Anorexia nervosa, case study

Business

1. The case study. Christine is a sixteen year old girl who has severely restricted her dietary intake. She is currently forty nine kilograms and height 163cm. Her mother says she was 60kgs six months ago.

In form three, at age fifteen, Christine was removed from the public school she was attending and put into a private school, where she was awarded the dux prize. She did not have any friends during this year as she spent all recesses in the library, reporting that ate alone as she ‘ had no friends to eat with anyway’.

Her mother says that she attends roller skating sessions up to five nights a week and believes she does this to lose weight. She is pre-occupied with food and is constantly cooking for the family. She does not sit down with the family to eat, saying that she has eaten enough while cooking. An argument with her parents precipitated the diet as she decided that there was ‘ one area of her life that she could control and that was what she ate’.

She has commenced medication for sleep stating that she is unable to sleep after studying till late at night.

She recently took an overdose of sleeping pills and whilst in Emergency Department expressed a desire to die. The family live on a ten acre block and are ten kilometres from town. Her father is an accountant. Her mother is a school teacher and has a diagnosis of bipolar affective disorder.

She says she fights a lot with her mother and does not seem to be able to please her father. Her brother, two years younger, left home to join the navy earlier this year. 2. Provide a summary of the diagnosis and describe the course of the illness.

Wozniak, Rekleiti and Roupa (2012) outline early signs of anorexia nervosa (AN); preoccupation with food, weight and calories; rigidity and rituals around eating, avoidance of family meals, denial of hunger and excessive exercise. As it progresses the patient may seem withdrawn, absent sense of humour, angry and depressed and no longer spending time with friends.

The patient may become very rigid around other things also such as homework as obsessive compulsive behaviours begin to present.

Extreme measures are used to reduce weight; strict dieting, purging or eating fibrous foods, use of laxatives, appetite suppressants or diuretics (Australian and New Zealand clinical practice guidelines, (ANZCPG), 2004). To gain a diagnosis of AN a person has the following; a ‘ refusal to maintain a minimal normal body weight (defined as more than 15 per cent below expected body weight), be intensely afraid of gaining weight despite being significantly underweight, have disturbance in perceiving the correct size or shape of their body and (for postmenarchal females), amenorrhoea’ ((Edwards, Munro, Robins, Welch, 2011). . AN usually begins in adolescence, and is more prevalent in women (0. 2-0.

5%) than men (Wozniak, Rekleiti and Roupa, 2012). It has a slightly higher occurrence in socio-economic status (ANZCPG, 2004). It has the highest suicide rate of all mental illness at one and a half times higher than major depressive disorder. Approximately 15% die from the disorder 2/3 from malnutrition, one third suicide (Ommen, Meerwijk, Kars, Ellburg, Meijel, 2009). Although 70% of patients regain weight within 6 months of onset of treatment, 15–25% of these relapse, usually within 2 years (ANZCPG, 2004).

The prognosis is better for patients with a short duration of illness, if treatment does not require hospital admission and it is treated early.

Long term illness can still be treated but with a poorer prognosis. A long duration of illness, vomiting in emaciated patients, coexisting psychiatric illness, disturbed family relationships, serious medical complications and later onset of illness are indicators of a poor outcome (ANZCP, 2004). The psychological impact is immeasurable as formative teenage years are spent in an obsessive eating disordered thinking.

Those who ‘ recover’ from AN often retain certain features of atypical eating disorder, eating disorder not otherwise specified (EDNOOS) (ANZCPG, 2004). Surtess (2007) outline physical complications associated with AN which range from dry skin and hair, electrolyte disturbances and cardiac complications, endocrine disorders, suicide or death from starvation, osteoporosis and a possibility of long-term adverse effects through prolonged severe weight loss. Downy hair over the body (lanugo), insomnia and early wakening are also characteristic (Wozniak, Rekleite and Roupa, 2012).

3.

Key elements to recovery include patient oriented recovery, therapeutic relationships, collaboration. Reduce further deterioration and complications of the illness. The patient is admitted to a psychiatric ward when the risk of death either from suicide or physical effects of starvation is high (ASEN, 2002). During treatment, as a patient’s weight increases, anxiety and depression may return, increasing the risk of suicide (Asen, 2002). A

comprehensive psychiatric assessment will be carried out including a mental state exam (MSE) and a risk assessment.

Depression is assessed with Hamilton Anxiety and Depression

Rating Scale or Beck as depression and anxiety are associated with AN (ANZCPG, 2004). Medication may be prescribed in the form of antidepressants such as fluoxetine; olanzapine decreases hyperactivity of AN and may reduce overvalued ideas about food, shape and weight (ANZCPG, 2004). The nurse will monitor vital signs, weight and other tests including, blood tests for deficiencies such as anaemia, electrolyte balance and cardiac function with ECG (ANZCPG, 2004). In the first stage of recovery the nurse takes control of the patient, directing and supervising their eating of meals.

Meal times and social activities are opportunities for nurses facilitate the development of social skills with other patients in the ward (Bakker, Meijgel, Bukers, van Ommen, Meerwijk and van Elburg, 2011).

Therapeutic relationship established. Care takes place in an environment of empathy, safety, trust and mutual respect as interpersonal relationships are key to recovery (Tozzi, 2003) and the more differentiated relationships, the better they can manage stress and the social and physical aspects of the disorder (Bakker, et al. , 2011).

