

Reflection Assignment

Noticing	Interpreting	Responding	Reflecting
<p>What did you notice during your mental status examination of the client? Were there any assessments that were abnormal or that stood out to you?</p> <p>I chose this additional assessment based upon my client having suicidal ideation-self harm precautions being listed in her chart. During the additional assessment I noticed my client being very fidgety, avoiding eye contact while still engaging in conversation, and being very open to me. What stood out to me was the client stating her past attempts of suicide by overdosing on Clonidine and self-harm with a razor blade.</p>	<p>If something stood out to you or it was abnormal, explain it's potential cause or patterns that you noticed. Describe any similar situations you have experienced/ as well as the similarities or differences between the experiences. Is your interpretation of the situation links to pathophysiology at all, if so - briefly explain.</p> <p>The potential cause of the clients' past attempts of suicide is an abusive relationship the client had with her boyfriend. She had also stated that she believes her depression has been affecting her feelings and decision making for a while. A similar situation I have experienced in an abusive relationship myself while pregnant and not wanting to be alive. The difference is I never attempted suicide but had a plan. Depression can have a major impact on someone's choices and rational thinking, in both situation's depression had impact on our feelings and rational thinking.</p>	<p>What additional assessment information do you need based upon your interpretation? What can you do as a nursing student? What did you do? What could you do as a nurse? What therapeutic communication techniques did you utilize?</p> <p>Based on interpretation, I could have asked my client does she still associate with the person that contributed to her attempts of suicide. As a nursing student, I could have asked if her overdose on Clonidine had any long-term effect on her health. I listened to my client thoroughly and used therapeutic communication by having silence when she spoke and proper body language. As a nurse, I could have done a PHQ-9 to assess her major depressive disorder.</p>	<p>What is something that you learned? What is something that you might do differently in the future? What is something that you did well? What additional knowledge or skills do you need to help you with future situations like this. Describe any changes in your values or feelings based on this interaction.</p> <p>I learned that everyone goes through something and handles it differently. I would have engaged more with my client because I just asked strictly the questions on the paper and kept it brief. I introduced myself and told my client what I was going to do thoroughly. Getting more interaction and having to respond to "not so comfortable" answers will help with future situations. My feelings changed because I have never had someone tell me about attempting to kill themselves. I wanted to cry for her because at some point in</p>

			her life, she felt that things were that bad to attempt suicide.
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<p>Why did you choose this additional assessment? What did you notice during your additional assessment of the client? Were there any assessments that were abnormal or that stood out to you?</p> <p>I noticed my client had avoidant eye contact, was restless and fidgety, and her mood was depressed. My client was very cooperative while talking, she answered all my questions without hesitation. What stood out to me was my client stating “I don’t want to be here” yet she voluntarily put herself there because she knows she needs the help.</p>	<p>If something stood out to you or it was abnormal, explain its potential cause or patterns that you noticed. Describe any similar situations you have experienced / as well as the similarities or differences between the experiences. Is your interpretation of the situation links to pathophysiology at all, if so - briefly explain.</p> <p>The one abnormal thing that stood out to me was how my client laughed after she explained her overdose and she told me that she laughed because she’s embarrassed about it. I personally laugh things off and know many people that do when things are embarrassing for them, but I’ve never experienced that reaction with such a serious situation.</p>	<p>What additional assessment information do you need based upon your interpretation? What can you do as a nursing student? What did you do? What could you do as a nurse?</p> <p>I could have added the PHQ-9 because my client had no emotion when speaking, it was like a breeze for her to conversate with me. I used therapeutic communication by restating what my client said to me, direct eye contact, and silence when she was talking.</p>	<p>What is something that you learned? What is something that you might do differently in the future? What is something that you did well? What additional knowledge or skills do you need to help you with future situations like this. Describe any changes in your values or feelings based on this interaction.</p> <p>I learned that it’s important to engage in conversation while doing the mental status exam. I would make sure to keep a good conversation going and no pauses when completing the metal status exam in front of the client. I observed my client well without her noticing that I was doing it. In the future, I can take more mental notes and fill out the mental status after visiting with the client. This will prevent me from having to try to keep good conversation while completing it. My feelings about my client admitting that she knows she needs the help was changed because I am look down on asking people</p>

			for help and now I don't view it as a problem.
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Mental Health Assessment Tools