Week (# 7): (FOCUSED SOAP NOTE AND COMPLEX CASE STUDY PRESENTATION)

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PRAC 6675: PMHNP Care Across the Lifespan II

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Subjective:

CC (chief complaint): Patient reported crying daily, feeling sad all the time, having difficulty sleeping at night, and loss of energy and motivation.

HPI: **HPI**: A.G is a 37 year old black female who presents for psychotherapeutic evaluation with symptoms of depression. She is currently prescribed Lexapro and Ativan which she finds ineffective. Her PCP referred her to a mental health provider for evaluation and treatment. She reported having daily crying spells, feelings of sadness all the time, problems sleeping at night, and loss of energy and motivation. She reported not sleeping well because it takes her many hours frequently to fall asleep. She also reported that the nights that she manages to fall asleeps, she only sleeps a few hours. She stated that while awake, all she does is think and worry about her family. She admitted that some of her worries include that she's a bad mother and she thinks she is a problem to her husband. She also reported that some of her thoughts are about her original family and the poor relationship with her mother and some of her friends. She stated that she her depression got worse after the the death of her best friend 2 years ago in a car accident. During the first interview, A.G said she was alright and the response was automatic and immediate. After a little while of silence she reported she always has a low spirit because of thoughts and worries, and she feels like everyone is talking and looking at her. She denied suicidal thoughts and ideations. She reported that it would be good if she can run away from her problems, but unfortunately she can't do it. A.G admitted that her depression is affecting her life in too many ways. First is her relationship with her husband and children. Secondly, it is affecting her socially because she is not able to participate in family events. She also reported that she's not able to work outside of her home which is affecting her financially. She expressed not being happy and that she is not the person she wants to be. She reported her depression is destroying her life. A.G reported that she requested help for her depression 5 years ago following the issues she had with her mother and some of her friends. The depression got worse after the sudden death of her best friend from high school who was involved in a car accident. She stated that the depression continued to worsen because they were too close and she was the only friend she could talk to. She reported that when her friend just had the accident, she can remember

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being tired, sad, crying several times during the day and had no energy. She stated that she feels very tired but unable to sleep. She reported she feels like she has lost control of her life and the feelings continued months after her friends burial. Her psychiatrist had prescribed Lexapro 10mg po daily and Ativan 0.5mg as needed for anxiety which she has been taking for the past 5 years. She reported that she stopped taking the Lexapro because she doesn't think it is helping her. She reported the medication was ineffective and she hasn't seen any change in her depression since she started taking the medication. She stated that she doesn't like taking medications.

Past Psychiatric History:

- General Statement: A.G is alert and oriented to person, place, time and situation. She was diagnosed with depression when she was 34 years old due to poor relationship with her mother and some of her friends. The depression got worse after the sudden death of her best friend 2 years ago who got involved in a car accident.
- Caregivers (if applicable): Husband, Timothy, 43, her 9 year old daughter, Rebecca, (from a previous relationship), son Joshua, 5 years old and son, Chris 3 years old.
- Hospitalizations: Hospitalized 9 months ago for chest tightness and pounding due to anxiety.
- Medication trials: Lexapro 10mg po every day for depression and anxiety
- Ativan 0.5mg 1 tab by mouth as needed for anxiety and Ibuprofen 800mg 1 tablet 3 times a day by mouth as needed for back pain
- Psychotherapy or Previous Psychiatric Diagnosis: History of depression. Weekly group psychotherapy and family psychotherapy

Substance Current Use: Used to smoke 3-4 cigarettes a day when she was in high school. Used to drink occasional 1 to 2 glasses of wine. No history of drug use. Current use of caffeine about 3 times a week in the morning.No current use of nicotine, illicit substance including marijuana and alcohol.No history of withdrawal problems.

Medical History: She has depression and anxiety issues and a history of occasional back pain and was previously hospitalized 9 months ago for chest tightness and pounding due to anxiety. No past surgeries reported, no history of seizures and head injuries reported.

- **Current Medications**: Lexapro 10mg by mouth daily for depression and anxiety. Ativan 0.5mg 1 tab by mouth twice a day as needed for anxiety.
- Ibuprofen 800mg 1 tablet three times a day by mouth as needed for back pain.
- **Allergies**: NKDA
- **Reproductive Hx**: Date of last menstrual period 6/28/2023, not pregnant, nursing/lactating.No contraceptive use, is heterosexual and uses vagina for sexual intercourse. Has a husband and children she currently lives with.

ROS:

GENERAL: A.G 37 years old black female, alert and oriented to person, place, time, and situation. No recent weight loss reported, has normal weight, poor sleep pattern, with a variable appetite. No fever or chills reported,weakness reported with low energy and lack of motivation and poor concentration. She appeared clean, well groomed, appropriately dressed, and in no acute distress. She was calm, pleasant and cooperative. She reported occasional back pain which is relieved with medication.

HEENT: No visual changes and double vision noted, no yellow sclerae or jaundice.

Ears, Nose, Throat: No difficulty hearing, no nasal drainage, no changes in hearing, no nasal congestion, rhinorrhea, or sore throat. No sneezing and runny nose.

SKIN: No changes in skin color. No rash or itching. No skin lesions, no bruises.

CARDIOVASCULAR: Reported previous chest tightness, palpitation and chest pressure. Reported previous heart pounding and racing. No edema

RESPIRATORY: No shortness of breath, no sweating, no sneezing, cough, or sputum.

