

<b>Noticing</b>	<b>Interpreting</b>	<b>Responding</b>	<b>Reflecting</b>
<p>During the mental status exam, the patient appeared to be disheveled and a little guarded at first. However, as the exam went on, she became more open and elaborate with her answers. Some abnormal assessments were her mood, perception, and thoughts. She stated she was depressed and suffered from hallucinations that led to paranoia.</p>	<p>The client stated that the hallucinations began after giving birth four years ago to a child she put up for adoption. She said before giving birth, she had already struggled with depression and anxiety, but giving birth drove her into postpartum psychosis. The client states she hears voices telling her she's "going to get into trouble" and being "set up." She also says she feels like bugs are crawling on her. When she has her medication (Seroquel), the hallucinations subside. However, she recently had her purse stolen, which contained her meds. The hallucinations began again, and it led her to her current admission.</p>	<p>As a nursing student, I thought it was essential for me to ask open-ended questions when the client admitted to having hallucinations. I asked her how long it has been happening, what she hears/sees, and what makes it better. I also assured her several times that at any point, if she did not feel comfortable answering questions, she didn't have to. She became less guarded as the assessment went on.</p>	<p>Something that I learned was postpartum psychosis. I had never heard of it before, but it made sense once she mentioned it. I looked it up when I got home and learned the severity of it, and I completely empathized with her. She has been through a lot in her life, and I wish there were more free resources for postpartum moms. Something I did well was provide a calm and nonjudgmental environment.</p>

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<p>Since I got to partner with Presley, we conducted two assessments. We chose to use the DAST-20 and Suicide Risk Screening Tool. We selected these because the client was admitted with suicidal ideation and relapsed on drugs and alcohol. The client scored an eight on the DAST-20, which means she has a substance abuse/dependence problem. She identified a potential risk for suicide as well.</p>	<p>The client stated that she had been clean from drugs and alcohol for some time but relapsed once she had her purse stolen and had no more Seroquel. She said the hallucinations came back quickly, and the only way she could silence them was with drugs and alcohol. I'm not sure if this counts, but I once saw a show where a guy would abuse heroin because it was the only way he could stop seeing "the ghosts." It's so sad that people revert to such an extreme because the hallucinations are that. I cannot even begin to imagine how that feels. I am not saying there are other ways, but people in very unfortunate situations feel that's the only way or perhaps the easiest. Whatever the reasoning, it is sad to witness.</p>	<p>I think it would've been somewhat helpful to know how long the client has had substance dependence. I did not think to ask it because the questionnaire focused on the present time. As a nursing student, I have to remember that I do not have to only ask the questions on the questionnaire. It is okay to ask others if it is pertinent to the client's reason for admission.</p>	<p>I previously learned about grandiosity in class, but it's a different experience when you witness it. Granted, your everyday people do it too, to an extent, but a patient diagnosed with a mental health disorder takes it to another level. For the future, it's essential to take things said with a grain of salt. Regardless, You will not know when they are telling the truth.</p>

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N323 Assessments & Reflections