Dover Behavioral Health
Clinical Assignment
2024

Student Name: Kimberly Joseph Date: 10/09/24

Patient's Initials: B.S. Age: 68 Sex: Female

Psychiatric Diagnosis(es): Major Depressive Disorder, Substance Use Disorder

Pathophysiology of the main Psychiatric Diagnosis:

Neuroanatomical Factors:	Decreased serotonin leading to poor impulse control, decreased appetite, irritability, norepinephrine is decreased which leads to anergia, anhedonia, dopamine is decreased affecting the ability to express emotion and alters the learning process of the individual
Neurotransmitters:	Decreased dopamine, norepinephrine, serotonin
Course/ characteristics of illness:	Loss of interest in activities, anhedonia, weight change, insomnia or hypersomnia, fatigue, lack of energy, worthlessness/guilt decreased concentration with indecisiveness, recurrent thoughts of suicide/ death

Medications

Medication Name What is this for?	Classification & Action	Side Effects	Nursing Implications
Zoloft/ Sertraline Used for depression	SSRI(selective serotonin reuptake inhibitor) Action: actively inhibits the reuptake of serotonin which increases the concentration and availability of serotonin at the pre synaptic terminal.	indigestion, nausea, diarrhea, loss of appetite, epitaxial, diaphoresis, tiredness, insomnia, anxiety, tremors, agitation, diminished sexual functions	Educate client to not take with MAOIs Educate client sx of serotonin syndrome: diaphoresis, HTN, Increased HR, delirium, seizures and that these occur 2-727 hrs after starting Report any suicide thoughts while taking Take in the am Educate client that it will

			first cause wt. loss then wt. gain It can cause GI disturbance so client should be educated to take with food. Do not d/c abruptly, taper dose slowly s/sx of withdrawal: n/v, dizziness, visual disturbances, tremors
Abilify/ Aripiprazole Used for major depressive disorders	Atypical antipsychotic It stimulates and inhibits dopamine while engaging the D2 receptors. It also lowers the dopamine firing which increases dopamine concentrations.	Metabolic syndrome: wt. gain, hyperglycemia, dyslipidemia Agitation Dyspepsia Constipation Dizziness Insomnia Akathisia Headache disorder Nausea Vomiting Hypertriglyceridemia Increased appetite Tardive dyskinesia Extrapyramidal disease	Educate client on proper diet and exercise while taking Educate the client that they may need blood draws to monitor glucose levels Educate that it can elevate cholesterol levels

Mental Status Exam:

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	Subjective Data	Objective Data
Appearance	n/a	• Poor hygiene • Hair brushed and not matted • Jacket with holes • Facial expression is neutral • Nutritional status indicates slight obesity • Looks appropriate for age
Behavior	n/a	• Avoids eyes contact when speaking • Scans the environment constantly • No abnormal movements noted • Reduced body movements
Speech	“I got to force myself to eat to keep my strength up”	• Speech at normal rate • Speech volume is normal, sometimes soft • Speech has occasional slurs,

		with a noticeable Southern accent
Mood	n/a	• Affect is flat and bland, makes statements to make others laugh but doesn't smile when doing so • Mood is sad, complacent
Disorders of the Form of Thought	n/a	n/a
Perceptual Disturbances	n/a	n/a
Cognition	"I moved from Georgia in 1971 to Dover to escape domestic violence from my ex-husband" "my son died 2 years ago from DM, and ESRD, he quit on himself by stopping dialysis treatments"	• AxO x4 • Alert • Able to recall why admitted, events leading up to admission • Aware of present illness, reason for admission, and treatment plan to recover • Judgment is appropriate by being aware of need for rehab
Ideas of harming self or others	"I walked out in front of traffic hoping someone would run me over" "I usually cut myself when my ex husband use to beat me"	• High r/f suicide • Homeless • Blames self constantly for son's death/ use for drugs • Blames self for undergoing DV situation with husband • Cuts wrists

Problem #1: Risk for Suicide
Priority Patient Goal:

1. Client will not self- harm and seek for help when having thoughts of self harm durin my time of care.

Assessments:

- Assess for support system prn, assess for current thoughts of suicide STAT, assess for suicide plan and method of lethality STAT

Top 2 Interventions with rationale:

1. Maintain safety by placing in paper scrubs continuously , removing potential hazards in room/ environment continuously, and keeping in arms reach continuously. Ensuring the client's safety is the top priority intervention because there will be no new alternative methods to carry out plan for suicide.
2. Encouraging to participate/ go to group therapy continuously. Encouraging to go to therapy is important because the client is forced to be around others and interact. Hopefully hearing other's speak about their issues will help client relate and see they are not alone and can come out of this depression.

Problem #2: Ineffective coping

Priority Patient Goal:

1. Client will demonstrate proper effective coping mechanisms instead of resorting to alcohol by the end of my care.

Assessments:

- Assess for current methods of coping mechanisms upon admission and prn, assess for support system prn, assess for triggers STAT, assess for stressors STAT, assess for willingness to go to rehab upon admission and prn_

Top 2 Interventions with rationale:

1. Educate client to avoid triggers and stressors continuously. Avoiding stressors and triggers will inhibit the want to start using again.
2. Promote alternative coping mechanisms such as listening to music, going for a walk prn. These are healthy alternative coping mechanism rather than picking up alcohol that could deteriorate their life.

Patient Teaching

List 2 teaching topics that you taught a client.

1. I encouraged my client that although her family is a trigger, she can reach out to one person she trusts and utilize them for a support person when she feel stressed.

2. I educated my client that it is normal to feel depressed after losing a loved one, and that she is not alone.

Growth & Development

1. Discuss norms of growth and development for your patient, including development stage.
My client is in the late adult stage and it is normal for this age group to experience death of loved ones and experience integrity vs. despair in which my client is experiencing a lot of despair. It is also normal for them to start having changes in family structure with increase risks for Cardiovascular issues in which my client has a hx of HTN.

2. Discuss any deviations of growth and development.

My client is experiencing depression from a loved one, she also is experiencing a lot of despair because she feels as though her current situation is a punishment from her history of utilizing alcohol and cocaine. She also blames herself a lot and resents herself from putting up with her ex-husbands abuse. She feels as though her children allow for their wives to disrespect her which is the reason for isolating herself from them. Instead of attending family gatherings she'd rather seep in her car.

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.
My perception of how I did today was much better. I was less afraid with talking with the clients today and was less afraid of rejection today. I went in with the mindset that I have a lot of experiences and am going to find something in common with each person and that helped me interact better. Instead of imposing personal experiences, I listened more to my clients and let them tell their story without feeling like I had to find something in common. I don't feel like I could've did anything better because I came full out my shell today and was proud of doing so because I heard a plethora of life experiences today.