Anorexia case study jess

Business

She informs you that she is eating lots now, even though everyone keeps “ bugging me about my weight and how much I eat. ” She eventually admits to a weight loss of “ about 40 pounds and I’m still fat.

” 1. How is the diagnosis of anorexia nervous determined? Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal, or, for children and adolescents, less than that minimally expected. Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight main, even though at a significantly low weight. 0 Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight. 0 Specify whether: Restricting Type: During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (I.

E. Self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.
Binge-Eating/Purging Type: During the last 3 months, the individual has engaged in recurrent episodes of binge eat- ins or purging behavior lie. E.

, self-induced vomiting or the misuse of laxatives, diuretics, or enemas). Specify if: In partial remission In full remission Specify current severity: mild:

IBM17 keg/mm Severe: IBM 15-15. 99 keg/mm Moderate: MM’ 16-16. 9 keg/lilt Extreme: IBM

Place a star or asterisk next to those that J. M. has. Excessive weight loss, hypothermia, bradycardia, hypotension, dema, lanugo, metabolic changes, amenorrhea, Individuals with anorexia nervosa may be obsessed with food. For example, they may hoard or conceal food, talk about food and recipes at great length, or prepare elaborate meals for others, only to restrict themselves to a limited amount ot low-calorie t behaviors, such as hand washing, may also be present.

ke. Compulsive 3.

What other disorders might occur along with anorexia nervous? Depression, bipolar, COD, self mutilation, anxiety, substance abuse- CANS stimulants, alcohol 4. How does bulimia nervous differ from anorexia nervous? Alumina: excessive, insatiable appetite, Bulimia nervous is an episodic, uncontrolled, compulsive, rapid ingestion of large quantities of food over a short period of time tinning), followed by inappropriate compensatory behaviors to rid the body of the excess calories. Anorexia: prolonged loss of appetite, Anorexia nervous is Characterized by a morbid fear of obesity.

Symptoms include gross distortion of body mage, preoccupation with food, and refusal to eat. 5. Name behaviors that J. M. Or any other patient with anorexia may engage in other than self-starvation.

Hiding food, self induce vomiting, use of laxatives or diuretics, question #2, purging 6. What common family dynamics are associated with anorexia

nervous? In the theory of the family as a system, psychosomatic symptoms, including anorexia nervous, are reinforced in an effort to avoid spousal conflict. Parents deny marital conflict by defining sick child as family problem.

Unhealthy family environment: members strive at all cost to maintain appearance. Control. Passive father, domineering mother, overly dependent child, perfectionism- child feels that she must attics standards.

He child eventually begins to feel helpless and ambivalent toward the parents. In adolescence, these distorted eating patterns may represent a rebellion against the parents, viewed by the child as a means of gaining and remaining in control. The symptoms are often triggered by a stress that the adolescent perceives as a loss of control in some aspect of his or her life. O review her admission laboratory studies. An EGG has also been ordered. Admission Lab Work Sodium 135 meg/L Potassium 3.

4 meg/L Chloride 99 meg/L JNI 18 MGM/del Creating 1. MGM/del Hemoglobin 11 g/del 7. Which lab results might be of concern at this time? Explain your answers. Hypoglycemia is a problem. Depression, low blood pressure, dysphasia, weakness, and fatigue. She is at risk for falls, depression, over feed reaction, delirium, and if it goes too low, cardiac arrest.

Hemoglobin is low, so anemia is an issue 8.

Distorted body image Self-evaluation based largely or entirely in terms of weight and appearance Pre- occupation or obsessive thoughts about food and weight Refusal to accept that one’s weight is dangerously low despite

warnings from family, rinds and/or health professionals Low self esteem Mood swings Clinical depression Industrial from interpersonal relationships in favor of social isolation Disturbed personality image Spiritual distress Defensive coping Disturbed thought process Ineffective denial Social Isolation Impaired social interactions Disabled family coping 10.

What would indicate successful treatment with J. M.? Establish adequate nutritional intake, correct fluid and electrolyte imbalances, development of realistic body image, develop support network and could possibly include family and other groups, understanding that treatment regimen and why it’s in place, plans to place to meet needs after discharge date, and weight gain with a tolerance towards self After 3 weeks, you are providing discharge teaching for J.

M. You ask her whether she IS ready to go home.

J. M. States, “ I’ll be so glad to get out of this place.

I’m so fat and ugly. I need to lose 10 pounds. I bet I can do it in Just a couple of days. Otherwise, I don’t want to live anymore. ” 11.

What will you discuss with the physician before any further discharge teaching or plans? Whether J. M needs to be discharge. Her primary diagnosis was anorexia nervous, and it appears as though the treatment has not Nortek. By losing more weight, she can be a danger to herself.

It is important for the physician to know that she is going to try and lose more weight or else she “[doesn’t] Ant to live anymore” 12. You report J.

M. ‘ s statements to the physician. What do you expect to be ordered by the physician? Florentine is the medication of choice for anorexia nervous. However, the physician may also order a reassessment of the patient. This is a STRETCH but because she said “ I don’t want to live anymore”, they doctor could order 51-50 for further assessment.

She is considered a dangerous to herself and this may be the option of choice for the time being.

13. What medications would be indicated anorexia nervous and major depression? Or M. To assist Witt resolution to boot near Girls like Florentine can be given to J. M. Because they are indicated for anorexic people who have depressive, obsessive, or compulsive symptoms.

Tricycle antidepressants may also be effective, but they should be used with caution because f the risk of cardiac complications (like arrhythmias and hypertension).

Anorexic people have compromised cardiac function, so their response to tricycle should be closely monitored. CASE STUDY OUTCOME After 2 weeks, J. M. Has gained 5 pounds and seems to be more willing to eat.

She still expresses fears of “ getting fat,” but she states that she is ready to go home and back to school. The PC arranges for J. M. To participate in an outpatient partial hospitalizing program that specializes in eating disorders. J. M.

Expresses interest in meeting others with the same problems.