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About the Authors

Marilyn Hanser, RN, BSN, MA, graduated from Baylor University School of Nursing in 1976. Upon graduation she joined the U.S. Navy and was stationed at Naval Regional Medical Center in Oakland, California, where she achieved the rank of Ltjg before she was honorably discharged in 1978. She earned a masters degree in humanities from California State University Dominguez Hills in 1993 and has owned her own health education and consulting business specializing in women’s health issues.

Shelda L. Hudson, RN, BSN, PHN completed her Baccalaureate Degree in Nursing and public health certificate at Azusa Pacific University. As the Director of Healthcare Information at NCCE, she is responsible for the activities of this department, selecting qualified, credentialed authors for the courses offered by the National Center as well as advising staff of required course design and criteria. Ms. Hudson has over 20 years of extensive experience in publishing courses in continuing education for health care professionals with the National Center.

Purpose and Goals

The goal of this course is to help the nurse understand and appropriately respond to the major issues confronting the adolescent girl and her family. Emphasis is on normal physiological, cognitive, and psychosocial development, and nursing interventions to address complications to normal development.

Instructional Objectives

Upon completion of this course, the learner will be able to:

1. Select the characteristics of the stages of adolescence.
2. List the major cognitive and psychosocial tasks of early, middle, and late adolescence.
3. Enumerate the major nutrition and exercise issues for the normal adolescent female.
4. Select the lifestyle choices and psychosocial factors that often complicate the normal developmental process of the adolescent female.
5. List the symptoms and major health risks of each type of eating disorder.
7. Outline sexually transmitted diseases prevalent among adolescent girls.
8. Enumerate factors to help the nurse recognize the adolescent at risk.
9. List nursing diagnoses and interventions appropriate to the adolescent girl.
10. Cite two community resources available to help adolescent girls cope.

Normal Physiological Development

There are three stages of adolescence, all of which have as their organizing principle the development of sexual and emotional maturity. These stages are labeled early, middle, and late adolescence.

Early Adolescence

This stage typically begins between 10 and 13 years of age and lasts from 0.2 to 1.2 years. It is initiated by the secretion of pituitary gonadotropins and growth hormone during sleep. From this beginning stage of adolescence to adulthood, the female body changes from a body fat content of approximately 8% to 22-25%. Even though there is little change in the rate of growth in weight and height during this early stage, the estrogen-induced redistribution of body fat toward the breasts, hips, and thighs, as well as an increase in total body fat content, is already underway.

Very early in this stage of adolescence the pituitary gland begins to secrete follicle-stimulating hormone (FSH), which stimulates growth of the ovaries. The ovaries begin to secrete estrogen, which starts the process of breast development, thickening of the vaginal mucosa, and enlargement of the uterus. Estrogen also causes increased pigmentation, vascularization, and eroticization of the labia, and enlargement of the clitoris. The endometrium thickens and undergoes a process of cellular differentiation resulting in an increase in the cellular content of actinomycin, creatine kinase (CK), and adenosine triphosphate (ATP). These changes in cellular content are necessary to prepare the body for the onset of menses. Estrogen stimulation also causes an increase in...
glycogen levels in the vaginal mucosa resulting in increased levels of acid-forming bacteria. This changes the pH of the vagina and increases the chance of developing yeast infections.

There are other physiologic changes at this stage of adolescence as well. The first and second pre-molars, permanent cuspids, and molars appear at this time. There is continuing neurodevelopment with increases in alpha and decreases in beta brain wave production. By the age of 12 girls should register a “mature” response on all standardized neurodevelopmental assessment tools.

These rapid physiological developments result in a preoccupation with the body. A girl may spend a lot of time in front of the mirror watching the changing mystery of her body as it unfolds. She often becomes obsessive about minor flaws and may tend to exaggerate the importance of certain body characteristics. Difficulties with minor grooming issues such as having a “bad hair day” or chipped nails may seem tragic.

**Middle Adolescence**

This stage usually occurs between 12 and 14 years of age and is the period with the most obvious physical changes. There is a dramatic increase in height (about 8-9 cm/year) followed in about six months by a weight increase. The average teen gains about 10 pounds a year between the ages of 10 and 14. This increase in weight often occurs before full adult height is achieved, resulting in a slightly chunky appearance that can be hard on a girl’s self-esteem.

This is the stage when the most fat tissue is deposited and the secondary sex characteristics are further developed. The breast and areola enlarge while pubic hair darkens, coarsens, curls, and expands. The stages of development of these secondary sex characteristics are outlined in Table 1. Menarche (the onset of menstruation) occurs at a mean age of 12.5 years in the U.S. and is closely linked to the weight increase curve. Menarche is also affected by factors such as genetics and nutritional status. There are changes in sleep patterns that tend to increase daytime sleepiness. Girls may also need more sleep at this time due to the enormous energy required by the adolescent growth spurt. Many of the hormones responsible for increased growth and other pubertal changes are released during sleep.

**Late Adolescence**

This stage usually occurs between 14 and 17 years of age. There is little height added and the development of secondary sex characteristics is completed. Pubic hair extends to the inner surface of the thighs, breasts achieve their full adult size and shape, and uterine fundal growth is completed. As far as we know there is no further neurodevelopment.

**Normal Cognitive and Psychosocial Development**

Cognitive changes from infancy to adulthood are often described in terms of Piaget’s theories of human cognitive development. Piaget was a Swiss psychologist who postulated stages of cognitive development that closely approximate physical development.

It is possible to draw some general conclusions about adolescent cognitive abilities based on Piaget’s theories.

**Early Adolescence**

Since this stage spans ages 10 to 13 years, the younger girls will probably still show signs of concrete thinking while the older girls may be moving into the next stage and thus be capable of abstract thinking. While there is a great deal of overlap between the two stages, the general direction of cognitive growth at this age is toward increased ability to:

- process information
- organize information
- think abstractly
- think about thinking, and enjoy the competitive nature of thinking
- exhibit autonomous thinking when dealing with moral issues

In both early and middle adolescence, girls exhibit black-and-white thinking and a tendency to over-generalize.

The early adolescent girl functions as a member of a family, a peer group, and a student in a school environment. Her major psychosocial task

<table>
<thead>
<tr>
<th>Development of Secondary Sex Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breast Development</strong></td>
</tr>
<tr>
<td>Stage 1: Papilla elevation</td>
</tr>
<tr>
<td>Stage 2: Breast bud development and enlargement of areola</td>
</tr>
<tr>
<td>Stage 3: Further enlargement of areola and breast</td>
</tr>
<tr>
<td>Stage 4: Projection of areola and papilla</td>
</tr>
<tr>
<td>Stage 5: Maturity – projection of papilla only</td>
</tr>
</tbody>
</table>

| **Pubic Hair Development**                  |
| Stage 1: Prepuberty – not developed past abdominal wall |
| Stage 2: Sparse growth of long hair along labia |
| Stage 3: Hair darkens, coarsens, and curls   |
| Stage 4: Hair adult in type but not spread medially |
| Stage 5: Hair adult in type and spread medially to surface of thighs |

Table 1
is to begin the process of separating from her family. She does this primarily by turning to girls in her peer group to meet her social needs. These relationships center on activity rather than on relationship issues. There is a lot of conformity in them, but they serve the purpose of initiating family separation simply because they are not family relationships. True autonomy comes later. At the same time girls want to remain close to their parents and may even initiate arguments just to maintain an emotional connection to the family.

Functioning in the school environment is not usually a problem unless a girl develops physically at an earlier or later age than her peer group, in which case self-image problems may develop. Some studies do show a disturbing trend toward subtle favoring of boys in the junior high and high school years (by parents, teachers, and principals), which may dampen the confidence of girls and hinder their academic progress.

**Middle Adolescence**

The movement from concrete to abstract thinking continues but this movement is a process, not a clearly defined point in time. Peer and school groups continue to gain importance. Girls at this age are learning interpersonal skills and as a result are beginning to value loyalty, commitment, intimacy, and privacy in their peer relationships. There are more arguments with their mothers and distancing from their fathers during this time.

The social group extends to members of the opposite sex and paired dating may start. Sexual identity is established and a sense of sexual adequacy develops. For some girls this may be a time when certain vocational and educational decisions are made as well.

**Late Adolescence**

The important psychosocial task of late adolescence is the development of the capacity for intimacy. This is possible only if the girl has achieved the tasks of earlier development and individuated from family and friends. Loyalty, trust, and emotional availability are priorities in peer relationships. There is a gradual return to the family with a new family homeostasis established as the adolescent begins to dialogue with her parents.

**Normal Nutrition Needs**

During the period of rapid growth that occurs in adolescence, the body has increased nutritional needs. It needs more calories, more protein to build muscle, more calcium to build bones and teeth, and more vitamins and minerals for metabolic activities. A summary of these nutritional requirements is provided in Table 2. A girl’s diet during these years not only affects her own health but that of her future children as well. She needs three square meals plus three healthy snacks each day.

The importance of adequate calcium intake at this stage of life cannot be over-stressed. Low levels of calcium intake may limit longitudinal bone growth and adversely affect adult height. Inadequate calcium intake in adolescence can substantially increase the risk of osteoporosis in old age. The generally recommended adolescent intake is 1200 mg/day of elemental calcium; some experts recommend amounts as high as 1600 mg/day. The 1200 mg recommendation is equivalent to about a quart of milk or calcium fortified orange juice each day. Other food sources rich in calcium are yogurt, cheddar and swiss cheese, and tofu.

Vitamin D is needed for calcium absorption and is found in adequate amounts in milk; it can also be obtained in supplement form. Recommended intake is 400 IU daily. Sun exposure helps the body produce its own Vitamin D in the skin.

