Week Three: Training Title Two

The PMHNP must be able to differentiate between the various mood disorders listed in the DSM-5 and their criteria in order to correctly diagnose patients. Giving a patient the correct diagnosis is vital to ensure they receive the proper treatment because, if not, there are serious consequences, such as suicide. The purpose of this assisngment is to complete a comprehensive psychiatric assessment on the patient in my selected video and describe how I reached my primary and differential diagnoses and my reflection on what I would change or add in the psychiatric interview, considering things like ethics and the specific patient at hand.

NRNP/PRAC 6635 Comprehensive Psychiatric Evaluation

Subjective:

CC (chief complaint): "Mom says I get moody this time of year, every year."

HPI: JH is a 19-year-old caucasion female presenting to the clinic today to undergo a psychiatric evaluation for her "moodiness" that she experiences every winter. The patient's mother was worried about her so she wanted the patient to see a mental health professional for evaluation and possible treatment options. The patient has never been on a psychotropic medication. She says each year around winter time, she feels down, lacks motivation, and has trouble focusing. This year, she noticed these symptoms were starting again around the beginning of October and have continued to worsen since. The patient has been struggling in school due to her lack of motivation and trouble focusing and has even had to leave her business program. She has difficulty finishing projects and cannot retain information, stating that she will read something and then after five seconds, she is unable to recall what she just read. She also has been experiencing hyperphagia and has had a 10 pound weight gain this year. Additionally, she is experiencing hypersomnia and frequently misses classes due to accidently sleeping through them. The patient makes friends easily and was very socially active in the summer, but now prefers to stay inside due to the colder weather. She even finds that her friends irritate her and describes them as "dull" since they have a new interest in playing board games. Due to this, the patient has been isolating herself from her friends. The patient has significantly changed from what she was like in the Summer. She went out all of the time with her friends to various shows and concerts in August, stating "it was a blast". She describes herself as "a summer girl" and that she doesn't necessarily hate the cold, but dislikes it due to not being able to go outside for

activities like going to the beach. She states the city shifts to a "dark", "grey", and "miserable" place when winter comes that continues to worsen the longer it occurs. Overall , the patient feels she is not currently doing well.

Past Psychiatric History:

- **G**eneral Statement: The patient has never received treatment for a psychiatric condition. She experiences symptoms each year when it gets cold out. Does not experience symptoms any other time of the year, specifically times of the year that she can go outside and do things and is not too cold. She also likes it when it looks pretty outside. For example, she thought September was still pretty since the leaves were changing and the sun was still out. She states she does not like the winter because everything looks "dark" and "grey".
- **C**aregivers: The video and the case history report does not say if the patient has other caregivers, such as a PCP. However, the PMHNP must always ask about this because each provider taking care of the patient should be on the same page so that they all are aware of what the patient's treatment plan is and avoid harmful things like medication interactions (Carlat, 2017).
- **H**ospitalizations: The patient has no history of being hospitalized for a psychiatric condition.
- **M**edication trials: The patient has never been prescribed a psychotropic medication.
- **P**sychotherapy or **P**revious Psychiatric Diagnosis: The patient has never been diagnosed with a psychiatric disorder and has never had psychotherapy.

Substance Current Use and History: The case study report says that the patient does not have a history of substance use. It does not say if she was assessed for using substances currently. It is essential to assess anyone experiencing presenting with depression for susbstance use, especially college students (Welsh et al., 2019). According to Welsh et al. (2019), substance abuse is a leading health concern among United States college campuses. Those who abuse substances are shown to miss class more, not study as much, and not graduate compared to those who do not use substances (Welsh et al., 2019). Those who are depressed also are at increased risk for substance abuse due to using this as a way to cope (Carlat, 2017) Therefore, it is critical to assess the patient for substance abuse to determine if this has caused her symptoms or if she now has a problem due to her symptoms (Carlat, 2017).

Family Psychiatric/Substance Use History: The patient does not have a family history of substance use. She also does not have a family history of psychiatric disorders. It does not mention if the patient has had any family members that have committed suicide. This would be important to note since this may place the patient had higher risk for suicide (Carlat, 2017). I would also want to ask about medical conditions that family members possibly had that can lead to depressive-like symptoms that places the patient at high risk for these conditions, like thyroid problems, MS, diabetes, HIV, liver disease, and kidney disease (First, 2020).

