Dover Behavioral Health
Clinical Assignment
2024

Student Name: Rachel Dietz Date: 9/25/24

Patient's Initials: M.N Age: 31 Sex: F

Psychiatric Diagnosis(es): MDD

Pathophysiology of the main Psychiatric Diagnosis:

Neuroanatomical Factors:	• abnormalities in the brain's gray and white matter • the prefrontal cortex exhibits a dysfunctional metabolic state, this is characterized by decreased blood flow, neural activity, and neuronal metabolism
Neurotransmitters:	• Serotonin ↓ • Norepinephrine ↓ • Dopamine ↓
Course/ characteristics of illness:	• Depressed Mood • Anhedonia • Change in weight • Insomnia or hypersomnia • Psychomotor agitation or retardation • Fatigue or energy loss • Feelings of worthlessness or guilt • Diminished concentration or indecisiveness • Recurrent thoughts of death or suicidal thoughts

Medications

Medication Name What is this for?	Classification & Action	Side Effects	Nursing Implications
Sertraline (Zoloft) Treat depression	SSRI • Selectively blocks the reuptake of serotonin	Dizziness, drowsiness, lightheadedness, increased appetite, weight gain, dry mouth, or constipation	• Antidepressants might contribute to suicidal behavior. • Look out for Serotonin Withdrawal Symptoms: Nausea, headache, dizziness, visual disturbances, tremors
Clonazepam-paliperidone (Invega)	Atypical antipsychotic • mediated through a	Drowsiness, dizziness, lightheadedness, drooling,	• Can cause blood sugar to rise • Risk for falls

treat the symptoms of psychotic disorders, including schizophrenia	combination of central dopamine and serotonin (5HT2A) receptor antagonism	stomach/abdominal pain, weight gain, or tiredness	• May cause TD S/S- unusual/uncontrolled movements (especially of the face, lips, mouth, tongue, arms, or legs) report to doctor immediately.

Mental Status Exam:

	Subjective Data	Objective Data
Appearance	n/a	-Hair unkept and chunks of dandruff are present
Behavior	"I hate when people stare at me" "Stop the noise!"	-Agitation with others, constantly looking around and shields her face when others are near her. -Does not maintain prolonged eye contact -fidgeting when speaking and stares off into the distance.
Speech	"I fucking hate it here, I hate everyone here they I are all white trash"	-Rapid speech, soft tone until provoked or triggered and then becomes loud and aggressive.
Mood	n/a	-goes through multiple affects in a conversation: anger, withdrawn, paranoid, bland, energetic -eye brows scrunched, face tilted down, arms hugging self. Faces away from others
Disorders of the Form of Thought	"I really like anime; my favorite is Naruto-that guy is really pissing me off why is he looking at me- last night I didn't sleep well."	-thought process not organized, scattered conversations. -goes from one topic to the next with no pauses

Perceptual Disturbances	n/a	n/a
Cognition	n/a	- aware of illness and triggers -unable to use problem solving when agitated or triggered -memory recent, does not remember traumatic memories, like how she got here. -full LOC -AO x 4
Ideas of harming self or others	"my moms voice annoys me now, that's why I'm here I tried to stop it"	n/a

Problem #1: Risk for self- or other-directed violence

Priority Patient Goal:

1. Patient will be able to identify one trigger to their aggressive behavior.

Assessments:

- becomes loud and shouts vulgar slurs to other patients, looking around and shielding face out of view of others. Screams when door is slammed, states "her mother's voice annoys her now and she can't handle it", does not attend group activities. Picks at skin aggressively when speaking upon feelings.

Top 2 Interventions with rationale:

1. Assist in using coping skills PRN for aggressive behavior towards others. – Clients that struggle with managing their aggressive behavior may need an outlet to put the extra energy into, like coloring or drawing or journaling.
2. Encourage physical activity PRN escalated situations - this will allow any pent-up aggression or energy to be delivered through walking.

Problem #2: Ineffective Coping

Priority Patient Goal:

1. Patient will use a coping strategy when overstimulated during my time of care.

Assessments:

- Denies participation in group therapy and activities, sits alone in separate room, leaves room when people occupy it, lashes out toward others, understands triggers but does not use de-escalation techniques.

Top 2 Interventions with rationale:

1. Practice deep breathing techniques PRN when overstimulated. – Deep breathing techniques allow the patient to focus in on their breath and let go of the thoughts or surroundings. this will then center them back to reality and lower anxiety
2. Help identify possible behaviors delaying coping PRN overstimulated lashing out. – it's important for the patient to be able to identify triggers and express why they might have reacted that way. Then we can work on coping skills when warning signs arise before a full incident occurs.

Patient Teaching

List 2 teaching topics that you taught a client.

1. I taught deep breathing exercises.
2. I taught about lithium and adverse effects to watch out for.

Growth & Development

1. Discuss norms of growth and development for your patient, including development stage.
MIDDLE ADULTHOOD (30-65)

- This stage is where work is crucial
- Achieve life goals established for oneself while also considering the welfare of future generations
- Significant relations are found within the workplace, community and family.

2. Discuss any deviations of growth and development.

- Unemployed
- Does not have goals/aspirations
- Dependent and lives with parents
- Has no concern for the welfare of others
- Withdrawn and keeps to self
- Difficulty making relationships
- Believes no one will love them

Self-Evaluation: Answer the following question.

1. What is your personal perception of your performance during your clinical day? What did you do well? What could you have done better? Give specific examples.

At the end of these two days, I am leaving with so much empathy and compassion towards the patients I have been lucky enough to meet. I had no idea what some of these people have gone through and I am glad I was able to talk to them before looking in their charts, I was able to have a baseline to go off of what they were like when they were admitted to the unit. Some were appearing better in some ways, where others were showing little progress.

Today it felt easier to talk to the patients. I think that is because of the trust/rapport I had built on day 1 with them. Many times, today I did not need to approach patients, most came up to me and remembered my name and seemed excited to open up or talk. It made me feel grateful to be a part of their journey.

I could have been better today when it came to understanding and being mindful to other triggers. For example, I gave up my seat to another patient that was standing. And a different patient got physically and verbally upset with me. She pulled me aside and explain herself. I felt that was a very educational moment and something I will take with me when I have future patients. Not everyone reacts the same and its important to ask specific questions before assuming it is okay.