Girls should normally get their calcium and Vitamin D from dietary sources, but on occasion supplementation may be needed. Not all calcium supplements are the same. The most popular form is calcium carbonate, but it may cause an upset stomach or constipation in some people. In such cases calcium citrate, gluconate, or phosphate is recommended. Recommended dosages refer to the amount of elemental calcium in each pill. For example, Oscal 500 comes in a tablet size of 1250 mg but it yields only 500 mg of elemental calcium per pill. To meet the recommended daily calcium requirement an adolescent girl would need 2 1/2-3 tablets each day. Antacids like Tums contain 200 mg of elemental calcium per tablet and are especially good if money is tight because they are much cheaper than other supplements.

Another important consideration in discussing the calcium requirements of adolescent girls is the ratio of calcium to phosphorus. The important psychosocial task of late adolescence is the development of the capacity for intimacy. This is possible only if the girl has achieved the tasks of earlier development and individuated from family and friends.
to phosphorus intake. Phosphorus is important in the development of bones and teeth and in most of the metabolic pathways of cells, including the formation of nucleic acids, proteins, phosphatides, and ATP. However, for optimal bone health, the ratio between calcium and phosphorus intake must remain in balance. The ideal ratio is 1/1. If phosphorus intake exceeds calcium intake over an extended period of time it upsets complicated calcium homeostatic mechanisms, resulting in calcium losses and a negative impact on bone mass. Chocolate, soft drinks and phosphate additives in processed foods are common items in adolescent diets. They are all also high in phosphorus and likely to contribute to an imbalance in the calcium-phosphorus ratio. (See Table 3.)

Normal Exercise Needs

Adolescent girls are increasingly unlikely to make recreational choices that involve significant amounts of time in physical activities. The average adolescent gets only about two to three hours of physical education a week as part of her school curriculum, and much of that time is spent standing around rather than in actual exercise. It is important for adolescents to begin to develop healthy exercise habits that will last a lifetime. They need to learn about exercise as a stress reducer and as a way to build self-confidence as they become more comfortable with their changing bodies. Chemicals called endorphins are released in the brain during aerobic exercise. These chemicals serve as a major source of tension reduction. They also help elevate mood, decrease anxiety, increase self-esteem, improve body image, decrease menstrual cramps, and promote healthy sleep patterns. Therefore, normal teens should be encouraged to get some form of aerobic exercise every day. This can be achieved by walking to school, biking to friends’ houses, and/or participating in sports such as tennis, swimming, or hiking. If good exercise habits are developed during the adolescent years there is a greater likelihood that girls will be active as adults.

Complications to Normal Adolescent Development

Complications to normal adolescent development fall into two broad categories:

1) lifestyle choices made by the teen herself; and 2) psychosocial factors that discourage healthy lifestyle choices. To assess an adolescent’s lifestyle choices look at her current eating patterns, exercise and activity levels, and television viewing habits. Psychosocial factors which impact her ability to make healthy choices include society’s obsession with thinness, the need for peer acceptance, a history of sexual abuse, the high incidence of sexually transmitted infections among teens, and teen pregnancy.

Lifestyle Choices

Although adolescents today are more knowledgeable about nutrition than past generations, they are not necessarily putting that knowledge to personal use. The typical adolescent diet is still too high in fat, refined sugar, and salt; and too low in fiber, dairy products, iron, magnesium, zinc, phosphorus, and essential vitamins. Middle class teens often try to make up for dietary deficiencies by taking supplemental vitamins. This suggests their diets are deficient in some of the recently discovered phytochemicals found only in whole foods (primarily fresh fruits and vegetables). These phytochemicals contain important substances with anti-carcinogenic properties not found in vitamin supplements. Surveys show that most teens don’t know which foods are supplements. Surveys show that most teens don’t know which foods are high in fiber. Obviously this directly impacts their ability to make healthy choices in that regard. Soft drink consumption is on the rise and affects nutrition in these ways:

- carbonated beverages are often a substitute for milk, thereby decreasing calcium intake
- they are high in phosphorus, upsetting the calcium/phosphorus ratio
- they are high in refined sugar

As a result of these factors today’s adolescent is at an increased risk for many diseases as she ages, such as obesity, heart disease, diabetes, osteoporosis, dental caries and diet-related cancers. If she leads a sedentary lifestyle she is not burning off the excess calorie intake from a diet high in fat and refined sugar. For example, the average teen watches about three hours of TV a day. During this time

<table>
<thead>
<tr>
<th>Food</th>
<th>Serving</th>
<th>Ca (mg/serving)</th>
<th>Phosphorus (mg/serving)</th>
<th>Ca/P</th>
</tr>
</thead>
<tbody>
<tr>
<td>White Bread</td>
<td>1 slice</td>
<td>35</td>
<td>30</td>
<td>1/0.9</td>
</tr>
<tr>
<td>Whole Wheat Bread</td>
<td>1 slice</td>
<td>20</td>
<td>74</td>
<td>1/3.7</td>
</tr>
<tr>
<td>Skim Milk</td>
<td>1 cup</td>
<td>302</td>
<td>247</td>
<td>1/0.8</td>
</tr>
<tr>
<td>Whole Milk</td>
<td>1 cup</td>
<td>291</td>
<td>228</td>
<td>1/0.8</td>
</tr>
<tr>
<td>Plain Yogurt</td>
<td>1 cup</td>
<td>415</td>
<td>326</td>
<td>1/0.8</td>
</tr>
<tr>
<td>Cheddar Cheese</td>
<td>1 oz.</td>
<td>204</td>
<td>146</td>
<td>1/0.7</td>
</tr>
<tr>
<td>Apple</td>
<td>1</td>
<td>10</td>
<td>10</td>
<td>1/1</td>
</tr>
<tr>
<td>Banana</td>
<td>1</td>
<td>7</td>
<td>22</td>
<td>1/3.1</td>
</tr>
<tr>
<td>Oatmeal</td>
<td>1/2 cup</td>
<td>9</td>
<td>89</td>
<td>1/9.9</td>
</tr>
<tr>
<td>Ground Beef</td>
<td>3 oz. cooked</td>
<td>8</td>
<td>135</td>
<td>1/16.9</td>
</tr>
<tr>
<td>Chicken</td>
<td>1 piece dark meat</td>
<td>13</td>
<td>81</td>
<td>1/6</td>
</tr>
<tr>
<td>Corn</td>
<td>1/2 cup</td>
<td>2</td>
<td>39</td>
<td>1/20</td>
</tr>
<tr>
<td>Potatoes</td>
<td>1 baked</td>
<td>21</td>
<td>115</td>
<td>1/5.5</td>
</tr>
<tr>
<td>Green Beans</td>
<td>1/2 cup</td>
<td>30</td>
<td>16</td>
<td>1/0.5</td>
</tr>
</tbody>
</table>

Table 3
she is not exercising and, since more than 60% of all advertising is for food products, gets many false messages about food consumption as well. (Soft drink, coffee and alcohol advertising comprise a large part of these commercial messages.) Studies correlate excessive TV viewing with poor physical fitness in adolescents. The more TV an adolescent watches the more likely she is to snack and the more likely she is to choose less nutritious snacks. The obvious result is a girl who is taking in more calories and expending fewer calories than is her less TV dependent peer. An adolescent who spends a lot of time watching TV is also not involved in other activities that require more energy expenditure.

Psychosocial Factors

American society is very weight conscious and preoccupied with body image. For many adolescent girls it is not enough to be at a healthy weight or to have an average sized body. Instead, they are preoccupied with attaining the reed-like body of fashion models, TV personalities, and movie stars. For most girls this is an impossible goal, since this particular body type is naturally present in only about 5% of the population.

In her book, Never Too Thin: Why Women are at War with Their Bodies, Roberta Pollack Seid, PhD, traces the historical development of the desire to be thin. Today, she asserts, the obsession with thinness has become a religion and women’s bodies are sacrificed at its altar. Adolescent girls are very much aware of this new religion. At puberty a girl sees her body changing, becoming more and more unlike the new “religious” ideal. Often she tries to assert control over this process of physical maturation, a process in which she, in reality, has virtually no control. It is out of this attempt to control the uncontrollable that eating disorders develop. The primary reasons girls give for following a nutrition or fitness plan are to lose weight and to look better.

Even if a girl is fortunate enough to live in a home where the parents question society’s obsession with thinness, she is still in a precarious position because her peer group has bought into the obsession. If her peers are constantly talking about body size, weight, and dieting, it is difficult for the individual girl to resist the preoccupation with her own body and its “faults.” To fit in she, too, must adopt the new religion. If her family hasn’t seen the need or found a way to resist these messages, the individual girl has little chance of escaping the “sacrificial altar.”

Normal Eating Patterns

There are numerous internal signals that control food intake. Most are aimed at sustaining a certain caloric and nutrient intake rather than regulating food volume. The result is that a normal person will eat less of a calorie- and nutrient-dense food and more of a food low in calories and nutrients.

Internal signals for eating come from the brain, stomach, intestines and liver. The brain has receptors that respond to the amount of blood glucose available for metabolic use. The stomach responds to food volume as well as nutrient density of the food consumed, and the duodenum releases a hormone called cholecystokinin (CCK) in response to the presence of food. When blood levels of CCK reach a certain point, the brain is signaled to stop eating. Immediately after a meal, blood glucose is plentiful and the body is not able to use it all; therefore, much of it is converted into glycogen and fatty acids in the liver and stored. Some satiety signals come from the liver in response to the increasing amounts of glycogen and fatty acids.

Other signals to eat come from outside the body rather than as a response to the body’s need for internal homeostasis. The taste, smell, and texture of food are powerful inducements to eat. Other signals may include stimuli such as the expected mealtime hour, seeing others eating, and the attractiveness of food presentation, and the learned response to these stimuli is to eat.

Food selection is another factor in determining food intake. It is not only necessary to decide whether to eat but what to eat as well. Human beings, in general, eat a wide variety of foods, a tendency that increases the likelihood that consumption of all necessary nutrients will occur. There are often cultural reasons behind food choices. For this reason food selection can be an avenue for making symbolic statements, distinguishing between social and family groups, and/or asserting independence and identity.