Psychosocial History:

- **Childhood**: Patient wsa born and raised in South Carolina. Both parents raised the patient growing up. She has one sister and two brothers. It does not say her birth order, which has a role in how the patient develops psychologically (Carlat, 2017). For example, the

middle child tends to feel ignored, which contributes to various mental health complications down the road (Carlat, 2017).

- **Current Residence**: The patient now lives in Boston, MA at housing off-campus with two girl roommates.
- **Relationships and Children**: She is single and does not have any children.
- **Education and Work**: She has a high school degree. She is currently a full-time student in college pursuing an undergraduate business degree. The patient does not work currently.
- **Legal Issues**: The patient has no history of legal problems. It does not say if she has any current legal issues. This is important to ask about because this can identify malingering patients (Carlat, 2017).
- **Sexual History:** The video and case study report do not mention the patient's sexuality. This is critical to assess in a patient because someone's sexual orientation can sometimes place them at high risk for psychiatric disorders (Moleiro, 2018). For example, there is significant victimization and stigmatization among the LGBTQ community that increases their risk for mental health disorders that can result in suicide (Moleiro, 2018). Another example is that obtaining a detailed sexual history can help identify if an individual is at risk for diseases, like HIV that is a depression mimicker (Carlat, 2017).
- **Trauma/Violence:** The video and the case study report do not mention if the patient experienced trauma or violence as a child or in adulthood. All patients presenting for psychiatric evaluation should be assessed for trauma and violence because these are significant risk factors for developing mental health conditions (McLaughlin et al., 2020). They have been shown to alter how individuals process information, typically

interpreting it as a threat and resulting in difficulty controlling emotions and leading to mental health conditions (McLaughlin et al., 2020). Additiionally, it is important to ask about the winter and if is represents an anniversary of a traumatic event in the patient's life that may be causing her depression each year (Carlat, 2017). It would have been helpful if the interviewer asked her what year the patient started getting these seasonal depressive episodes to pinpoint what the cause may be, but he did not.

Medical History: The video and case study report do not say if the patient has any medical condition. Asking about her medical history is essential because many medical conditions can cause depressive-like symptoms, such as cancer or hypothyroidism (Carlat, 2017). Having a history of seizures also places someone at risk for psychiatric disorders (Carlat, 2017). In addition, those with mental health disorders are not the most reliable patients, so by asking about medical disorders, the PMHNP can assist with getting the patient treatment for their medical condition (Carlat, 2017). Medical and mental disorders can worsen one another if not properly treated, so the PMHNP must use a holistic approach to ensure every aspect of the patient is taken care of to reach the best outcome (Carlat, 2017). Properly treating the mental health condition also may help increase adherence to treating the medical condition so it is important to be aware that it exists (Carlat, 2017).

Surgical History: The video and case study report do not say if the patient has had surgery in the past. This is vital to know because the surgery can identify past medical problems, an accident/traumatic experience, etc. that has led to the patient's current mental health state (Carlat, 2017). This is also important to know for psychopharmacological treatment in case a patient has

had bariatric surgery and the medication dose needs adjusted due to the body absorbing, metabolizing, etc. the medication differently than others (Stahl, 2021).

Current Medications: She does not take any medications currently.

Allergies: She has no known drug allergies. The PMHNP should also ask about any possible environmental or food allergies along with their reaction to the substance to ensure we prevent causing harm in the patient and not prescribing the patient a medication that has an ingredient in it that the patient is allergic to. Seasonal allergies have also been shown to lead to mental health conditions, like depression and anxiety (Oh et al., 2018).

Reproductive Hx: The video and the case study report do not mention the patient's reproductive history, but this is critical to assess in every woman presenting for evaluation for a mental health disorder. For example, PMDD is a debilitating condition that women can go through that causes some similar symptoms the patient has, such as depression, concentrating problems, hyperphagia, weight gain, hypersomnia, and lack of interest in activites (Yonkers & Casper, 2021). The patient does not mention the frequency of her symptoms (e.g., constant, intermittent, etc.), so its important to assess the patient's mood in correlation with her mentstrual cycle (Yonkers & Casper, 2021). Thus, the patient should be asked when her last period was, her typical cycle, any associated symptoms, etc. (Carlat, 2017). She should be asked if she could possibly be pregnant since this can also cause mood changes, and it is important to know if the patient is going to be started on any psychotropic medications due to their associated risks to the fetus (Li et al., 2021; Stahl, 2021). She has no children and therefore is not nursing, which could indicate possible postpartum depression if she were and also guide treatment (Li et al., 2021;

