

Dover Behavioral Health
Clinical Assignment
2024

Student Name: Amanda Benson Date: 10/30/24

Patient's Initials: M.E. Age: 36 Sex: M

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

Pathophysiology of the main Psychiatric Diagnosis:

Neuroanatomical Factors:	Structural changes in brain regions like prefrontal cortex, amygdala, hippocampus, and basal ganglia – reduced volume in these areas
Neurotransmitters:	Decreased Serotonin, decreased norepinephrine, decreased dopamine
Course/ characteristics of illness:	Depressed mood, loss of interest or pleasure in usual activities (anhedonia), symptoms present for at least 2 weeks, no hx manic behavior, not related to substance use, recurrent thoughts of death or suicide.

Medications

Medication Name What is this for?	Classification & Action	Side Effects	Nursing Implications
Fluoxetine (Prozac) SSRI: treats major depressive disorder, OCD, eating disorders, PMDD, panic disorder, resistant bipolar 1, PTSD, raynaud's	Antidepressant Blocks reuptake of serotonin in CNS, enhancing serotonergic function.	HA, lack of energy/strength, insomnia, anxiety, drowsiness, nausea, diarrhea, decreased appetite, dizziness, tremor, fatigue, vomiting, constipation, dry mouth, abd pain, nasal congestion	Assess mental status and suicidal tendencies, renal function, LFT, blood counts. Supervise suicide risk pts closely, monitor mental status, anxiety, bowel activity.

Mental Status Exam:

	Subjective Data	Objective Data
Appearance	Nothing stated regarding appearance	Groomed, good hygiene, same clothes as yesterday but doesn't appear dirty, facial expressions match spoken word, good nutritional status, appearance and age congruent
Behavior	Stated he's, "practicing woo-sah" to remain mentally calm	Normal body movements, normal level of eye contact
Speech	Nothing stated regarding speech.	Normal rate and volume
Mood	When asked how his night was, stated, "They got me sleeping on the floor right here", pointed to where we were standing. Also stated he's, "learning how to be patient while I'm here".	Flat affect, withdrawn. Depressed, frustrated mood
Disorders of the Form of Thought	Nothing stated	None observed
Perceptual Disturbances	Nothing stated	None observed
Cognition	Insight: pt stated, "I needed to get away from everything for a few days" when asked why he came for tx. Aware that he needs help with coping through life stressors.	AO x4, memory intact, appropriate attention, insight, and judgement
Ideas of harming self or others	"Not after getting this perspective"	No plan or means of carrying out suicidal ideation. Stay at DBH has renewed his appreciation for life.

Problem #1: Risk for Suicide

Priority Patient Goal:

1. Will not harm self or others during time of care

Assessments:

- Assess for suicidal ideations, triggers, support systems, purpose, any resource deficits, depression hx, trauma hx, Hamilton depression scale on admission and PRN

Top 2 Interventions with rationale:

1. Ensure pt is in a safe, calm environment during time of care – to create an atmosphere of healing and allow self-reflection.
2. Help patient identify areas of his life that they cannot control – this allows patients to break down the big picture in to smaller, more attainable problems.

Problem #2: Ineffective Coping

Priority Patient Goal:

1. Will verbalize understanding of at least one healthy coping mechanism by end of care.

Assessments:

- Assess support systems and availability of outpatient therapy, current coping mechanisms and success rate, willingness to change, willingness to use psychiatric medication as a tool for mental health upon admission and PRN.

Top 2 Interventions with rationale:

1. Educate on alternative coping mechanisms like deep breathing or having a meaningful hobby – to help pt build resiliency and work through life's stressors.
2. Encourage expression of thoughts and feelings – to help patient dig deeper and figure out how to minimize unhealthy coping, impulses, and anger.

Patient Teaching

List 2 teaching topics that you taught a client.

1. The benefits of using psychiatric medications as a tool to work through crises.
2. The importance of incorporating self-care into a busy life.

Growth & Development

1. Discuss norms of growth and development for your patient, including development stage.

Middle Adult (30-65): Formal operational, generativity vs stagnation. Normally this phase of development involves doing activities that benefit others, taking pride in accomplishments,

enjoying watching children grow, adjusting to physical changes (ageing), enjoying mature love with a partner.

2. Discuss any deviations of growth and development.

If acceptable ways of being productive are not met, may develop feelings of stagnation and worthlessness. Those who experience a loss of job, spouse, family, sibling etc... can feel deep despair and loss of self during this time. Big life changes can really affect those in middle adulthood because they have gotten used to life being a certain way for 20+ years.

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.

I feel like I did better today than yesterday. It was much more comfortable to initiate conversations with patients after having been introduced to them and the facility. I felt more of a responsibility to improve the patient's experience and was able to observe things that could be done to facilitate a more therapeutic environment. Cleaning the tables and chairs in the group rooms was highly appreciated by the patients, as evidenced by many of them thanking us for doing so. I also felt like my interview with M.E. was beneficial for him. He was receptive to the coping mechanisms (deep breathing, finding the positives in situations, going for walks), and agreed that he had a unique opportunity to practice patience while in DBH.

I could improve my ability to prompt patients in meaningful directions. In normal conversation, I have no problem asking good questions, and have been told I am "Easy to talk to". In the mental healthcare setting, it is difficult to leave all personal experiences and opinions out. I realized one of the ways I tend to offer help is through validation – usually by trying to normalize others' feelings by sharing my own experiences. Now I understand that that might be perceived as belittling expressed feelings and can invoke a lack of empathy.