Eating Disorders

Eating disorders often begin in adolescence; a time of rapid physical changes, extreme sensitivity to social and cultural input, and stressful, challenging developmental tasks. Many adolescents find negotiating the teen years very difficult. Issues of dependency/autonomy, power/control, intimacy, personal effectiveness, and adequacy in on-going new situations are raised again and again. These normal adolescent challenges are exacerbated by a culture that elevates extreme thinness to a moral victory. Weight loss and thinness may be equated with self-control, power, self-esteem, or rebellion. Thinness can also mask the physical changes and sexual development that cause conflict, fear, and confusion for many teenagers. Many emotions may be put aside or assuaged by preoccupation with food, weight, binging or by the actual eating behavior. As a result, many eating-disordered adults are emotionally arrested at the adolescent state of development and must undertake those tasks as an adult in order to heal.

Prior to the onset of illness, some characteristics have been recognized in eating-disordered patients. Often the patients are over achieving, eager-to-please, feel that they must prove themselves and be successful, superior, even perfect. Clients may be overly concerned about or sensitive to their parents’ reactions to them and feel overly responsible for others. Non-expression of feelings may prevail when hurt, anger, etc., are depressed and harbored; such emotions are often shut out and denied as rapidly as they are experienced.
An eating disorder is defined as a disturbance in eating behavior that jeopardizes a person’s physical and/or psychosocial health. Eating disorders fall into three main types: anorexia nervosa, bulimia nervosa, and compulsive binge eating. Each of these has its own diagnostic criteria and potential medical and psychological dangers. Generally, however, they all have their roots in adolescence or late childhood.

**Anorexia nervosa** is found most frequently in middle to upper class white female adolescents. A loss of 15% or more of premorbid body weight (unexplained by other medical disorders) is one of the criteria for diagnosis. These girls appear emaciated and malnourished to others. However, the fear of becoming fat is so pervasive that they often have disturbed body images and do not appear emaciated to themselves. They deny they have a problem, believing, instead, that those concerned about their weight loss are the ones with the problem. This denial is extremely difficult to penetrate.

Most anorexics come from families that place more emphasis on achievement in sports, academics, and/or social status than they do on personal growth, maturation, developing independence, and interpersonal relationships. Often the anorexic has no sense of control over her life and believes she can achieve a sense of control by mastering her food intake and body size. She uses food to make a symbolic statement about her need for her own identity, to assert her independence, and to gain a sense of control. Paradoxically, what she finds is that the anorexic eventually controls her. As the disease develops she loses the ability to eat.

Sometimes anorexia develops due to a girl’s athletic aspirations. Prospective athletes and performers such as gymnasts and dancers are under severe pressure to conform to an ideal body type. They will voluntarily restrict food intake resulting in nutrient deficiencies, endocrine imbalances related to menstruation, eating disorders, and skeletal stress fractures. The younger a girl develops anorexia the greater the toll on her peak bone mass. Those at particular risk are girls with delayed onset of menarche due to insufficient body fat. If a girl begins training for a sport prior to menarche she is at high risk for developing the menstrual irregularities associated with poor skeletal development. A recent study also showed an increased calcium excretion rate, a decreased rate of bone formation, and an increased rate of bone reabsorption in anorexics. These results suggest appreciable deficiencies in mineral metabolism in patients with anorexia nervosa.

The most common physical findings of anorexia nervosa, besides the obvious emaciation and loss of muscle mass, are lanugo on the extremities, bradycardia, hypotension, abdominal pain and delayed emptying of stomach contents, very dry skin, brittle nails and hair, intolerance for cold weather, constipation, and ankle edema. Occasionally a heart murmur develops due to shrinkage of the heart muscle as the body begins to break down muscle to survive. This can result in abnormal blood flow patterns through the heart chambers and valves, which often show up on EKG.

Anorexics typically have never started menses or they have stopped menstruating due to the loss of body fat stores. A body fat content of 15-17% is necessary to keep estrogen at levels conducive to menses. Laboratory findings include anemia, low WBC count, low platelet count, low serum protein, and disturbances of the thyroid.

**Bulimia nervosa**, an eating disorder far more common than anorexia nervosa, is characterized by the practice of binge eating followed by self-induced vomiting or other forms of purging such as excessive laxative use, extreme dieting, and/or over-exercising. The binge eating is typically done in secret and is not in response to the body’s normal hunger signals. Instead, it is behavior associated with anxiety states and is an attempt to achieve an emotionally soothing effect. The foods consumed require very little chewing and are high in calories. A bulimic may consume as many as 20,000 calories within a one or two hour period. A binge usually ends with self-induced vomiting, abdominal distention and discomfort, social isolation, the use of diuretics and/or laxatives, fatigue, and sleep. This binge/purge cycle may be repeated as often as several times a day in the late stages of the disorder. The binge/purge cycle usually begins as a home activity but as it progresses girls will skip classes or other school activities in order to engage in the behavior.

The bulimic, in sharp contrast to the anorexic, is often aware of the abnormal nature of her eating patterns. As a result of this awareness she experiences shame and guilt. She may be filled with self-deprecating thoughts leading to severe depression. She is also more likely to be involved in other activities that demonstrate a problem with impulse control such as alcohol and/or drug abuse, shoplifting, and sexual acting out behaviors. She is often at normal weight.

There are serious medical concerns associated with bulimic behavior. Gorging can cause severe abdominal pain, gastric distention, nausea, and stomach rupture. Heart failure is a danger if she has a history of starving herself as part of her purging ritual. Eating excessive amounts of high calorie and high sodium foods may predispose the bulimic to hypertension, atherosclerosis, and/or elevated cholesterol and triglycerides as she ages. Self-induced vomiting can lead to esophageal rupture requiring immediate surgical intervention. Vomitus on the teeth can erode the enamel, while aspiration of vomit can lead to a life-threatening form of pneumonia. Frequent episodes of vomiting may also cause a painless enlargement of the parotid gland, a symptom often used to identify recent bulimic activity.

Some bulimics use drugs to induce vomiting and/or diarrhea; these drugs may have serious side effects. Ipecac syrup, when used repeatedly, can cause myocarditis. Overuse of laxatives can lead to dehydration, hypokalemia, and laxative dependency. Symptoms of hypokalemia include...
fatigue, muscle cramps, weakness, headache, heart palpitations and/or serious cardiac arrhythmias, and abdominal pain.

The sad fact that gets missed in this diet/binge cycling is the scientifically determined futility of the behavior: diets do not work. Diets cause changes in fatty acid synthesis, increased fuel mobilization, decreased energy expenditure, increased energy efficiency, and increased ability to store fat. The result of these changes in metabolism during dieting is increased weight once normal eating is resumed.

There are psychological changes that occur while dieting which also have a negative effect on the dieter's chances for overall success. Most dieters believe that dieting is just a matter of willpower. This belief is confirmed during the first few days of a diet when mood may be elevated and an increase in energy ensues. Soon, however, the restriction in calories leads to cravings, which are followed by a binge. The negative emotions resulting from the binge cause the dieter to renew her resolve, and dieting resumes, but the next binge is just around the corner. Over the course of a lifetime this can have a devastating effect on self-esteem. Adult women may eventually come to question the value of a behavior that has such consistently negative results, but the adolescent does not yet have adult experiences from which to draw. She sees the problem as her lack of willpower.

Both anorexics and bulimics have a strong tendency to initiate smoking as a means of weight control. Concern about weight may be an early predictor for the risk of smoking because the desire to be thin often outweighs concerns about the health risks of smoking. These girls also have a tendency to gain weight at a faster rate than their peers do once they stop smoking.

Obesity. Obesity is defined as weight 15%-20% more than the ideal weight established by the Metropolitan Life Insurance Standards, with an excessive proportion of fat tissue relative to body mass. It often begins in infancy and worsens at puberty. It tends to run in families, which makes it difficult to know whether the tendency to gain weight is genetically determined, or a psychosocial factor of the home environment. Most experts think it is probably a combination of the two factors. Studies show that if a child is not fed according to its own internal hunger cues but, rather, according to a timetable set by the caregiver, then that child may learn to ignore its own internal cues and eat in response to external cues. Others suggest that obesity is a direct result of parent/child conflict. If mealtimes are filled with tension and negative conversation a child may rebel against this emotional climate by soothing herself with food. If the child is used as a scapegoat in marital conflicts, she may turn to food for comfort.

In evaluating the environment in which a particular girl is reared, it is also important to consider cultural and ethnic influences. Different cultures place different emphasis on food, food preparation, and the length of mealtimes.

Sexual Abuse

Sexual abuse is defined as using children, adolescents, or other vulnerable persons in sexually exploitive behavior including such activities as fondling, masturbation, removal of clothing, genital and/or oral contact, and the use of objects for the purpose of providing sexual gratification to the perpetrator(s). Incest is one form of sexual abuse. It is defined specifically as sexual activity performed on a child by a member of the child's family group for the purpose of providing sexual gratification to the perpetrator.

Sexually abused adolescents are frequently hospitalized for symptoms they experience related to the abuse. These symptoms include feelings of guilt, anger, dissociation, depersonalization, disturbances in memory and sleep patterns, drug and alcohol abuse, impaired social functioning, self-mutilation, and eating disorders. Often the adolescent is unable to integrate the abuse experience into her developing personality. This keeps her from protecting herself in the future and leaves her at risk for re-victimization. Such betrayal at a young age can lead to doubts about the meaning and purpose of life.

Sexual abuse victims tend toward behavioral reenactment of the trauma. This reenactment may take three forms: harm to others, harm to self, and re-victimization. If such reenactment takes the form of violence toward others it generally means the victim has identified with her abuser and the power he/she wields, and that she is willing to act out the abuse on her own victim to attain some of that power herself. This scenario is more common in male sexual abuse victims than in females, but it does happen in females as well.