Stahl, 2021). Additionally, asking about her past sexual encounters, number of partners, if she has about one week of increased sexual behaviors unsual for her typical self, etc., can help to identify a possible past manic state and helping diagnosis probable bipolar depression at this point (Suppes, 2020). The patient should also be asked (if she has sex) what type of contraception she uses, her number of partners in the last year, and if she has or has had sex with men who have sex with other men or use drugs administered by injecting (Carlat, 2017). This helps assess the patient's risk for HIV that can cause similar symptoms as depression (Carlat, 2017).

ROS: (This was not performed in the video and not included on the case study report, but is essential to perform to rule out medical causes for the patient's symptoms and catch anything that the patient may have forgot to mention (Carlat, 2017).

- **General**: I would ask the patient about general symptoms that may indicate a possible infection that can be causing her symptoms, such as if she has been having generalized weakness, fatigue, a fever, or chills (Carlat, 2017). I would also ask about night sweats since this TB causes this and can mimick depression (Carlat, 2017). The patient does say that she has had a recent 10-pound weight gain with hyperphagia as well as hypersomnia.
- **HEENT**: I would ask the patient if she gets headaches since this can indicate various conditions, such as a brain tumor, CNS infection, or stroke, that can lead to depressive symptoms (Carlat, 2017; First, 2020). I would also ask the patient if they have experienced a head injury in their life since this has been shown to cause changes within the brain and lead to mental health conditions (Carlat, 2021). Next, I would ask the patient if they have any changes or problems with their vision or hearing (Carlat, 2021).

This could help to identify if the patient is having auditory or visual hallucinations (Carlat, 2017). I would also ask the patient if they smell things that the people around them do not smell since this can be a sign of temporal lobe epilepsy (Carlat, 2017).

- **Skin**: I would ask the patient if she has been experiencing skin problems that could indicate systemic lupus which can cause depressive-like symptoms (Carlat, 2017). I would also ask if the patient has noticed a rash to assess for syphilis (Centers for Disease Control and Prevention, 2017).
- **Cardiovascular**: I would ask the patient if she experiences palpitations, which could indicate conditions that can lead to depressive symptoms, like thyroid problems, anemia, or withdrawal (First, 2020). I would ask about shortness of breath with exertion/lying down, lower extremity edema, abdominal distention, and chest pain to rule out CHF that can cause fatigue and lethargy that are associated with depression (Carlat, 2017).
- **Respiratory**: I would ask the patient if she experiences wheezing (possible asthma or CHF), shortness of breath (possible CAD or emphysema), or if she coughs a lot (possible lung cancer or CHF) (Carlat, 2017). Each of these conditions can lead to depressive-like symptoms (Carlat, 2017). I would also ask her if she has signs of frequent infections, such as getting a sore throat repeatedly, to ensure this is not causing her symptoms (Carlat, 2017).
- **Gastrointestinal**: I would ask the patient if she has been having diarrhea and/or vomiting since this could possibly indicate that her electrolytes are off due to dehydration (First, 2020). I would ask the patient if she ever forces herself to throw up after eating or if she uses any laxatives or diuretics to screen for bulimia (Carlat, 2017). I would also ask about the patient's bowel habits and if she has diarrhea, constipation, or has had any changes

lately to screen for IBS that frequently occurs with mental health conditions (Carlat, 2017). I would also ask the patient if she has noticed any signs or symptoms of liver disease, such as abdominal pain, jaundice, and ascites, since this has been shown to cause depressive symptoms (First, 2020; Goldberg & Chopra, 2021).

