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1. Identify your thoughts and feelings about your first clinical experience on the unit. Underline your feelings and **bold your thoughts**

Our first experience on the unit was much more engaging than I expected it to be. Many of the patients were very open to talking to us and were very interactive. I understand the purpose of rounding every 15 minutes but that is essentially all that a designated person can do, especially if the unit is full. **I can imagine that it's very difficult to do when the unit is short-staffed. I was surprised to see that the nursing station was open to the patients and visitors, which I now realize is a horrible misconception on my part that probably has its roots in movies and other false representations. However, I will say that in the event that they were short-staffed and everyone working got busy I think it is a hazard to not have some sort of barrier to all of the items back there that could be used for self-harm. I would have liked to have more interaction with the nurses and to see what kind of things they were working on, whether it was assessing or passing meds.** There wasn't much interaction there. I was one of the students to observe report at change of shift around 7. I felt very uncomfortable hearing about some of the sad circumstances that brought patients in and contrasting it with the friendly, seemingly happy people I had conversations with earlier in the day. It always feels very intrusive to me to be privy to those kinds of details, especially in this circumstance. **I was a little confused about why report was recorded when all the nurses were still present**; it felt a bit awkward and there were some instances where clarification seemed like it was necessary. I felt one of the nurses who came on later was a little abrasive; judgmental about the clients and not having the tech he was expecting. **The group he led was also very brief and I'm unclear if that's what we should expect each time or not**.

2. List at least 1 misconception about Mental Health and state whether this misconception is true or false.

There is a misconception that mental health issues aren't real, that the individual experiencing them is making it up or it's related to some sort of other disease state that can be "fixed" medically. This is false, we now know that many people have biological and genetic differences that can predispose them to various conditions. The DSM-5 is also a powerful tool backed by the collective knowledge of the American Psychiatric Association and over a decade of research on various conditions, so diagnostic criteria and signs and symptoms are now better defined and backed by evidence and clinical observation. There is also the impact of nature vs. nuture, or the environment, that can influence how individuals develop when they experience trauma, abuse, or neglect as a child when genetically there may be no known risk factors predisposing them to mental health issues.

3. Explain at least one thing you are interested in seeing or learning in this clinical.

Ideally none of our clients will become agitated or upset, but I would really like to see de-escalation approaches in action. At my current job as a HCT at Carle we often have patients who get upset or have TBI or strokes that have altered their behavior. Being new to the job it would be an added bonus to learn helpful techniques for them as well, and for my future as a nurse dealing with patients and their loved ones.