The more common response for girls who have been sexually traumatized is to act out the abuse on themselves through cutting and mutilation of the body, eating disorders, and/or suicide. If these girls survive to adulthood they are more likely to be re-victimized by rape, physical violence in their marriages, prostitution, posing for pornographic pictures, and by receiving unwanted sexual advances from men in authority such as clergymen, professors, doctors, and therapists. The children of these women are more likely to be sexually abused, perpetuating the cycle of abuse for generations. For these reasons it is imperative that health care professionals be aware of the dynamics involved in sexual abuse so they can intervene early in the cycle.

Pregnancy, Contraception, and Adolescence

While it is beyond the scope of this course to address the topic of pregnancy in detail, the prevalence of teen pregnancies makes it important to address the specific implications pregnancy has for the adolescent. Eighty per cent of teens presenting for pregnancy testing do not want to be pregnant. As a result they face difficult decisions regarding the consequences of their sexual behavior. The nurse may function as a counselor to help the girl clarify her choices regarding abstinence, contraception, safer sex, and STI screening.
The cultural pressure to be thin that may cause adolescents to neglect their nutritional needs often worsens during pregnancy. Their already fragile body image undergoes almost daily assault from the rapid physical changes associated with pregnancy. Since many teens are still growing themselves they must get adequate nutrients during pregnancy to provide for their own growth needs as well as the nutritional needs of the fetus.

Because the pregnant adolescent’s bones are still developing she needs 1200-1500 mg of calcium and phosphorus each day. She also has higher needs for iron (30 mg/day), protein (60 g/day), folic acid (400 micrograms/day), and calories (300 more/day) as well as slight increases in some of the other vitamins and trace elements. If these increased nutrient needs are met by supplementation rather than by diet, calcium and iron supplementation should occur at different times because calcium may interfere with iron absorption.

The normal weight gain for a single pregnancy is about 25-35 lbs. Teens, however, are sometimes underweight when they get pregnant; in this case a weight gain of 40 lbs. is recommended. Since perinatal mortality increases with maternal obesity, an obese pregnant teen should only gain about 15 lbs. However, she should not lose weight while pregnant since this could result in a low birthweight baby and seriously deplete her own nutrient stores as well.

Both adolescence and pregnancy are times when psychological issues arise. These issues include body image, society’s expectations about the role of the female, doubts about the parenting one received as a child, and separation and abandonment issues. It is hard enough when the experience of adolescence and pregnancy occur separately but when they occur simultaneously it can be very difficult for the adolescent to cope. If the pregnant teen also suffers from an eating disorder the situation is further complicated.

Currently, condoms or oral contraceptives with condoms are the most effective and widely accepted contraceptive methods for teens. Every teen must decide about the ease, efficacy, and safety of different methods. Unfortunately, the most effective methods for preventing conception provide the least protection against STDs. No one method is highly effective in preventing both, so the use of two methods concurrently is widely recommended.

**Sexually Transmitted Infections**

Many adolescents report having multiple sexual partners by their senior year in high school. As a result, they have a high incidence of sexually transmitted infections (STIs) including human papillomavirus (HPV), syphilis, gonorrhea, chlamydia, and HIV. *(See Table 4.)* Other factors contributing to this incidence include early onset of sexual activity, engaging in unprotected intercourse, and having sex partners that are at high risk for STIs.

STIs can have serious short-term and long-term consequences. Gonorrhea and chlamydia increase the risk for upper genital infections such as pelvic inflammatory disease (PID), which can lead to infertility, chronic pelvic pain, and ectopic pregnancy. HPV has been associated with cervical dysplasia and some cancers. HIV infection often causes death.

Chlamydia is the most commonly reported STI in the US today. Its symptoms are mild and therefore often go unrecognized and untreated. Symptoms include burning with urination and vaginal discharge and typically start one to two weeks after exposure. Diagnosis can be made with a simple urine test and does not require a pelvic exam.

**Nonsuicidal Self-Injurious Behaviors (NSSI)**

It is estimated that one to two million people in the U.S. deliberately and repeatedly cut, burn, bruise, mark, scratch or mutilate different parts of their own bodies.

Self Injurious Behavior (SIB) includes self-injury (SI) and self-poisoning and is defined as the intentional, direct injuring of body tissue most often done without suicidal intentions. The most common form of self-harm is skin-cutting but self-harm also covers a wide range of behaviors including, but not limited to, burning, scratching, banging or hitting body parts, interfering with wound healing, hair-pulling (trichotillomania) and the ingestion of toxic substances or objects. Although suicide is not the intention of self-harm, the relationship between self-harm and suicide is complex, as self-harming behavior may be potentially life-threatening. There is also an increased risk of suicide in individuals who self-harm to the extent that self-harm is found in 40–60% of suicides.

Self-injury has long been recognized as being related to many mental disorders. It is listed in the DSM-IV-TR as a symptom of borderline personality disorder. However, patients with other diagnoses may also self-harm, including those with depression, anxiety disorders, substance abuse, eating disorders, post-traumatic stress disorder, schizophrenia, and several personality disorders. Symptoms associated with each of these diagnoses will vary as they relate to NSSI; common symptoms include somatic problems, emotional inexpressivity, distress resulting from trauma, impulsivity, and other self-destructive behaviors. Self-harm is also apparent in high-functioning individuals who have no underlying clinical diagnosis. The motivations for self-harm vary and it may be used to fulfill a number of different functions.
These functions include self-harm being used as a coping mechanism that provides temporary relief of intense feelings such as anxiety, depression, stress, emotional numbness or a sense of failure or self-loathing and other mental traits including low self-esteem or perfectionism. Self-harm is often associated with a history of trauma and abuse, including emotional and sexual abuse. There are a number of different methods that can be used to treat self-harm and which concentrate on either treating the underlying causes or on treating the behavior itself. When self-harm is associated with depression, antidepressant drugs and treatments may be effective. Other approaches involve avoidance techniques, which focus on keeping the individual occupied with other activities, or replacing the act of self-harm with safer methods that do not lead to permanent damage.

Self-harm is most common in adolescence and young adulthood, usually first appearing between the ages of 12 and 24. Self-harm in childhood is relatively rare but the rate has been increasing since the 1980s.

Suicide

The emotional turbulence of the teen years puts adolescents at an increased risk for suicide. Often the triggers seem minor to adults, but keep in mind that an adolescent does not have adult experiences on which to draw. Adults have lived long enough to know that cycles of pain and joy are a normal part of human existence. We know that no matter how bleak things seem in the moment, they will eventually get better. Adolescents do not know this. This lack of knowledge, combined with the hormonal and emotional roller coaster of the teen years, often leads adolescents to believe situations are more catastrophic than they really are. They need caring adults who will listen without judgment and help them put things in perspective.

Recognizing the Adolescent at Risk

Factors affecting the health status of the adolescent girl are numerous and complex. It is often difficult to distinguish between the physical, emotional, spiritual, and cognitive factors affecting girls in general, but it becomes even more complicated when trying to assess each girl individually.

The first step in assessing the adolescent girl is a holistic assessment of her general health status. This covers the physical, emotional, cognitive, social, and spiritual dimensions. Answers to the questions posed will highlight areas that need further assessment. (See Table 5.)

To assess the physical development of the adolescent the nurse notes height and height velocity (this requires accurate measurement at 3-6 month intervals to determine a pattern); weight and body fat content (skin fold tests can be used to determine fat content); system development; sexual development (breast and genital development, age of menarche); and skin condition. A rapid growth pattern may result in orthopedic problems, while slow growth might indicate possible endocrine abnormalities. A thorough family history of growth and development will establish further norms against which to measure the individual adolescent.

The nurse should use the time of the physical exam to explore other possible areas of concern such as family problems, academic and peer pressure, and sexual development. Ask the adolescent to describe a typical day to determine sleep and eating patterns, social involvement, and general health habits. Ask about sexual activity and contraceptive use.

Disturbances in eating and sleeping patterns could signal depression, abnormal anxiety levels, and/or the beginnings of an eating disorder. Social withdrawal may be a sign of an alcohol or drug problem. Often an adolescent with a substance abuse problem will appear disinterested and moody and may be impulsive and self-destructive. A sexually active teen who is not using contraceptives needs further assessment to rule out pregnancy; ask questions such as: When was your last normal menstrual cycle? Handle the issue delicately because some teen pregnancies are the result of incest or of promiscuous behavior that developed as a reaction to incest or other sexual abuse.

A sexually active teen should be assessed for STDs (ask if she has any symptoms such as burning, itching, or sores in the genital area) and given information about the symptoms and dangers of her particular class of infection.

The National Cholesterol Education Program Expert Panel on Cholesterol in Children and Adolescents suggests the following screening guidelines in assessing a particular girl’s long-term risk for elevated cholesterol levels:

- screen all offspring whose parents and/or grandparents have undergone diagnostic testing or treatment for atherosclerosis by the age of 55
- screen all offspring whose parents and/or grandparents have been diagnosed with angina, M.I., vascular disease, or cardiac arrest by age 55
- screen all offspring of parents who have shown a cholesterol level of 240 mg/dl or greater.

Use the information gathered to assess whether the emerging patterns promote health. Is there consistency and balance between sleep, exercise, eating, eliminating? Is there balance between leisure and academic activities? If there is not a healthy balance make the appropriate nursing diagnosis and follow up with appropriate nursing intervention.