- **Genitourinary**: I would ask the patient if she has been experiencing polydipsia and polyuria to rule out diabetes that can cause depressive-like symptoms (First, 2020). In addition, I would ask the patient about symptoms of renal disease, such as oliguria, since this can cause psychiatric symptoms from various mechanisms, such as electrolyte abnormalities (Rosenberg, 2021). I would ask if the patient has noticed pain/burning with urination, abnormal vaginal discharge, a vaginal odor, any vaginal itching/irritation, or pain with sex to rule out an STD (Carlat, 2017). Studies show that young females with depression are at high risk for STDs due to increased vulnerability during the depressive state (Huang et al., 2018). The PMHNP should also ask the patient if she has had an STD in the past because this helps identify if she is high risk for HIV or syphilis, which are both associated with psychiatric symptoms (Carlat, 2017). Untreated Syphilis leads to neurological damage that can cause many psychiatric conditions, including depression (Crozatti et al., 2015). The patient should be asked if she has ever had a pap smear and if so, when her last one was and the results (Carlat, 2017). This also helps identify high-risk sexual behavior and/or if she is at risk for cervical cancer, which can have a negative impact on mental health (Carlat, 2017).
- **Neurological**: I would ask the patient if she has ever had a seizure (epilepsy), stroke, or if she has passed out (could be from brain tumor) that can all be caused by conditions that mimick depression (Carlat, 2017). I would ask the patient if she ever experiences tremors

(possible withdrawal or Parkinson's), trouble speaking or walking (Parkinson's, MS, or stroke), or paresthesia with weakness (stroke, vitamin deficiency, or demyelinating disease) (First, 2020). Neurological conditions can also lead to incontinence, so this should also be evaluated for (First, 2020). Each of these conditions again can lead to depressive-like symptoms (First, 2020).

- **Musculoskeletal**: I would ask the patient if she has been experiencing joint pain that could indicate systemic lupus which can cause depressive-like symptoms (Carlat, 2017). I would ask if she has noticed she has generalized musculoskeltal pain or weakness to identfy possible fibromyalgia that often accompanies mental health disorders (Goldenberg, 2020).
- **Hematologic**: I would ask the patient if she bleeds easily and/or a lot and if she has a history of anemia since anemia can cause depressive symptoms (Carlat, 2017).
- **Lymphatics**: I would ask if the patient has noticed any swollen lymph nodes which can indicate an infection as the possible etiology of symptoms (Carlat, 2017).
- **Endocrinologic**: I could also ask about polydipsia and polyuria in this section to rule out diabetes (First, 2020). Another endocrine disorder that is essential to ask about in the patient presenting with depressive symptoms is hypothyroidism (First, 2020). Thus, I would ask about symptoms like cold intolerance, coarse hair, brittle nails, hair loss, myxedema, and bradycardia (Surks, 2020).

Objective: Some observations I made was that the patient was fidgeting throughtout the entire interview. Her eye contact was poor. However, she did make eye contact a few times during the interview. She did have slowed thought processes apparent by prolonged time taken to answer

questions. Despite feeling down, the patient did display good hygiene and was well-groomed. Her affect was flat and did not smile once.

Physical exam: Since the patient does not have a history of a psychiatric condition, it is important to perform a thorough physical examination so that nothing is missed and result in an inaccurate diagnosis and improper treatment (Lyness, 2021). The physical exam was not noted in the video or on the case study report, so I will provide what components should be included in this assessment below.

- **HEENT:** The provider should assess the patient's head for signs of trauma to rule this out as a possible cause of the patient's symptoms (Carlat, 2017). The patient's ears, eyes, and nose should be evaluated for any abnormalities that could contribute to the patient's symptoms (Carlat, 2017). For example, assessing the patient's pupils can identify substance use that may be contributing to the patient's symptoms, such as pupil constriction can indicate opioid use (First, 2020). The patient may also demonstrate light sensitivity which could be a sign of meningitis (First, 2020). The provider should perform a fundoscopy to evaluate for signs such as papilledema that can be a manifestation of elevated ICP, which can cause behavioral changes (First, 2020). The provider should also assess the patient's throat, which can identify a possible infection that can contribute to feeling down, fatigued, unmotivated, etc. consistent with depression (Carlat, 2017).
- **Neck:** The patient's neck should be assessed for lymphadenopathy, which can indicate infection, and/or a stiff neck, which can indicate meningitis (First, 2020).

