Clinical Assignment: Sarah Brown-Callahan Topic: Anxiety disorder with body dysmorphic disorder

Assignment: Develop a Case Study similar to those found in your textbook (NOT the same scenario, you will make up your own). *See example Care Plans in your textbook or utilize the Internet to visualize the appearance of a care plan. Put your case study on the page following the instructions.

Part I: Develop the Case

Scenario: A detailed patient description. Tell a thorough, descriptive story about the patient and the problem(s) they are having. Include descriptions of the environment, patient actions, family involvement, communication, and nurse actions. Include assessment data from below. This should be a minimum of 2 paragraphs and will likely be longer depending on your attention to detail. *You will find the more detailed your scenario the easier it will be to complete the remainder of the assignment.

Assessment data: Next clearly list (A) Objective data and (B) Subjective data based upon your scenario. Identify associated pathophysiology related to the topic. Include at least two ways that the patient is using defense mechanisms in their disease process. Include ABCT assessment guidelines when describing your patient: Appearance (age, posture, body movements, dress, grooming), Behavior (LOC, speech, mood, affect), Cognition (orientation, concentration, recent and remote memory, judgment, insight), and Thought Processes (content, process, perception). *Be sure to use mental health based describing words for patient behaviors/assessment and quote what the patient with that disease might say.

Part II: Develop the Plan of Care

Nursing diagnosis: Provide two priority nursing diagnosis including supporting data from your assessment.

Goals: Develop two goals for each nursing diagnosis above.

Interventions: Next develop three interventions you will implement to meet each goal (*in your overall plan of care for this patient, your interventions must include each of the following: medications most commonly utilized for the disorder, communication techniques, teaching point(s), major safety issue(s), and continuing assessment).

Rationale: You need to have a rationale (including source) for each intervention you develop.

***Sources:** You must use a different source for each intervention rationale per goal. For example, for one goal with three interventions you can use (1) your textbook, (2) evidence-based article, and (3) the Internet. You can use the same three sources for your other goal interventions, but there is a minimum total

number of three sources for this assignment. *At least 2 sources on your reference list must be EBP articles.

Reference page: Include your references in APA format.

Part III:

Last, you will develop **three** exam questions based upon your scenario. DO NOT copy an exam question from a NCLEX book or your textbook (I can tell, trust me). Your questions should be specific to your scenario (the answer should be discernible from your assessment data, nursing diagnosis, goals, interventions, or rationale). *Include the correct answer **and** the rationale for the correct answer (including a source) after each question you develop.

PART I

Scenario:

Client CK is a 28-year-old Caucasian female. She arrives at her appointment well-groomed, dressed appropriately and wearing heavy makeup. She is visibly sweaty and seems anxious. At the beginning of her appointment, she reports that she is needing a referral for reconstructive surgery to fix her ears, face, stomach, thighs, and butt. She states the sensation of clothing touching her skin is making her upset and it is getting harder and harder to be alive in this body. She has pulled a small compact mirror out of her handbag and checked her face several times at this early point in the appointment. At one point, she says her family thinks she is “crazy” and tells her she is “fine”. She says it is frustrating because she knows her symptoms are real, and her family must love her how she is because they are her family. The client reports, “I know I spend around five hours a day in front of the mirror to get myself looking just right and surgery to fix all of my bad parts would cut down on the time it takes to get ready.” I go to the gym every day, twice a day to try to get rid of the fat in my stomach and thighs.

The physician comes in and takes the client’s vitals. Her temperature is 98.6 F, BP is 124/83, respirations are at 16, and O2 100%. As her sleeve is raised to take the blood pressure, healed cuts over her wrists are revealed. The patient gets upset and flushed and covers her wrists and says that she had an accident. The physician begins to suspect the patient may have anxiety with body dysmorphic disorder with possible suicidal tendencies. He attempts to calm her and tells her that her wanting to change her body, feeling anxious and “having accidents” can all be attributed to anxiety that is correlated with body dysmorphic disorder.

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The patient denies that her negative body image and self-deprecation are worse than anyone else experiences. She states that if she could get a few of her body parts fixed that she would be just fine. She screams she is going to get a second opinion as soon as possible. Seeing she is becoming more and more out of control; you recommend an inpatient stay on the psych unit on another floor of the hospital.

The nurse encourages her to keep a journal of times of grooming, things she doesn't like about herself, and amounts of exercise while in the hospital. The nurse encourages her to practice relaxation techniques and see if the symptoms are relieved when she is grooming or exercising more than an hour.