Assessing the emotional status of the adolescent can be somewhat difficult because even normal adolescence is a time of emotional lability, especially between the ages of 12-15. Emotional difficulties are often indicated by the following symptoms: sleep difficulties, changes in eating patterns, disruptions in friendships, increased conflict with family members, mood swings, preoccupation with bodily processes, and lack of impulse control. The presence of these symptoms may indicate the need for a depression assessment. Look for withdrawal and loss of interest in usual activities, acting out behaviors such as angry outbursts or
**STIs**

<table>
<thead>
<tr>
<th>STI</th>
<th>Symptoms</th>
<th>Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genital Warts (HPV)</td>
<td>Many have no symptoms Soft fleshy warts in the genital area</td>
<td>Newborn infection Cervical cancer</td>
</tr>
<tr>
<td>Trichomoniasis</td>
<td>Frothy, yellow vaginal discharge Discomfort during urination and intercourse Irritation and itching</td>
<td>Premature delivery Increased risk of HIV</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>75% have no symptoms Burning sensation when urinating Vaginal discharge Abnormal vaginal bleeding Lower abdominal pain</td>
<td>Pelvic inflammatory disease Infertility Ectopic pregnancy Infections in newborn</td>
</tr>
<tr>
<td>Syphilis</td>
<td>Primary: painless chancre at site of infection Secondary: skin rash, enlarged lymph nodes, flu symptoms</td>
<td>Neurological damage, paralysis Heart disease Newborn infection Stillbirth</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Night sweats or fever Weight loss Fatigue Skin rashes and spots</td>
<td>Severe infections Neoplastic diseases Newborn infection</td>
</tr>
<tr>
<td>Genital Herpes (HSV)</td>
<td>Recurrent painful genital sores Flu-like symptoms Painful urination</td>
<td>Meningitis, myelitis Urethral strictures Newborn infection</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>Many have no symptoms Painful urination Vaginal discharge or abnormal bleeding Lower abdominal pain</td>
<td>Pelvic inflammatory disease Newborn infection</td>
</tr>
<tr>
<td>Trichomoniasis</td>
<td>Frothy, yellow vaginal discharge Discomfort during urination and intercourse Irritation and itching</td>
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</tr>
</tbody>
</table>

Table 4
### Holistic Assessment Tool for Adolescents

**Affect**
- What is the adolescent’s affect?
- How appropriate is her affect?

**Mood**
- What is your predominant mood?
- Do you have mood swings?
- How well do you control your emotions?
- How well do you express your feelings?
- What are your fears and anxieties?
- Are you depressed, suicidal, angry?
- Do you feel hopeless?
- What are your coping skills?

**Table 5**

<table>
<thead>
<tr>
<th><strong>Self-concept</strong></th>
<th><strong>Dependence-independence</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe yourself, including your strengths and limitations.</td>
<td>What evidence is there of dependence-independence conflicts?</td>
</tr>
<tr>
<td>What kind of person would you like to be?</td>
<td>In what areas does the adolescent demonstrate autonomy?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Interpersonal relations</strong></th>
<th><strong>Spiritual Dimension</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is your best friend?</td>
<td>Philosophy of life</td>
</tr>
<tr>
<td>How do you get along with your parents, your brothers and sisters, your peers, and people at school, at work, and in the community?</td>
<td>What is the purpose of life?</td>
</tr>
<tr>
<td>How much time do you spend with your family?</td>
<td>What is important about life to you?</td>
</tr>
<tr>
<td>Who is supportive for you?</td>
<td>Who is your hero?</td>
</tr>
<tr>
<td>How do you get along with authority figures?</td>
<td><strong>Sense of transcendence</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Cultural factors</strong></th>
<th><strong>Concept of deity</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>What traditions do you and your family observe?</td>
<td>What is your view of God, or a higher power?</td>
</tr>
<tr>
<td>What conflicts arise from these traditions?</td>
<td>How similar is it to your parents’ or family’s view?</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th><strong>Environmental factors</strong></th>
<th><strong>Spiritual fulfillment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>What situations or events are stressful for you?</td>
<td>What is beautiful to you?</td>
</tr>
<tr>
<td>In what risk-taking events do you participate?</td>
<td>What are your creative abilities?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Level of socialization</strong></th>
<th><strong>How much do you question or reject your parents’ beliefs?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>How conforming or nonconforming is the adolescent?</td>
<td>How do you implement your own belief system?</td>
</tr>
<tr>
<td>What evidence is there of legal difficulties?</td>
<td></td>
</tr>
</tbody>
</table>
Genetic history
Who in your family has had any of the following mental or emotional illnesses?
- depression
- suicide
- drug addiction
- schizophrenia

Health history
What illnesses, injuries, hospitalizations, or surgeries, have you had?

Growth and development history
Describe your physical growth.
Describe your sexual growth.
Tell me about your experiences in kindergarten, elementary school, high school, college, or work.

Activities of daily living
Describe your typical day beginning with when you get up in the morning through the day until you go to bed at night.

Diet and elimination
What changes in your appetite and weight have occurred and over what period of time?
What problems are you having with elimination?

Exercise and activity
What kinds of activities do you participate in? How often? For how long?
What kinds of exercise do you participate in? How often? For how long?

Sensation and perception
Do you see, hear, feel, smell, or taste things that others do not?
Do you believe that your actions are outside your control?
How realistically does she perceive events and situations?

Memory
Immediate: Ask adolescent to repeat a question you asked.
Recent: Ask for events leading up to the adolescent’s seeking help.
Remote: Ask for descriptions of events in the adolescent’s early childhood.

Cognition
Is the adolescent oriented to time, place, person?
What is her knowledge of current events?
How well is she functioning academically?

Judgment
How does the adolescent make decisions?

Insight
Does the adolescent recognize that she is ill and needs help?
How much does she blame others for her difficulties?
How much awareness does she have of the impact of her behavior on others?

Abstract thinking
What is the adolescent’s style of thinking, concrete or abstract?

Attention
What is the adolescent’s ability to listen and concentrate?

Communication
What is the rate of speech?
What is the tone of speech?
Does the adolescent have any speech impediments/Is she verbally active?
Does she respond freely to questions?
Are her responses relevant?
How well organized are her thoughts?
Does she demonstrate blocking, circumstantiality, tangentiality, flight of ideas, loose association, neologisms?

Flexibility-rigidity
How open to new ideas and alternatives is the adolescent?
How upset does she get when her routine is disrupted?

Sleep and rest
How many hours of sleep do you get? Is it adequate?
What difficulties do you have going to sleep or staying asleep?

Tobacco, drugs, alcohol
How much do you smoke?
What drugs or medication do you take?
How much alcohol do you drink? What kinds of alcohol?
In what ways do drugs or alcohol interfere with your daily activities?

Leisure activities
What do you do for fun and recreation?

General appearance
The nurse notes any unusual physical characteristics, the style of dress, grooming, gait and posture, and general behavior.

Body Image
Describe yourself physically.
What do you think about your body?
Do you see yourself as normal?
What would you change about your body if you could?

Sexuality
What are your worries, concerns about your sexual self?
What problems are you having with menstruation, birth control, intercourse, or masturbation?
What is your sexual preference?

Genetic history
- depression
- suicide
- drug addiction
- schizophrenia

Health history
What illnesses, injuries, hospitalizations, or surgeries, have you had?

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Describe your physical growth.
Describe your sexual growth.
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How much awareness does she have of the impact of her behavior on others?
running away, low self-esteem and negative attitude (particularly hopelessness), unpredictable behavior, inability to pay attention, flat affect and/or mood swings, and appetite changes.

If the nurse suspects a girl is depressed it is important to determine whether the depression is related to a specific event (such as a death in the family) or is a chronic problem. Depression related to a specific event usually occurs within three to nine months after the event and does not seriously disrupt family or social relationships. Chronic depression is more likely to lead to drug use and suicide attempts.

Warning signs that a teen may be suicidal include:
- personality changes (e.g., an outgoing social girl suddenly becomes inactive)
- sudden mood swings
- inability to concentrate, resulting in poor grades
- apathy
- loss of friends or a significant change in the type of friends
- important losses (e.g., parental divorce, breakup with boyfriend)
- feelings of hopelessness, which may present as loss of interest in previously enjoyable activities, lack of usual concern about appearance
- obsession with death or suicidal threats
- putting personal affairs in order (e.g., giving away important possessions, making a will)

Some adolescents exhibit anxiety reactions which may have similar, but less severe, symptoms to those of depression. These symptoms may include distractibility, fear of the future, and irritability. These, too, can be the result of specific events or they may be indicative of a chronic problem. Try to determine when the symptoms first developed. Ask about deaths in the family, divorces of significant people in the patient’s life, illnesses, etc. From her responses, assess whether the patient’s emotional difficulties might stem from one of these events. Usually symptoms will develop within three months to two years in cases of anxiety reactions, and three to nine months in cases of depression.

Cognitive abilities increase rapidly during the adolescent years. To assess an individual’s intellectual development look first at her academic record. Consistency of grade point average, achievement, and classroom performance are obvious indicators of appropriate cognitive development; inconsistencies may signal problems in the emotional as well as the intellectual realm. If poor classroom performance is evident try to uncover the source of the problem. Observe and interview the family, school personnel, and sometimes even the girl’s peers. Look for clues that might explain poor academic performance, with particular attention to declines in performance over a relatively short period of time.

Because the adolescent is at risk for severe acting out behaviors in response to physical, emotional, or sexual abuse, experts now recommend that adolescents be screened annually for a history of abuse. This screening should be part of a regular exam.

Suggestions include:
- ask about treatment by caretakers (mother, father, grandparents) and ask about each one separately
- use both direct and indirect questions: “Were you ever mistreated?” and “How did your father act when he was drunk?”
- use a non-threatening approach, such as asking how a specific injury was obtained
- use follow-up questions to obtain more information: “Did anyone else ever hurt you?” or “Tell me more about that?” or “Has that ever happened before?”

Assessment of adolescent abuse is difficult because there are barriers to disclosure. These barriers include incomplete recall; belief that the abuse was deserved or an appropriate punishment; and family loyalty issues that cause the youth to hesitate in reporting a family member.

Disclosure may follow a pattern of denial and then a tentative admission that becomes clearer over time. This may be followed by a period of recanting, especially if there is family pressure to do so. Usually, however, if the nurse is patient the adolescent will reaffirm the allegation over time.