- **Skin/Hair/Nails:** The patient's skin should be assessed for rashes that may indicate systemic lupus or syphilis (Carlat, 2017; Centers for Disease Control and Prevention, 2017). The temperature, color, and texture of the patient's skin can also give clues to medical problems. For example, someone with hypothyroism may have pale skin that is cool to the touch and feel rough (Surks, 2020). The patient may also have brittle nails and alopecia, which should be assessed in this patient (Surks, 2020). Anemia, which can also cause depressive symptoms, may also cause similar symptoms (Surks, 2020). The patient should also be assessed for jaundice, which could indicate liver disease (First, 2020). Additionally, the provider should always assess the patient for self-injury wounds since patients may not always be upfront about this (First, 2020). Lastly, signs of trauma or violence should be assessed to determine the patient's safety risk and possible cause of her current symptoms (First, 2020).
- **Cardiovascular:** The provider needs to assess the patient's heart since this can identify possible causes for the patient's symptoms, such as heart failure (Carlat, 2017). The provider should assess for symptoms like extra heart beats, tachycardia, edema, cardiomegaly, and high jugular venous pressure (Colucci & Borlaug, 2021). Bradycardia can indicate hypothyroidism so this should be assessed (Surks, 2020).
- **Respiratory:** The patient should be assessed for pulmonary congestion (usually heard as rales), which could indicate heart failure (Colucci & Borlaug, 2021). Assessing the patient's lungs also helps identify a respiratory infection that may influence mental health changes. For example, those who have had COVID-19

are shown to be at a higher risk for mental health disorders, such as depression (Mikkelsen & Abramoff, 2021).

- **Gastrointestinal:** The patient should be assessed for a kidney infection by evaluating for flank tenderness (First, 2020). The patient should also be evaluated for signs like spider angiomas, ascites, hepatomegaly, and right upper quadrant pain that can indicate liver disease (First, 2020).
- **Genitourinary:** If the patient's ROS is positive for symptoms that warrant further evaluation, then a pelvic exam could be performed.
- **Neurological:** The patient should undergo a thorough neurological exam. This includes the using the GCS to determine if the patient's awareness level is impaired, indicating a brain injury (Shahrokhi & Asuncion, 2021). The PMHNP should assess the patient's mental status (performed below), which looks at if the patient has lesions in various cortex areas (Shahrokhi & Asuncion, 2021). Assessing the cranial nerves also help determine if the patient has lesions of the brain or brainstem (Shahrokhi & Asuncion, 2021). A motor exam should be performed to assess any musle or joint injuries or diseases and to determine the side of the injury/disease and if it is distal or proximal by evaluating muscle strength (Shahrokhi & Asuncion, 2021). A sensory exam should be performed to detect abnormalities of areas such as the sensory cortex, peripheral nerves, brainstem, spinal cord, and thalamus (Shahrokhi & Asuncion, 2021). For example, vitamin B12 and thiamin can manifest as stocking-glove paresthesias (First, 2020). The patient's gait and balance should be assessed because this can indicate specific neurological conditions (Shahrokhi & Asuncion, 2021). The

provider should evaluate the patient's DTRs to determine if upper or lower motor lesions are present (Shahrokhi & Asuncion, 2021). Lastly, the patient's speech should be assessed for difficulty producing words and slurred/garbled speech that can indicate a stroke (First, 2020). Any disorder that impacts the CNS is likely to cause mental health disorders, so this should always be assessed if a patient presents with mental health changes (Carlat, 2017).

- **Lymphatics:** I would assess the patient for swollen lymph nodes which can indicate an infection as the possible etiology of symptoms (Carlat, 2017).

Diagnostic results:

- **Vitals:**
  - Weight: 184 lbs
  - Height: 5'2"
  - Respirations: 18
  - Blood Pressure: 119/74
  - Pulse: 78
  - Temperature: 98.1 F
- **Labs:**
  - **Vitamin D**: Although most research is unclear as to whether low vitamin D levels contributes to depression or not, some studies do provide detailed and reasonable explanations as to its mechanism behind depression, making it a good lab to check in someone presenting with depressive symptoms (Berridge, 2017). According to Berridge (2017), elevated glutamate levels and

decreased GABA levels are the primary factors behind depression due to this alteration leading to more Ca2 intracellularly. Vitamin D is a major regulator of Ca2, so if an individual has low levels, Ca2 levels continue to elevate in neurons and further lead to increased depression (Berridge, 2017). This patient is likely deficient in vitamin D because she is not going outside due to not liking this time of the year and vitamin D is made from sunlight hitting the skin (Berridge, 2017). Thus, her vitamin D levels should be checked to determine if she needs supplementation or not.

