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Diagnostic Skill Application II: A Case Study

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Abstract

Based on the case description of Kimi, one of the central issues accounting for her distress or danger entails separation from her husband. Such a state of separation causes sadness, anger, and emotional struggle. For Kimi, additional insights from the case description point to an individual who is likely experiencing an eating disorder. As described, self-consciousness from high school (such as the need to wear a form-fitting uniform) to the college account for additional distress, a situation exacerbated by her Danish parents' preference for privacy in which they (the parents) remain unaware of their daughters' situation. Such a lack of adequate communication regarding an individual's private life in relation to challenges surrounding proper eating patterns pose a danger of deteriorating one's physical and emotional health, besides the formation of healthy relationships and the realization of productivity. Overall, Kimi is experiencing two major problems whereby she is struggling with a poor eating pattern (due to self-consciousness since high school) and also a marriage breakup, with the situation becoming direr due to her parents being troubled by Robert's behavior. Particularly, she eats a lot then "throws up" or vomits as a coping mechanism for her distress and also a remedy to curb against gaining weight, which is also her dislike in life (due to the aforementioned state of self-consciousness). In summary, it is worth contending that Kimi's problems lie within systemic or mental health-focused view of psychopathology because poor eating patterns and issues surrounding divorce have been documented to account for dramatic psychosocial imbalances in the affected persons' lives.

Introduction

As mentioned above, the case description indicates that Kimi's coping strategy, when faced with stressful moments such as divorce and the struggle surrounding her state of self-consciousness, involves eating a lot but again resorts to throwing up to avoid gaining weight, actions that tend to relieve her the distress. From the current literature, possible conditions or eating disorders with which Kimi could be associated include binge-eating disorder, bulimia nervosa, and anorexia nervosa. Indeed, Kimi is experiencing an eating disorder because Murray and Le Grange (2014) asserted that these disorders cause disturbances in the emotions, thoughts, and eating behaviors of individuals, attributes that are evident in Kimi. Also, eating disorders have been documented to be characterized by individuals' preoccupation with shape, body weight, and food, features that are evidenced by Kimi's state of self-consciousness.

For anorexia nervosa, individuals perceive themselves as overweight even at a time when they are underweight. Thus, they restrict their amount of food intake severely and repeatedly and, instead, engage in excessive exercise and also force themselves to vomit (Le Grange, Lock & Agras et al., 2015). Given that Kimi throws up, the latter feature is evident in her eating or food behavior. Overall, features of anorexia nervosa include self-esteem due to the heavy influence of perceptions regarding body shape and weight, intense fear of gaining weight, relentless pursuit of thinness, and extremely restricted eating (Brown and Mehler, 2013). Kimi demonstrates the feature of vomiting, but restricted eating is not evident. Instead, she eats a lot (but throws up afterward).

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Relative to bulimia nervosa, a major feature involves frequent and recurrent episodes of eating unusually large food amounts, with a lack of control over the perceived episodes often evident (Touyz and Hay, 2015). Given that Kimi eats a lot and uses this step as a coping mechanism to her distress, the aforementioned feature of bulimia nervosa is evident in her eating behavior. It is also worth indicating that for bulimia nervosa, binge-eating behaviors are often accompanied by compensatory behaviors aimed at countering the overeating, including excessive exercise, excessive use of diuretics or laxatives, and forced vomiting (American Psychiatric Association, 2013), with the latter feature evident in Kimi (because she throws up after eating a lot of food to cope with stress). Regarding the binge-eating disorder, binge-eating is evident but such periods are not accompanied by compensatory mechanisms such as fasting, excessive exercise, or purging (Murray & Le Grange, 2014). Based on the mixed outcomes regarding the symptoms surrounding the three conditions characterizing Kimi's differential diagnosis (binge-eating disorder, bulimia nervosa, and anorexia nervosa), it is worth inferring that she is experiencing bulimia nervosa, a mental disorder.