The abused girl may exhibit signs of fear, anxiety, sadness, guilt, hopelessness, depression, suspicion, withdrawal, hostility, mood swings, substance abuse, suicidal tendencies, and other erratic behavior. Fear in the presence of her parents is a good sign that abuse has occurred. The girl may exhibit academic difficulties and school-related behavior problems (e.g., cutting classes or dropping out of school), a poor attention span, or other signs of memory impairment. She may also exhibit spiritual conflict such as feeling unworthy of God’s love, having internalized the belief that she is unlovable. In her mind this is the only explanation for why her parents treat her in such an un-loving way.

There is a tendency for the victim and other family members to collude in protecting the abuser. The adolescent who admits to being sexually abused by a family member risks not only her relationship with the abuser but with other family members as well. This need to keep the secret may cause the victim to distance herself from her spiritual support system. Because of the emotional damage inflicted by the abuser (telling her that the abuse is her fault, that nobody will believe her if she tells) the teen may feel spiritually unclean and unworthy.

If the girl is a victim of physical battering the nurse might see physical signs such as bruising on the face, hematomas, neck marks suggesting strangulation, rope burns on the wrists and/or ankles, blisters and burns, bite marks, and evidence of multiple fractures.

The main developmental task of the adolescent period is identity formation. The adolescent girl must answer the question “Who am I?” One of the ways she does this is by interacting with her peers and observing ways in which she is different from them and ways in which she is similar to them. She is simultaneously moving away from identifying herself as a member.
of her family and trying to see herself as an individual instead.

To assess the social development of the adolescent girl ask her questions designed to identify identity problems. For example, “What are your fantasies about yourself?” “Where do you see yourself in three years?” “If you could be anyone or do anything, who would you choose to be and what would you choose to do?”

As the adolescent moves through the process of identity formation, conflicts with parents, other family members, and peers are inevitable. Difficulties in any of these relationships can adversely affect her developing autonomy, her self-esteem, and her ability to communicate effectively. Because she is so unsure of who she is, the adolescent is often ambivalent about intimacy lest she will lose herself in the relationship. Acting out behaviors like running away, serious fights over curfews, shoplifting, reckless driving, drinking, lying, gang involvement, drug abuse, promiscuity, eating disorders, and suicide attempts all signal that the adolescent is having difficulties in social development and needs further assessment.

To assess progress and problems in the adolescent’s push for independence and identity, observe the emotional climate in the family. Look for warmth, freedom to express true feelings, honesty in communication, unconditional love, age appropriate expectations, and encouragement of individual pursuits. Assess her peer group relationships by observing:

- endurance of her relationships (in general, are her relationships lasting or are they more transitory in nature?)
- amount of time spent with peers
- active or passive approach to making friends
- degree of conflict with parents over social activities and friends
- amount of peer pressure she feels regarding sexual activity, drug and alcohol use.

Spiritually, the adolescent task is to understand the meaning of life and to apply that meaning to the decision making process. This is a time of intense questioning of her parents’ religious beliefs as well as a time of rejection of institutionalized religion in general. The reality of human mortality becomes apparent, perhaps for the first time in her life, as she begins to ask the question “What is life all about?” She seeks perfection in all the people in her life as well as in herself. As a result she is often disappointed. This disappointment can be especially intense when she sees those she respects and admires behaving in ways that contradict their stated values. Often this leads to rejection of the values and religious beliefs of the adults in her life and an intense bonding with the moral code of her peers. Uncover this code by presenting hypothetical problem situations that require a moral code to find solutions. For example: A 13-year-old boy has been caught shoplifting. Should he be kicked out of school? Grounded for 6 weeks? Lectured by his parents? Turned over to the police?

Once an answer has been solicited, ask, “What is the most important part of this situation?” In listening to her responses look for the guiding principles behind her choices. Assess concepts such as fairness, honesty, loyalty, importance of family, peer pressure, and dependence vs. independence. Determine which beliefs are most important to her, how she uses them in her decision-making process, how similar her beliefs are to those of her peer group, whether she is working toward an integrated and consistent set of beliefs, and whether her belief system is flexible enough to allow for new information.

Nursing Diagnosis

The following nursing diagnoses might result from the above assessment process:

1. Altered nutrition: more than body requirement
2. Altered nutrition: less than body requirement
3. Altered thought processes and anxiety due to unrealistic body image
4. Sleep pattern disturbance due to repeated abuse
5. Self-esteem disturbance due to repeated abuse
6. Fear related to abuse
7. Spiritual distress
8. Personal identity disturbance
9. Impaired social interaction

These diagnoses demonstrate the importance of a holistic approach in assessing the adolescent girl. Nutrition, exercise, body image, self-esteem, eating disorders, and child abuse are all very much interrelated. Once any of these diagnoses has been made, further assessment is necessary to determine if any of the related diagnoses might apply as well. For example, the diagnosis of altered nutrition requires further assessment to determine the cause of the problem. Is altered nutrition: more than body requirement due to a sedentary lifestyle or to binge eating? If it is due to binge eating then the reasons for binge eating must be determined (e.g., child abuse may be present in these cases) before appropriate intervention can occur. If the altered nutritional status is due to a sedentary lifestyle then a different intervention would be needed. Those diagnoses pertaining to abuse require further assessment to determine what kind of abuse occurred, has it stopped, who is/was responsible, and what kind of intervention is necessary.

Nursing Interventions

No matter what the nursing diagnosis, the nurse needs to develop a treatment plan before she can effectively intervene on the adolescent’s behalf. The treatment plan should consist of the nursing diagnosis, short-term and long-range goals, criteria for evaluating the effectiveness of the intervention, the specific interventions planned, and rationales for making the interventions.

Altered Nutrition: More than Body Requirement (Obesity)

The first step is to determine the cause of the increased food intake, such as related to sedentary lifestyle, use of food for anxiety reduction, and/or eating in response to external cues.
If the nurse determines that a particular client is obese due to sedentary lifestyle the goals would involve a moderate dietary intake using sound nutritional principles (see Tables 6 and 7) and a moderate aerobic exercise program. Specific criteria to measure outcome might include a weight loss goal based on body frame and height, specified daily caloric intake which the adolescent keeps track of herself through the use of a food diary, and documentation of attendance at an aerobic class three times a week.

Teach her that all activity can aid in weight loss. Explore with her the kinds of things she already likes to do and incorporate those into the care plan. Help her identify feelings that might trigger the impulse to eat and teach her healthier ways to express those feelings. Help her confront any beliefs and attitudes that may be contributing to her overeating such as, “I can’t change my eating behaviors because being overweight runs in my family.” It is important to replace these negative ideas with more reality-based concepts such as, “I am in control of my eating.” Break goals down into short-term ones such as controlling intake at one meal only to help her develop more confidence in her ability to successfully control her eating.

It is difficult to make these changes alone. Help her develop a support system to rely on at difficult moments. Remember, however, adolescents often feel so much shame around these issues that sharing with one person, even the nurse, can be overwhelming. If she is willing, however, support groups are a good way for the obese to deal with weight issues because they are surrounded by others who are suffering in the same way and, therefore, can understand the problem and give the needed support. Include the girl’s family in the treatment plan. Family members, out of a misguided desire to help, often nag and criticize the adolescent’s food intake. This can be detrimental to achieving weight loss goals, especially if she eats for emotional reasons. Family members constantly hovering and criticizing will send her to the refrigerator faster than anything will.

If family dynamics are part of the problem, suggest family therapy as an intervention to improve communication patterns. Often the obese adolescent is ostracized by peers and therefore has not developed age-appropriate social skills. A therapist can help with this as well.

Consider any dietary taboos practiced by the girl or her family. These may include cultural practices, religious taboos, or simple preferences. By accepting these practices you model respect for the adolescent and her family and encourage the girl to respect herself. This also discourages feelings of hopelessness and depression that often accompany obesity.

Nursing intervention is considered successful when the client eats a balanced diet, exercises regularly, demonstrates improved self-esteem, and has an awareness of the feelings that trigger eating.

Altered Nutrition: Less than Body Requirement

A nursing care plan for an anorexic with the above nursing diagnosis should include long-term goals to restore normal nutritional status and to gradually increase weight to 10% above the girl’s ideal weight. Short-term goals need to address the irrational fear of gaining weight with cognitive intervention designed to teach a more rational attitude toward weight gain. New ways of thinking are crucial if the anorexic is to achieve long-term success in alleviating her disease.

Criteria for evaluating the achievement of goals involves the adolescent establishing a pattern of eating that includes foods high in calories, proteins, and complex carbohydrates. She must learn to monitor her own weight gain and maintain her goal weight once it has been achieved. As she learns to trust herself and those around her she will verbalize fewer fears about gaining weight.

Help her develop a food plan that is nutritious and high enough in calories to facilitate weight gain. She also needs to choose a desired weight goal. Assist her in these goals by explaining the connection between the fear of weight gain and the anorexic behavior. Awareness of this connection leads to more rational thinking. While it is important that the nurse assist the adolescent in goal setting, the nurse should not assume responsibility for the outcome. To be successful the anorexic must take responsibility for her own recovery. As she recovers teach her assertiveness and other effective skills for functioning in an independent manner. Work to instill a sense of hope in her by helping her discern the reasons for her existence. Once she has an understanding of her higher purpose it will be harder for her to behave in a self-destructive manner.

Most treatment for anorexics involves family therapy to ensure a home environment conducive to continued recovery. Therapy is most successful when a combination of various treatment methods are used: group, individual, and family therapies; behavioral and nutritional therapies; self-help groups; and in some cases prescription medications.