Subjective Data:

Client reports feeling anxious and panicky at the thought of leaving her house and wears copious amounts of makeup and scarves to cover as much of her body that she can. Client has trouble leaving the house in the daytime or even at all. Client is feeling alone since her family doesn't understand what she is going through, and they believe she is great just the way she is. She is exercising too much to lose weight when she is not overweight.

Objective Data:

F, 28yo. Dressed appropriately with scarf to cover neck area. Well educated, well-groomed and wearing copious amounts of makeup. Vitals: Temp 98.6 F, BP 124/83, RR 16, P 88bpm, O2 100%, pain reported as 0/10.

PART II

Plan of Care:

1. Nursing Diagnosis: Anxiety with ineffective coping.

	Immediate	During Hospitalization	Community
Goal 1.1: Client	1 Actively listen to	Client will find	1.Client will sit

will learn some effective coping mechanisms	client's reasons for feeling anxious. Ask open ended questions.	member of staff if needed to help calm down. Client will acknowledge and talk through feelings.	down and deep breathe when she starts feeling anxious.
	2. Nurse will encourage client to deep breathe.	Client will take note when symptoms are lessened when stress levels go down.	2. Client will call counselor/support person if she cannot calm herself.
	3 Client will count to 10, and nurse will reassess how client is feeling.	Prozac/ fluoxetine while inpatient. Nurse will educate client on when/ why to take this medication.	3. Client will be taking Prozac (fluoxetine) as prescribed.
Goal 1.2: Goal 1.2: Client will use journal to monitor symptoms.	1.Client will write down how she is feeling.	Vitals will be taken twice per shift.	Client will write symptoms to bring to therapy appointments.
	2. 2. Nurse will ask client to share what has been written and practice open therapeutic communication to assess where feelings might be coming from.	Client will write down vitals.	Client will agree not to look up symptoms prior to appointments.
	3. Client will write outcomes and how they made her feel.	Client will write down outcomes/ "what provider said"	Client will write down outcomes/ "what therapist said"

2. Nursing Diagnosis: Risk for Self-Harm related to feelings of helplessness, loneliness, or hopelessness secondary to psychiatric disorder bipolar disorder.

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	Immediate	During Hospitalization	Community
Goal 2.1: Client will remain free from self-harm	1 client will contract to safety within 24-48 hours of hospitalization.	Client will express her feelings about why she wants to harm herself.	Client's family will verbalize 4 ways on how to recognize levels of impending self-harm that may be committed by the patient.
	3. Client will verbalize 3 techniques on developing copings skills to help her handle stressful situations.	client will verbalize how and when to use the 24-hour emergency hot-line when she gets feelings of self-harm at discharge.	Client will assist in identifying thoughts, feelings, and behavior that leads up to her wanting to commit suicide.
	3 sitters at client's bedside within arm's reach	Client will verbalize understanding that self-harm is a choice, not something uncontrollable at discharge.	Client will journal, reach out to a safe person to talk to when client is feeling the urge to self-harm
Goal 2.2: Client will not over exercise	1. Client will not exercise more than 2 hours a day	Client will become educated on the importance of exercise as prescribed	Client will start walking more and do less invasive exercise at the gym
	2. client will list reasons why over exercise is not healthy for the body.	Client will watch educational videos on exercise that are provided by the hospital through the tv in client room	Client will keep a record of exercise in daily journal
	3. Client will talk to someone when they feel the compulsion to exercise.	Client will only walk laps in the hallway and not perform any invasive exercise.	Client will begin to identify the negative feelings they have that trigger compulsions and learn CBT as a therapeutic tool

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PART III

NCLEX Questions with Rationale:

Question #1: When caring for a patient during an acute panic attack, which of the following actions by the healthcare provider is most appropriate?

Choose 1 answer:

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A Offer the patient reassurance of safety and security

B Explore common phobias associated with panic attacks

C Ask open-ended questions to encourage communication

D Use distraction techniques to change the patient's focus

Question #2: During a panic attack, a patient states, "I feel like I'm going to die!" The patient is hyperventilating, tachycardic, and reports feeling upper extremity numbness and tingling. Based on this patient's presentation, the healthcare provider would anticipate which additional clinical manifestation of the panic attack?

Choose 1 answer:

A Kussmaul respirations

B Respiratory acidosis

C Respiratory alkalosis

D Hypercapnia

Question #3: When caring for a patient in an inpatient psychiatric setting, which of these will the healthcare provider establish as a priority goal for the patient?

Choose 1 answer:

A Improving communication skills

B Attending group therapy sessions

C Demonstrating decreased symptoms

D Demonstrating medication adherence