- **Vitamin B12**: When someone is low in vitamin B12, they experience symptoms like difficulty concentrating, forgetfulness, and mood swings (Mohamed et al., 2020). This is because vitamin B12 is responsible for myelinating nerves and making blood cells, so if the body has low levels, the person starts to experience and macrocytic anemia and neuronal deterioration that can lead to psychiatric symptoms (Mohamed et al., 2020). Thus, this is why it is important to assess these levels in anyone presenting with psychiatric symptoms.
- **Folate**: Folate defiency goes hand-in-hand with vitamin B12 defieincy because vitamin B12 is the co-factor for 5-methyl THFA to be converted to its active form THFA (Khan & Jialal, 2021). Folate is essential for many processes in the body and without it, cell division is impeded, toxins build up within the body, and gene expression is altered (Khan & Jialal, 2021). This can lead to mental health changes, like depression (Khan & Jialal, 2021).

- **Iron**: Iron-deficiency anemia can manifest as depressive symptoms (Lee et al., 2020). This is because it has a significant role in the brain and contributes to many of its functions; thus, with less iron, the brain gets less oxygen, which causes psychiatric symptoms (Lee et al., 2020). Iron also is responsible for metabolizing neurotransmitters and making DNA so this alteration within the brain also leads to mental health disorders (Lee et al., 2020).
- **CBC w/diff:** This test is used to rule out anemia or an infection that can lead to depressive-like symptoms (Soreff, 2021).
- **A1c and/or fasting glucose:** These tests are important to perform to rule out diabetes that can cause hyperphagia, weight gain, fatigue, mood changes, problems concentrating, and other symptoms consistent with depression (Soreff, 2021).
- **CMP:** This test assess the patient's electrolytes, kidney function, and liver function, which can all lead to depressive symptoms if abnormal (Soreff, 2021).
- **Thyroid hormones:** The patient should be evaluated for hypothyroidism since this can manifest as depression (Surks, 2020).
- **Lipid panel:** The patient should be assessed for dislipidemia that can cause complications in the body, such as liver damage, that again can lead to psychiatric symptoms (Soreff, 2021).
- **Other possible tests only if warranted:**
  - **HIV testing:** HIV can cause similar symptoms to depression, so if the patient is at high risk, she should be screened for HIV (Soreff, 2021).

- **Syphilis:** Syphilis can cause neurological damage that leads to psychiatric symptoms if left untreated, so again if patient is high risk, she should be screened for this (Soreff, 2021).
- **Antinuclear antibody testing:** This can be performed to test for lupus, which can manifest as depression (Soreff, 2021).
- **Gonadotropin (hCG), prolactin, and FSH:** This can be useful when assessing women of younger ages with possible PMS/PMDD who have irregular periods (Yonkers & Casper, 2021). This helps to track the possible etiology of irregular periods (Yonkers & Casper, 2021). However, research has not found differences among levels of sex hormones and gonadotropins in women without PMDD/PMS and those with PMDD/PMS (Yonkers & Casper, 2021).

Assessment:

Mental Status Examination: This is a 19-year-old Caucasion female who looks slightly older than her stated age. She is alert and oriented x3. She appears well-groomed and to have good personal hygiene based on her washed and combed hair. She is dressed appropriately in a sweater and jeans for this chilly time of year. The patient appears restless as she constantly fidgets throughtout the entire interview. Her affect is flat and appears sad the entire interview. She did not smile once. This is appropriate to her mood which she describes as "feeling down". She has poor eye contact, but does make eye contact occasionally during the interview. The patient was cooperative throughout the entire evaluation, answered each question appropriately, and overall seemed to be a

reliable historian. Her speech was clear and coherent. Volume of speech fluctuated throughout the interview, mostly normal, but at times low. She never raised her voice too loud. She stayed on track throughout the entire interview and did not get distracted at any point. Her thoughts had logical connections and she was able to give specific examples. There were no readily apparent disturbances in thought content. She denied hallucinations, delusion, suicidal thoughts, suicidal behaviors, and homicidal ideations (These were not asked in the video or reported in the additional data, but I would most certainly ask these questions since they are critical to the safety of the patient and others). The only abnormality noted was that she did have slowed thought processes represented by prolonged time taken to answer questions. There were no flight of ideas, perserverations, looseness of associations, circumstantiality, or mutism noted during the exam. Short-term and long-term memory were intact. Intelligence appears above average. She has good insight into her disorder. Her judgment is intact as she is seeking treatment today.