Methods

In this case, the assessment tool that is deemed worthy to apply to the case of Kimi involves the Eating Disorders Symptoms Severity Scale. Based on this scale, Kimi demonstrates severe binge eating (rated at 3) and that there is no food restriction (rated at 0). Also, there is no exercise (rated at 0) but severe vomiting is evident (rated at 3). Regarding the scale's rating of cognitions, Kimi's case demonstrates severe dissatisfaction with body image (rated at 3), moderate body distortion (rated at 2), severe fear of gaining weight (due to throwing up – and rated at 3), and severe influence regarding the importance of appearance to self-esteem (also rated at 3). There is also evidence of a severe preoccupation with food (rated at 3). For Kimi, this information is crucial because it aids in depicting her total symptom severity score and some of the interventions that might be tailored to her specific issues, proving relevant or appropriate.

Results

Given that the differential diagnosis reveals that Kimi's condition is bulimia nervosa (with an ICD-10-CM Code F50.2 and DSM-5 307.51), the current DSM criteria hold that an individual needs to exhibit persistent restriction to energy intake and that this trend causes significantly low body weight (Le Grange, Lock & Agras et al., 2015), features that are evident in Kimi, who eats a lot but throws up to restrict her energy intake persistently. Also, the current DSM for bulimia nervosa indicates that aspects of body weight and shape tend to influence one's self-evaluation unduly (Brown and Mehler, 2013). Regarding ICD, bulimia nervosa is evident when there are repeated binge eating and compensatory behaviors (such as excessive exercising and vomiting) (Touyz and Hay, 2015), features that are also evident in Kimi's case.

For Kimi, a referral for medical consultation is appropriate because she has presented with dangerous signs such as self-hatred, withdrawal, and undesirable eating behaviors that threaten to worsen her current psychosocial state, especially in the wake of a recent divorce and a high degree of self-consciousness. Given that Kimi is at risk for additional complications such as mental disorders (including anxiety and depression), medical complications, and even suicide, the need for early treatment cannot be overstated.

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Four major interventions that are deemed relevant include medications, nutritional counseling, medical care and monitoring, and family psychotherapy, especially given she is accompanied by her mother. Cognitive behavioral therapy has also been documented to be effective in eliminating or reducing purging and binge eating behaviors while family-based therapy has been associated with a beneficial effect of improving moods, eating habits, and regaining weight (American Psychiatric Association, 2013). For Kimi, some of the specific medications that are worth using include mood stabilizers, antipsychotics, and antidepressants.

From the perspective of Julio's case presentation, of the initial pointers of distress involved poor test-taking skills that caused his failure to follow through the plan of completing his studies in a community college. Due to this weakness, his workplace operations are seen to be marred by an inability to track details in an otherwise demanding firm (sales promotion company), causing previous losses of jobs. According to Seo, Lee and Park (2014), such stressful situations tend to yield negative effects such as stress, loss of income, life imbalance, depression, and anger. As avowed by Piñeiro-Dieguez, Balanzá-Martínez and García-García (2014), additional stressful situations, if any, are likely to worsen the processes of grieving the job losses and adjustment to unemployment.

Apart from the above-mentioned issues concerning Julio's weaknesses in the academic arena and workplaces, a social problem is evident and reflects a looming crisis. Particularly, he seems reluctant to plan for a wedding with Justin, his partner, yet the family continues to rely on his (Julio's) decision before welcoming Justin into the family. Thus, the chain of events holds that Julio has failed to plan the wedding and Justin is frustrated and, whereas Julio's parents exhibit traditional religious values, they are willing to welcome Justin into their family network but their decision also depends on Julio's moment at which he will make the plans known. Hence, focusing and personal organization have proved difficult for Julio, stretching from his academic areas to the workplace, as well as the family.

Based on Julio's case description, some of the disorders that are worth considering include executive function disorder, obsessive-compulsive disorder, and attention deficit disorder. According to Larsson, Chang and D'Onofrio (2014), individuals experiencing executive function disorder struggle to complete tasks on deadline or at all, schedule, organize, plan, and analyze. Due to the struggle to set schedule and organize materials, individuals with the executive functioning problems also depict features such as an inability to keep in mind and plan for far future events (and also experience time blindness) (Theiling & Petermann, 2014).