A nursing care plan for a bulimic with the above diagnosis should include long and short-term goals to restore normal nutritional status, to establish a realistic goal weight, to replace irrational fear of gaining weight with rational thinking, to identify the emotions that trigger a binge, and to teach alternative ways to cope with emotional triggers. Outcome criteria to measure whether the goals have been achieved include the establishment of regular eating patterns, cessation of self-induced vomiting, and less talk about the fear of gaining weight. Help her establish a nutritionally sound eating plan using the U.S. Agriculture Department’s Food Pyramid Guide (Table 7). Dietary counseling may be necessary as bulimics often have misconceptions about proper food intake. They need constant reassurance that eating normally will not result in obesity. They also need help in reconnecting with their hunger signals. After years of eating for reasons other than hunger, many bulimics do
not know what hunger feels like. A contract to stop vomiting and/or the use of diuretics and laxatives is often helpful. Vital signs are checked at each visit and any lab abnormalities are carefully followed. If she shows signs of dental disease refer her to a dentist.

As treatment progresses the girl’s diet should begin to include a few of the “forbidden” foods on which she used to binge. As she incorporates these foods into her diet in small amounts she is also taught how to deal with any uncomfortable feelings she may have about eating these foods in moderation. Be mindful of the gamut of emotions she will feel as the binge/purge cycle stops. These emotions include guilt, depression, helplessness, anxiety, frustration, and anger. Help her connect with these feelings by making observations about them, accepting them yourself, encouraging her to express them, and teaching her alternative ways to cope with them.

Some bulimics require anti-depressant medication. This determination is made by a psychiatrist and is based on the level of depression exhibited by the patient. Effectiveness is measured by the reduction in binge behavior.

Treatment for bulimia is considered effective when she is eating normally, maintaining a normal weight, using new ways of coping with difficult emotions, and has a realistic perception of her body. The preoccupation with thinness is significantly reduced and she now focuses on having healthy relationships and enjoying life.

**Abuse-related Interventions**

A nursing care plan for the sexually abused adolescent might have several nursing diagnoses to consider. Long and short-term goals, interventions, and evaluations should be developed separately for each diagnosis. For example, the diagnosis “sleep pattern disturbance related to the fear of being sexually abused” should include goals of reducing the fear and establishing normal sleep patterns. Interventions include encouraging her to express the fear and providing her with information on community resources available to her. Criteria for measuring the effectiveness of the intervention include the establishment of a normal sleep pattern, documentation that she is verbalizing her fears, and documentation that she can name resources available to help her.

Remain with the sexually abused girl as she is assessed for risk of pregnancy and STIs. Be nonjudgmental and supportive while assuring her that the abuse is not her fault. If a pregnancy is diagnosed allow the expression of all feelings associated with being pregnant under these circumstances. Such feelings include anger, hostility, or ambivalence. If she is hospitalized help provide a safe and predictable environment with as few potential threats as possible: keep her on one unit, make contact regularly so she knows help is readily available, and

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### Instructions for Food Diary (72 hr.)

1. Be sure to include everything you ate or drank.
2. Include where you ate.
3. Describe food – raw or cooked, fried, boiled, etc. Was it served with a sauce or dressing?
4. Include amount eaten.
5. Try to connect with feelings prior to eating and include the feelings in the diary.

<table>
<thead>
<tr>
<th>TIME</th>
<th>PLACE</th>
<th>FOOD</th>
<th>FEELING</th>
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Table 6
keep the same nurses assigned to her so she can develop therapeutic relationships with them. This safe and predictable environment is crucial in cases where flashbacks and nightmares are part of the symptomatology.

Therapy groups specific for sexual abuse are often effective. Typically, sexual abuse victims are shut down emotionally and unable to get angry about what happened to them. However, they often get very angry when they hear what happened to other group members. Over time, as they hear other group members getting angry for them, the victims reconnect with their own anger about their own abuse. Individual therapy can be effective as well, but most professionals believe a combination of group and individual counseling is the most effective.

Teach the girl she has a right to say “no” whenever anyone wants to touch her body in a way that makes her feel uncomfortable, but especially when an adult wants sexual contact with her. Negative attitudes toward sexuality are inevitable and must be addressed immediately to prevent a lifetime of sexual dysfunction.

State laws vary regarding the nurse’s legal responsibility in reporting cases of childhood sexual abuse, but most states have some kind of mandatory reporting law. Check with your state Board of Nursing for clarification. Many states have Child Protective Services organizations to assist the nurse in protecting the girl from her abuser. Clergy are available to help with spiritual difficulties resulting from the abuse. Our culture’s primary religious tradition is Judeo-Christianity in which God is portrayed as a male parent and addressed as “Father.” This can have a profound spiritual impact on the sexually abused girl, especially if she was abused by her father. As she matures the question becomes, “I thought Dad was good and trustworthy but he isn’t. If I was so wrong about him how can I be trusted to make judgments about the trustworthiness of others or of God?”

Adolescence is a time for questioning the meaning and purpose of life, and sexual abuse can throw a monkey wrench into this process. To heal from the abuse, the adolescent must integrate the experience into her life as a whole. If this integration does not happen she will compartmentalize the experience to avoid the emotional pain. This leads to self-destructive acts as the issue continually surfaces in an effort to be resolved. If she doesn’t deal with the pain she won’t have the skills to protect herself in the future and she may find herself in other situations with the potential for abuse. For example, date rape, acquaintance rape, and marriage to an abuser are real possibilities if she doesn’t learn how to judge the trustworthiness of those around her.

**Suicide**

**Take any suicide threats seriously and seek professional psychological intervention immediately**

In the absence of threats look for the warning signs listed in the assessment section of this course. Often a depressed or suicidal adolescent will respond to the question “Who am I?” with “Nobody.” Interventions should be geared toward changing the way she thinks about herself and include the following:

- discourage black-and-white thinking
- encourage her to identify options and to develop an internal sense of alternatives
- use active listening skills to encourage the expression of all feelings
- encourage group therapy with other adolescents to help her identify and express feelings
- encourage her to think about the future by asking questions such as, “Where will you be in five years?”
- explore intimacy needs and how best to meet them
- encourage positive “I” statements

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**The Pregnant Adolescent**

During the prenatal period the health care team assesses the maternal nutritional risk, assigns goals for weight gain, and educates about healthful eating practices. Therapeutic intervention takes place when a team member determines the adolescent is not complying with the nutritional standards set for her. Relevant history includes information about her eating habits, daily activities, medication history including the use of vitamin and mineral supplements, drug use, and smoking history. Particular attention should be paid to questions that might elicit responses indicating the presence of an eating disorder; e.g., “How much do you limit your food intake to control your weight?”

If problems are uncovered educate the girl about these issues. Tell her smoking during pregnancy increases the risk of low maternal weight gain, low birth weight for the baby, and perinatal morbidity. The use of alcohol and/or drugs increases the likelihood of inadequate nutritional intake and possible teratogenic birth defects.

Each prenatal visit provides the opportunity to do a nutritional assessment and provide an informal education program. Help her select a diet that consists of a variety of foods, including fruits and vegetables, whole-grain products, protein, and dairy products. Be sensitive to her cultural background to improve the chances for compliance. If she is at risk nutritionally, vitamin and mineral supplementation may be necessary, but patients should be cautioned against excess vitamin intake because such practice may result in birth defects. Vegetarians will need added B12 and zinc. Those with twin gestation, seizure disorders, and certain blood pathologies may need extra folate. Those with inadequate sun exposure or who eat an inadequate supply of dairy products will need vitamin D and calcium supplementation as well. Iron supplementation is especially important for adolescents. If she has difficulty complying with her nutritional plan or
Find your balance between food and physical activity

- Be sure to stay within your daily calorie needs.
- Be physically active for at least 30 minutes most days of the week.
- About 60 minutes a day of physical activity may be needed to prevent weight gain.
- For sustaining weight loss, at least 60 to 90 minutes a day of physical activity may be required.
- Children and teenagers should be physically active for 60 minutes every day or most days.

Know the limits on fats, sugars, and salt (sodium)

- Make the most of your fat sources, from fish, nuts and vegetable oils.
- Limit solid fats like butter, stick margarine, shortening, and lard, as well as foods that contain these.
- Check the Nutritional Facts label to keep saturated fats, trans fats, and sodium low.
- Choose food and beverages low in added sugars. Added sugars contribute calories with few, if any, nutrients.

<table>
<thead>
<tr>
<th>Vegetables</th>
<th>Fruits</th>
<th>Grains</th>
<th>Dairy</th>
<th>Protein Foods</th>
</tr>
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<tbody>
<tr>
<td>Eat more red, orange, and dark-green veggies like tomatoes, sweet potatoes, and broccoli in main dishes. Add beans or peas to salads (kidney or chickpeas), soups (split peas or lentils), and side dishes (pinto or baked beans), or serve as a main dish. Fresh, frozen, and canned vegetables all count. Choose &quot;reduced sodium&quot; or &quot;no-salt-added&quot; canned veggies.</td>
<td>Use fruits as snacks, salads, and desserts. At breakfast, top your cereal with bananas or strawberries; add blueberries to pancakes. Buy fruits that are dried, frozen, and canned (in water or 100% juice), as well as fresh fruit. Select 100% fruit juice when choosing juices.</td>
<td>Substitute whole-grain choices for refined-grain breads, bagels, rolls, breakfast cereals, crackers, rice, and pasta. Check the ingredients list on product labels for the words “whole” or “whole grain” before the grain ingredient name. Choose products that name a whole grain first on the ingredients list.</td>
<td>Choose skin (fat-free) or 1% (low-fat) milk. They have the same amount of calcium and other essential nutrients as whole milk, but less fat and calories. Top fruit salads and baked potatoes with low-fat yogurt. If you are lactose intolerant, try lactose-free milk or fortified soymilk (soy beverage).</td>
<td>Eat a variety of foods from the protein food group each week, such as seafood, beans and peas, and nuts as well as lean meats, poultry, and eggs. Twice a week, make seafood the protein on your plate. Choose lean meats and ground beef that are at least 90% lean. Trim or drain fat from meat and remove skin from poultry to cut fat and calories.</td>
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For a 2,000-calorie daily food plan, you need the amounts below from each food group. To find amounts personalized for you, go to ChooseMyPlate.gov.