Differential Diagnoses:

1. **Major Depressive Disorder with Seasonal Pattern, fall-winter onset**: This is my primary diagnosis because this disorder only occurs at a specific time of the year (American Psychiatric Association, 2021). It can occur in the summer, but the majority of cases tend to occur in the winter (American Psychiatric Association, 2021). Remission typically comes at a specific time, usually spring and sometimes summer (Avery, 2020). It typically occurs more in women than in men and in those ages 18 through 30 (American Psychiatric Association, 2021). It is thought that less natural light due to the

shorter winter days causes this depressive disorder (Avery, 2020). The typical symptoms for the fall-winter onset subtype is hyperphagia (specifically carbs), fatigue, hypersomnia, and weight gain (American Psychiatric Association, 2021; Avery, 2020). The symptom criteria is the same for MDD without seasonal patterns as it is to those with seasonal patterns (Avery, 2020). The only difference is that those with seasonal patterns have it only at the same time of the year (usually winter) and have remission at the same time every year (usually spring or summer) (Avery, 2020). This patient feels depressed, lacks interest in activities she once loved, has hypersomnia, has gained weight, has psychomotor agitation, lacks energy, and has difficulty concentrating. This condition has caused the patient debilitating symptoms that have severely impacted her daily life as shown by her leaving her school program. The patient's symptoms match the DSM-5 criteria exactly for MDD with seasonal pattern, which is why I have made it her primary diagnosis.

2. **Nonseasonal Major Depression with atypical features**: This disorder also has includes the patient's symptoms of hypersomnia, weight gain, and hyperphagia, so it is essential that the PMHNP includes this as a differential diagnosis (Avery, 2020). It differs from MDD with seasonal patterns though (Avery, 2020). A study comparing the two found that those with seasonal patterns had increased sleeping and eating patterns than nonseasonal depression (Avery, 2020). In addition, those with nonseasonal major depression with atypical features react to various stimuli and are more sensitive to rejection (Lyness, 2021). This is not seen as often in those with seasonal patterns as they tend to only feel down and sad (Avery, 2020). In addition, atypical depression does not just occur in set seasons and remit in another set season (Avery, 2020). Thus, since this

patient's mood did not change to different stimuli during the interview and her symptoms only occur during the winter and resolve in warmer months, I still consider MDD with seasonal pattern my primary diagnosis.

3. **Premenstrual Dysphoric Disorder (PMDD)**: I have included this as a differential diagnosis because to meet the DSM-5 criteria, a woman must have at least one symptom out of a list of mood changes such as, anger, irritability, sadness, depressed mood, hopelessness, anxiety, and tension (Yonkers & Casper, 2021). Then, the woman must also have at least one symptom of things like hyperphagia, decreased pleasure/interest in typical activities, lack of energy, weight gain, hypersomnia, insomnia, or being overwhelmed (Yonkers & Casper, 2021). The symptoms much reach a total of five in order to be diagnosed with PMDD (Yonkers & Casper, 2021). The symptoms have to occur the week before having period and go away a couple days after a woman starts her period (Yonkers & Casper, 2021). These symptoms have to occur for at least one year before a diagnosis can be made (Yonkers & Casper, 2021). Thus, the patient does have the majority of these symptoms, which is why this is included as a differential diagnosis. However, the patient's symptoms have not been occurring for at least one year and she does not mention that her symptoms only occur the week before she gets her period or that they resolve after she gets her period. Her symptoms have been present the whole winter and are continuing to worsen; thus, they are constant and seasonal, not one week out of each month. Therefore, MDD with seasonal patterns remains the primary diagnosis.