Relative to obsessive-compulsive disorder, symptoms include guilt, shame, rage or anger, sadness, and far, worry, or anxiety (Seo, Lee and Park, 2014). Another disorder whose symptoms are evident in Julio involves attention deficit disorder. As observed by Piñeiro-Dieguez, Balanzá-Martínez and García-García (2014), symptoms of attention deficit disorder include the failure to listen even one is spoken to directly, a tendency to lose crucial materials required to complete activities or tasks, tendency to avoid tasks that demand sustained attention, and forgetfulness while performing routine chores (Larsson, Chang and D'Onofrio, 2014). Other symptoms include a frequent failure to complete school assignments or work (even in situations where they understand

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what is expected of them and in the work), easy distraction by external stimuli, challenges organizing activities or chores, and frequent failure to pay attention to details (or associated with careless mistakes at school, work, and other chores).

From Julio's case, attention deficit disorder and executive function disorder emerge as the most appropriate conditions whose symptoms are evident in the 36-year-old single gay male. However, attention deficit disorder (ADD) is deemed the most accurate diagnosis for Julio, especially due to his failure to listen even in situations where he is spoken to directly.

In this case, an appropriate assessment framework for ADHD assessment in Julio involves the adult ADHD self-report scale (ASRS-v1.1) symptom checklist. Indeed, the scale reflects an 18-item checklist and allows adults to rate themselves on certain criteria. If the individuals report that they experience the factors or processes sometimes, often, or very often, they can be diagnosed with AD/HD.

According to Seo, Lee and Park (2014), some of these factors include the frequency of experiencing trouble wrapping up details, difficulty getting things or events in order, frequency of forgetting obligations or appointments, delay or avoidance of tasks demanding thought, frequency of squirming or fidgeting with feet or hands, and frequency of being overly active. Others include making careless mistakes, difficulty keeping attention, difficulty concentrating on what is said, misplacing or difficulty finding things, distraction by noise or activities in the surrounding, feeling restless, difficulty unwinding even when the time is available, and interruptions of other people's activities (Theiling & Petermann, 2014). For Julio, this symptoms checklist is deemed relevant because it aids in making an accurate diagnosis and, in turn, advocating for appropriate treatment – ensuring further that he reaches his full potential.

For attention deficit disorder, the DSM and ICD codes are DSM-5 314.01 (F90.2). Indeed, these codes hold that an individual is diagnosed for attention deficit disorder if they exhibit persistent patterns of inattention. For the inattention to occur, at least six certain symptoms ought to be present. Some of these patterns include difficulty organizing activities and tasks, failure to follow through instructions or finish workplace duties and chores, as well as schoolwork, failure to listen even in situations where they are spoken to directly, and difficulty to sustain attention during activities such as lengthy reading, conversations, and lectures (Piñeiro-Dieguez, Balanzá-Martínez and García-García, 2014).

Other predictors of inattention as a predictor of attention deficit disorder include making careless mistakes, forgetfulness regarding appointments, returning calls, running errands, and doing chores, loss of necessary items for accomplishing activities or tasks (such as paperwork, tools, books, and school materials), and the aspect of being distracted easily by extraneous stimuli (Larsson, Chang and D'Onofrio, 2014). For Julio, it is worth contending that at least six of these forces dominate his lifestyle, suggesting that he can perceivably be diagnosed with attention deficit disorder with reliable accuracy.

The case of Julio reveals the presence of attention deficit disorder (ADD) without hyperactivity. With the patient presenting with his partner, Justin, it becomes important to combine behavioral therapy (that also targets his family and the rest of the social setting) and medication. For

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the treatment of ADD, some of the prescription drugs that could be administered include non-stimulant drugs, antidepressants, and psycho-stimulants (methylphenidate and amphetamines) (Seo, Lee and Park, 2014). Antidepressants may include venlafaxine, bupuprion, monoamine oxidase inhibitors, and tricyclic antidepressants, which are responsible for increasing the brain's norepinephrine levels, hence exhibiting a positive effect on ADD symptoms (Larsson, Chang and D'Onofrio, 2014). Regarding therapy or behavioral modification, cognitive behavior therapy could be applied to Julio, especially due to its capacity to enhance self-management. Coaching is also important because it helps ADD patients to handle daily life challenges through the provision of encouragement (towards organization and time management), recommendations (towards achieving the clients' intended goals in life), and constructive feedback (Piñeiro-Dieguez, Balanzá-Martínez and García-García, 2014).

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