The therapeutic relationship is the ideal medium for patients to work through erroneous beliefs about eating and body image. Therapeutic relationships provide a foundation for meeting patient’s goals and facilitating behaviour change (Micevski and McCann, 2005). Nurses gain support from their

colleagues through sharing strategies for working with patients, indirectly benefitting the patient nurse relationship (Micevski and McCann, 2005).

This is congruent with a consistent treatment plan, supporting a trusting environment and quality of relationship.

Therapeutic optimism. With therapeutic optimism the nurse adopts a positive attitude towards the patient's recovery, instilling hope in the patient (Spandler, Secker, Kent, Hacking and Shenton, 2007). ' For people with mental health problems, hope lies at the heart of the individual's ability and willingness to take on the challenge of rebuilding and recovery' (Repper and Perkins, p. 52). The patient feels empowered and valued as she is given information regarding her physical progress, the gaols of treatment are discussed and those of the patient are explored.

A sense of competence and coping ability is regained. Research suggests that art therapy has therapeutic value for people with mental health needs (Spandler, Secker, Kent, Hacking and Shenton, 2009). Patient oriented recovery. The patient's goals and expectations of recovery are important, rather than a generic health focussed definition. Patients have choices and are supported to create and maintain the kind of life they want that is meaningful, satisfying and purposeful. Health care professionals are courteous and respectful.

National Standards for Mental Health Services, 2010) Family involvement is integral to treatment as parents are taught strategies to help and support their child. The adolescent is more likely to comply when the parents are supportive of and consistent with treatment. The nurse role models

strategies for parents to adopt particularly around mealtime activities. It is a difficult role for parents to undertake without support (Bakker et al. , 2011).

Asen (2002) establishes that randomised controlled trials in anorexia nervosa patients demonstrated improved outcomes for adolescent patients.

The study highlights the importance of parents learning to manage eating disorder symptoms early in treatment. 4. Apply the evidence to outline six outcomes which you would expect to see from the nursing care. The patient is beginning to develop normal eating habits and nutritional status is improving.

Menstruation has recommenced. There is no more use of laxatives and other pathological behaviours. Nurses have a structure based and directional interventions where rules around eating are utilised toward improving nutritional status.

Nurses are able to educate parents and provide strategies to parents to help their child (Bakker et al, 2011). Reduce risks of complications developing or further deterioration. A hospital is best able to treat adverse events such as cardiac arrest and other adverse events (Australian Commission on Safety and Quality in Health Care (ACSQH), 2010).

Hospital admission is particularly useful when BMI is reduced to such an extent further medical decline could result in death. Ongoing mental state exams monitor the progress of the patient and medical status is observed through testing and vital signs.

Depression and anxiety are associated with AN and can recur as weight is gained (Micevski and McCann, 2005) and can be monitored on the ward and medication provided as required. A therapeutic relationship is established. Interpersonal relationships are key to recovery (Tozzi, 2003) as the more differentiated relationships they have the better they can manage stress and the social and physical aspects of the disorder (Bakker, 2011). With therapeutic optimism the nurse conveys a positive attitude towards the patient’s recovery, fostering hope in the patient (Edward, Munro, Robins and Welch, 2011).

Perceptions of food as being healthful and life supporting. Therapeutic relationships provide a foundation for meeting patient’s goals and facilitating behaviour change. A supportive environment is an ideal environment in which to examine and address erroneous beliefs and distorted body image (Micevski and McCann, 2005). Provide links to peer support and web sites which enable people with anorexia nervosa to learn from others with similar conditions. Peers with anorexia provide valuable support and are effective role models (Bakker, et al.

2011). 5. Demonstrate how the nursing care can be consumer centred. Consumer centred care is ‘ responsive to the individual differences, cultural diversity and the preferences of people receiving care, and is achieved partly through providing choice in health care’ (ACSQH, 2010), The nurse is concerned about psychosocial aspects and asks the patient about her understanding of health and illness and recovery. What are her concerns and expectations and the perceived effect of the illness on her functioning?

She identifies the patient’s feelings, her goals and aspirations. How would she like to be treated while in hospital? Ask how she sees her life in the next five or ten years, her career, travel and family aspirations.

Initially the nurse assumes control, but as the patient recovers, she is more of a ‘ partner’ in recovery. The nurse empowers the patient, providing information about her illness, healthy eating and exercise and medications and alternative methods of coping. She is regarded as the ‘ expert’ and is empowered to make choices.

She is encouraged to ask questions and is involved in the care plan and making decisions in an emotionally supportive environment. Nurses develop a therapeutic alliance with the patient and family with an attitude of empathy, understanding and hope.

They see the disease as being the illness and its symptoms, not the patient. With an understanding of the neurobiological nature of eating disorders, nurses can play a role in educating parents that it is ‘ will’, ‘ blame’ or fault and that it is not a choice but a brain-based mental illness (Kaye, 2008).

Staff identify their barriers to consumer centred care as they reflect on their values, beliefs and participate in supervision. Staff attend education and training to further develop their skills. Staff is well trained, knowledgeable and have good communication skills (Micevski and McCann, 2005). References Attia, E.

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