. As of the fourth week, M.A. willingly played volleyball and Taboo. He started to say "good morning" to other patients in the clinic and their families. After receiving his medication, he said "thank you" to the clinic nurse. Although he communicates,

he continues to have difficulties in establishing eye contact.

Nursing Diagnosis 7: Risk of constipation

Etiological Factors: The patient presented with reduced fluid and nutrient intake.

Expected Outcome: M. A. will indicate that bowel movements continue to be adequate every 1-3 days.

Nursing Interventions

- Monitor daily fluid intake to ensure 2 liters are consumed as well as one glass of water when he wakes up.
- Educate M.A. about foods containing fiber (hazelnuts, walnuts, apples, pears, cucumbers, grapes, wheat bread, vegetables and fruit juice) and the importance of eating them.
- Assign a regular time for defecation and explain the importance of not delaying the need to defecate.

Evaluation: It was observed that M.A. is quiet and calm during the meetings and that he does not make eye contact. During the first two weeks M.A. stated that he needed to defecate every two days and that he would satisfy this need sometimes after four to five days. Towards the fourth- and fifth-week M.A. said that he did not experience any difficulty or pain during defecation.

Discussion

Eating disorders in men are very rare.[8] Because AN patients exhibit behavior related to continuous weight loss and sensitivity to low nutrient consumption during most of the day, their social interactions are impaired.[9] This patient has significant social withdrawal, he is not seeing any friends and his problems with family members are important factors regarding disrupted social interactions. The etiology of AN includes biological predisposition, psychological problems, developmental causes and stressful life events.[10] In this case, a burn on the patient's foot caused him to be bedridden for a long time. The feedback about his weight gain caused the disease to precipitate and the patient started to diet.

Restrictive approaches within the family and false attitudes and behaviors that prevent the development of autonomy of adolescents are reported to pave the way for the development of AN.[11] In this case, the mother-child relationship made it difficult to develop autonomy of the adolescent and led to the child remaining childish. In an article about male anorexic patients it was stated that fathers of male patients are either living away from home or are not living. If they lived in the same house they were estranged and distant;[12] contrary to mothers who are extremely protective and controlling and exhibit behaviors and attitudes that prevent the adolescent from gaining autonomy.[13] In this case the mother exhibited behavior that prevented the patient from developing autonomy and acting childish. Additionally, there was no distinct father figure, which is compatible with the family structure of a patient diagnosed with AN.

Studies reported that other psychiatric disorders, such as depression, personality disorders and anxiety disorders, are often accompanied by eating disorders.[14–16] The accompanying depression in this patient supports this information.

A therapeutic and empathetic patient-nurse relationship accelerates compliance with hospitalized AN patients.[17] In this case, planning and implementation of the interventions enabled the patient to express his feelings and thoughts. This facilitated this introverted patient who was unwilling to open up to talk about his positive aspects and future plans. An empathic approach and interaction have alleviated the patient's concerns about boredom, feelings of isolation, eating and weight gain. He began to improve his relationships with his peers in the clinic. In addition, the individual stated that less control over eating and exercise is necessary for recovery and he understood the importance of weight gain.

Inpatient treatment of an anorexic adolescent is a lengthy process. This process distracts the individual from their home life, school, family and friends. The patient can adapt to social life if the clinical setting is prepared in a therapeutic manner and if applications for social life exist in this environment.[18] In this case report the clinic offered sports hours, activity hours and sweet Tuesday activities. These were important for the patient in terms of participation in social and recreational interactions and having a rewarding time with other patients his age.

For an anorexic person, recovery is a challenge to his or her identity.[19] This is because anorexia is an ego-syntonic disorder.[20] The desire to be thin goes along with the person's attitudes, beliefs and values. It is very important that a person diagnosed with anorexia is stable and that their motivation for recovery is high. This can be achieved with motivation, and a therapeutic and empathic approach of the treatment team.[19] In this study, the willingness of the patient to recover increased with a motivating and empathic approach, which supports this information.

Conclusions and Recommendations

Studies on eating disorders are limited due to the limited number of cases. Information on this subject is mostly based on case reports.[1,21] In this case report, a male adolescent patient diagnosed with AN, was identified with inadequate nutrition, fluid volume deficiency, ineffective coping, discomfort with body image, discomfort in self-esteem, deterioration in social interaction and the risk of constipation. Interventions were implemented in line with the determined targets. The nursing care for the patient with anorexia nervosa was successful following the planned nursing care process. There is a need for increased information and further studies with larger samples on the planning of nursing care for adolescents with AN.

Limitations

Since nursing care for the patient was planned and administered twice a week it was not possible to organize the same

nurse every time. This could be seen as a limitation of the case study.

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