Reflections

Redo Session

There are a few things that I would do differently if I were to redo this session. Most of what I would do differently has been stated above. Something I would like to ask the patient is when she first started experiencing seasonal depression. The video and case study report do not say if it was before or after she moved from South Carolina to Boston, so it would be interesting to see if this had any influence on the patient's mental health. In addition, I would like to ask the patient further about her childhood and life experiences to determine if she has experienced any trauma or violence since this can significantly increase the risk for mental health disorders (McLaughlin et al., 2020). I would also like to assess her cultural factors, such as socioeconomic status, sexual orientation, gender identity, and spirituality/religion since these also can contribute to the psychopathology of developing mental health disorders (Moleiro, 2018).

Patient Factors

Due to the patient being in college, it was essential that the PMHNP consider substance abuse as a possible causes for the patient's symptoms (Welsh et al., 2019). College campuses are shown to have high rates of students who frequently participate in substance use (Welsh et al., 2019). More than 60% of those who are full-time students have tried alcohol and around 39% drink large amounts of alcohol regularly (Welsh et al., 2019).

The patient's age and gender also place her at high-risk for STDs, especially if she has experienced depression in the past (Huang et al., 2018). According to Huang et al. (2018), young women who experience depression are more vulnerable than most and tend to engage in sexual encounters without protection. Since the patient has experienced seasonal depression in the past,

it is important to rule out possible HIV or syphilis as causes for her symptoms even if her current symptoms are consistent with her typical seasonal depression since these both can mimick depression (Carlat, 2017; Crozatti et al., 2015).

Health Promotion and Disease Prevention

The patient should be encouraged to take vitamin supplements, including vitamin D, vitamin B12, folate, and iron if her labs show she is deficient in these since these can place her at risk for depression (Berridge, 2017; Khan & Jialal, 2021; Lee et al., 2020; Mohamed et al., 2020). She should be encouraged to work on her diet, increase water intake, and increase the amount of exercise she does to prevent complications like diabetes, dislipidemia, liver disease, and kidney disease that can all lead to depression (Soreff, 2021). She should be encouraged to get her thyroid levels checked annually to ensure she is treated promptly if an abnormality is noted since this can lead to depression (Surks, 2020). She should also be encouraged to practice safe sex practices and educated on the risks and complications of substance abuse that all can lead to mental health disorders (Carlat, 2017; Crozatti et al., 2015; Welsh et al., 2019).

Ethical Considerations

As mentioned above, the young depressed female may be more vulnerable than others, so the mental health professional must keep this in mind when treating them (Bipeta, 2019). The PMHNP should not prescribe the patient something that does not match their beliefs, needs, or wants, and should allow the patient autonomy to help come up with the best treatment plan that suits them (Bipeta, 2019). However, with this approach occasionally comes ethical conflicts because what the patient wants may not be what the provider believes is the best option (Aydin Er & Ersoy, 2017). If the patient does not receive proper treatment, then complications such as suicide can occur (Aydin Er & Ersoy, 2017).

Another ethical dilemma is if a patient does not "accept their diagnosis" and believes they have a different diagnosis, but the PMHNP is certain they have the diagnosis that the patient does not accept (Schneider, 2016). The patient is not likely to comply with treatment if they do not believe they have the condition that the provider says they do (Schneider, 2016). Therefore, this can be a difficult situation to deal with. The provider must educate the patient on what the disorder is, reduce its stigma, explain the benefits of treatment with the correct diagnosis, etc. (Schneider, 2016).

Treatment in women of childbearing ages can also cause ethical dilemmas because many psychotropic medications have little research in pregnant women, so their effects on the fetus are not well known (Schneider, 2016). Therefore, it can be challenging for providers to treat this population of individuals because they do not want to cause harm to the fetus if the patient was to get pregnant (Schneider, 2016). This means the provider and patient must look at all of the risks and benefits and determine the best option for the patient (Schneider, 2016). Education is again key so that the patient completely understands the risks associated with getting pregnany while on the medication (Schneider, 2016). This also is another reason as to why providers should go over disease prevention and health promotion techniques, like safe sex practices, which help with this concern (Huang et al., 2018).

Conclusion

Overall, I learned a lot from this case study due to not being as familiar with the DSM-5 criteria for Major Deprsesive disorder with Seasonal Patterns; thus, this helped further my understanding of this condition. This case study also helped me with my skills in developing differential diagnoses and using my critical thinking abilities to rule out disorders. This has given

me further insight into what it takes to become a successful PMHNP, which I will continue to work on to provide my future patients the best outcomes.

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