<table>
<thead>
<tr>
<th>Eat 2½ cups every day</th>
<th>Eat 2 cups every day</th>
<th>Eat 6 ounces every day</th>
<th>Get 3 cups every day</th>
<th>Eat 5½ ounces every day</th>
</tr>
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<tr>
<td>What counts as a cup?</td>
<td>What counts as a cup?</td>
<td>What counts as an ounce?</td>
<td>What counts as an ounce?</td>
<td>What counts as an ounce?</td>
</tr>
<tr>
<td>1 cup of raw or cooked vegetables or vegetable juice; 2 cups of leafy salad greens</td>
<td>1 cup of raw or cooked fruit or 100% fruit juice</td>
<td>1 slice of bread; ½ cup of cooked rice, cereal, or pasta; 1 ounce of ready-to-eat cereal</td>
<td>1 cup of milk, yogurt, or fortified soymilk; ½ ounce natural or 2 ounces processed cheese</td>
<td>1 ounce of lean meat, poultry, or fish; 1 egg; 1 Tbsp peanut butter; ½ ounce nuts or seeds; ¼ cup beans or peas</td>
</tr>
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</table>
doesn’t understand what is expected, refer her to a nutritionist.

Moderate aerobic exercise in pregnant teens can significantly decrease symptoms of depression and increase self-esteem. Encourage participation (after obtaining physician approval) in a low-impact exercise program two to three times a week. Each class should be 60 to 65 minutes long with 10 minute warm-ups and cool-downs included. This should improve her overall sense of well being throughout the pregnancy.

Some pregnant adolescents, especially if the presence of an eating disorder is suspected, may need a therapist included in their care plan. In general, binge eating and vomiting decrease substantially or stop altogether during pregnancy, but this cannot be relied upon without individual assessment. Therapy usually consists of making the fetus as real as possible. The nurse can help by providing information on gestational growth and development and connecting the problematic eating behavior to this growth and development process. Stress potential complications if she continues the behavior to this growth and development process. Stress potential complications if she continues the behavior to this growth and development process. Explain the physiological reasons for weight gain during pregnancy and emphasize the temporary nature of the problem.

**Contraception**

When counseling a teen about contraception stress that abstinence is the only method that is 100% effective. Even sexually active teens can choose to remain abstinent from now on. All adolescents should be encouraged to consider whether they are ready to accept the responsibilities and consequences of sexual activity - pregnancy, STIs, and the emotional ties that accompany sex. To combat peer pressure, stress that less than half of teens ages 15-19 are having sexual intercourse.

For most sexually active teens Depo-Provera is the most effective contraceptive method available. The injection provides protection against pregnancy for at least three months, so it is only needed four times a year.

It is considered safe, reversible, and it contains no estrogen. Side effects may include changes in menstrual bleeding patterns, amenorrhea, weight loss or weight gain.

**Sexually Transmitted Infections (STIs)**

Symptoms of the presence of an STI may include:

- vaginal discharge, itching, and/or odor
- burning pain with urination, urinary frequency
- bleeding between periods
- bleeding, pain with intercourse
- pelvic pain
- fever and flu-like symptoms
- rashes or sores in the genital area
- sexual partner with rashes or sores in the genital area, or with STI diagnosis

Abstinence is the best method available for decreasing the incidence of sexually transmitted diseases. However, for those teens who are sexually active, preventive education can decrease their risk of getting an STI. Recommend decreasing the number of sexual partners to limit exposure. Recommend latex condom use (rather than natural membrane condoms) because they are more effective against the transmission of most STIs. However, condoms may not protect against HPV and herpes simplex if the lesions are located anywhere other than the shaft of the penis. Stress that birth control methods other than condoms do not provide protection against STIs. For this reason, recommend latex condom use in conjunction with other birth control methods to insure maximum protection against STI transmission.

Condoms provide protection only if they are used properly. Therefore it is important to teach their proper use. Condoms must be used consistently and a new one must be used for each sex act. It must be put on prior to penetration, leaving some room at the tip for the ejaculate. It must be withdrawn while the penis is still erect, holding the condom firmly to prevent it from slipping off and allowing some of the ejaculate to be deposited in the vagina. Only water-based lubricants (not petroleum based) should be used in conjunction with the condom.

Studies show teens are more likely to use condoms if they get comprehensive sex education, believe that condoms prevent HIV infection, believe condom use is accepted by their peers, are not embarrassed to discuss the issue with their partners, carry condoms with them, and have easy access to them. Barriers to condom use among teens include confidentiality issues, cost, transportation, partner objection, and the perception of risk. Often condoms are placed behind counters requiring help from store personnel to purchase them. Some adolescent girls encounter judgmental and condemning lectures when they try to purchase condoms. Some adults object when schools provide detailed information on the correct use of condoms. There is even more objection when schools provide condoms for sale on the school campus. Often those objecting to these efforts believe that providing information on condoms encourages adolescent sexual activity. Due to the private nature of sexual activity it is difficult to document whether these concerns are valid. One way to overcome these objections might be to stress abstinence as the best method for prevention of STI transmission and the prevention of unwanted pregnancies. Latex condom use is the next best alternative.

**Community Resources**

There are several community resources that serve as intervention tools in dealing with the issues of adolescent girls. The most obvious one is the school system, where education is already the primary goal. Target audiences include adolescents, parents of children of all ages, teachers, and other school staff members. Appropriate education methods and interventions for each stage of the life cycle should be developed so that educational efforts have the best chance of success.

Experts suggest educational efforts begin by adding information on the above topics to already existing curricula such as health, physical education, and home and family life classes.
Techniques for resisting media influences could be added as well. They also recommend dealing openly with the developmental tasks of the adolescent girl (identity vs. role confusion, etc.) by helping her answer the question “Who am I?” Other major topics include:

- information on normal adolescent physiological, social, and psychological changes
- the connection between food, emotions, and body image
- the importance of exercise and other physical activity in weight management
- physiological information concerning the ill effects of binge-eating and dieting
- the role of women in society and how closely that role is related to the development of eating disorders
- autonomy, independence, and self-esteem
- stress management skills
- pregnancy and STD prevention
- health dangers from smoking and other substance abuse
- suicide prevention

Techniques such as role-playing and small group discussions may further increase the odds of girls internalizing the messages and continuing the new behaviors once the class is over.

The internet is an invaluable resource for finding local and national organizations. Nurses can search for associations in their community that provide assistance, support and advocacy for adolescents in need of help.

Another community resource available for those suffering from substance abuse or family violence is the Twelve Step group. The Twelve Step approach is built on sound psychological principles and also addresses the necessary spiritual issues. Consult the white pages of your phone book under Alcoholics Anonymous, Narcotics Anonymous, Overeaters Anonymous and others to find an appropriate meeting for referral. In some areas there are groups specifically for adolescents.

There are pitfalls with the Twelve Step approach. The groups are leaderless and, therefore, there is no opportunity to practice quality control.

As a result quality may vary from one group to another. Some men attend these groups with a hidden agenda to meet vulnerable women. It is imperative that the nurse encouraging a girl to consider Twelve Step support be honest about these potential problems. Any health professionals involved in her follow-up care must continually address these pitfall areas to prevent re-victimization. This is particularly crucial for a girl with a history of sexual abuse. Involvement in Twelve Step groups can provide the opportunity for her to learn how to listen to her own warning signals and to respond appropriately, thus preventing re-victimization. This ability to listen to herself is crucial for anyone recovering from an eating disorder and/or sexual abuse. The Twelve Step approach in conjunction with outpatient therapy can serve to help her learn how to live in reality.

Adolescence, under the best of circumstances, is a difficult time of life. The body undergoes major physical changes that affect a girl emotionally, socially, intellectually, and spiritually. It is a time of constant adjustment as she moves from childhood to adulthood. Some of these adjustments take place in the body, necessitating changes in diet and exercise patterns. Often, however, these adjustments take place in the mind as well. The rapidity of the physical changes makes it difficult for the mind to keep up and as a result body image difficulties may develop. Add to this the unrealistic societal preference for thin bodies, and the normal body-image problems are greatly exacerbated.

When society’s preference for thinness is echoed by a girl’s family (e.g., her body is ridiculed and/or she is pressured constantly about food intake), she may resort to strict dieting as a means of gaining acceptance. Dieting leads to binge eating, which eventually leads to obesity or the development of other eating disorders. The nurse must be aware of these dynamics so she can intervene appropriately in the situation.

Sometimes the presence of an eating disorder suggests other trauma such as physical or sexual abuse. The nurse must be aware of this dynamic so she can ask questions designed to elicit this information. It does little good to treat a girl’s eating disorder if she is going to return to an environment in which she feels constantly threatened by verbal, physical, or sexual abuse. This situation is a setup for relapse.

The nurse has a unique role as a member of the health care team. He/she may be the only professional involved who is trained to assess the whole person. The holistic assessment of all the dimensions of human existence enables the nurse to see the big picture. While the physician looks primarily at the physical dimension and the therapist sees the emotional and social dimensions, the nurse is trained to look at all dimensions and may function as an interpreter between the physician and the therapist. This is especially true in outpatient settings where the physician and therapist don’t have much contact.

The nurse uses this unique holistic assessment to make nursing diagnoses which lead to the development of a comprehensive nursing care plan designed to intervene in all dimensions of the adolescent’s life. The nurse helps ensure successful treatment by providing support for other family members and by informing all parties of community resources available to them. The nurse may be involved in implementing some of these community resource programs by helping school officials develop curriculum and programs to address these specific needs.

When caring for the adolescent girl the nurse is in a unique position to provide support to both the girl and her family. Our holistic approach provides a unique perspective. The nursing process provides the opportunity to aid the adolescent and her family in a way that no other member of the health care team can.
Suggested Reading


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