GASTROINTESTINAL: No nausea, vomiting and diarrhea. No anorexia, no abdominal pain or bleeding. Appetite variable. Normal bowel movements

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GENITOURINARY: No dysuria, burning on urination and hematuria. No hesitancy, frequency, and urgency. No odor and no color in urine.

NEUROLOGICAL: No syncope, headache, tingling and numbness in extremities. No dizziness, seizures, paralysis, ataxia. No changes in bowel control.

MUSCULOSKELETAL: Occasional back pain. No swelling or stiffness noted. No muscle and joint pain noted. ROM intact to bilateral upper and lower extremities

HEMATOLOGIC: No bleeding and bruising noted. No anemia noted.

LYMPHATICS: No enlarged lymph nodes. No history of splenectomy

ENDOCRINOLOGIC: No reports of sweating, heat, and cold intolerance. No polyuria or polydipsia.

Objective:

Physical exam: if applicable

Name: A.G

Gender: Female Age : 37 years-old black female

A.G was alert and oriented to person, place, time, and situation. She was able to express herself and feelings. She appeared clean, well groomed and appropriately dressed. She was cooperative, pleasant, focused and calm. She had good eye contact, no signs and symptoms of anxiety noted. She looked depressed with no discomfort noted. No vital signs, weight and labs done during the assessment due to her depressed mood.She participated well in the assessment.

Head: Normal, no evidence of trauma

Eyes: Bilateral white sclera and pink conjunctiva

Ears: No discharge noted, looked normal with grey pearl TM bilaterally.

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Nose: Bilateral pink mucus membranes, no congestion noted, turbinate intact

Throat/mouth: No swollen lymph nodes. Pink and moist oral mucosa with good dentition

Neck: No JVD and swelling noted.

Lungs: Symmetrical chest in expansion with resonant areas.

Cardiovascular: S1, S2 clear with no murmurs. 3+ peripheral pulses with no edema.

Abdomen: Soft, large and non distended. Bowel sounds normal at 4 quadrants. No masses noted.

Musculoskeletal: Full ROM to upper and lower extremities. Occasional back pain reported.

Neurological: No syncope and dizziness noted.

Lymph/Skin: No edema, no discoloration, no rash.

Diagnostic results: A.G has been having symptoms of depression and appeared worried and thinking constantly.Vital signs should have been done because they help assess a patient's general and physical health, gives clues about possible diseases and give progress towards recovery. Vital signs should have been done because when you experience depression, your have an increased heart rate and blood pressure which can later make you develop heart disease due to increased level of cortisol, a stress hormone. As a clinician, I believe the patient should be evaluated more for signs and symptoms of depression knowing that she complained of crying daily, feeling sad all the time, difficulty sleeping at night, and loss of energy and motivation. Depression can lead to weight gain/weight loss due to poor food choices and sedentary lifestyle. Diagnostic and lab tests for depressed patients should be to check their general health and well-being and come up with medical issues that may lead to depression. Common tests that can be done are thyroid test due to their mood, fasting blood sugar due to release of hormones that cause stress, and folate and vitamin B12 due to low energy.

Assessment:

Mental Status Examination: A.G is a 37-years old black female who was seen by the therapist for symptoms of depression which include daily crying spells, feelings of sadness all the time, difficulty sleeping at night, and loss of energy and motivation. She was alert and oriented to person, place,time and situation. She appeared clean, well groomed and appropriately dressed. She was calm, pleasant, cooperative and focused during the interview. She had a good eye contact, and her speech was clear and normal. She was able to express herself and lay her concerns. No involuntary movement were noted during the interview. She looked depressed with no signs and symptoms of anxiety noted. She was in a good mood and her affect was congruent to her mood. Her thought process and content was goal directed. She denied delusions and hallucinations, denied suicidal, homicidal, or self-harm ideation. She reported being paranoid when she mentioned she feels like everyone is looking at her. No reactions noted to external or internal stimuli. She was attentive, well concentrated and able to remember past events. Her short-term and long-term memory were grossly intact. Her insight and judgement was fair, and her knowledge and intelligence was good.

Diagnostic Impression: The three differential diagnosis for this patient are: Bipolar Disorder, Generalized anxiety disorder and Separation Anxiety disorder.

Bipolar Disorder

Bipolar disorder is a mental condition that leads to mood changes, poor energy and activity levels, lack of concentration, and inability to participate in activities of daily living (American Psychiatric Association, 2022). These mood changes can be manic which ranges from high, elated, irritable, and energized behavior to depressive mood which is feelings of sadness and hopelessness (American Psychiatric Association, 2022). Hypomanic episodes are usually not severe. Individuals with bipolar disorder go through periods of serious emotional changes, poor sleep routine, low level of activity, and poor behavior pattern very often without knowing that the effect is harmful. These unusual periods are called mood swings (American Psychiatric Association, 2022). Mood swings are very different from the typical behaviors of the person. When a person has an episode of mood swing, the symptoms usually last most of the day. According to American Psychiatric Association, episodes may also last for longer periods, from several days or weeks. According to the above symptoms, bipolar disorder is a possible diagnosis

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for the patient. Looking at the case presented, I have learned about the different mood disorders and their various symptoms. To come up with an accurate diagnosis, it is important to look at the factors that cause the stressors and triggers of the mood disorder. Bipolar disorder does not result from how you were raised by your mother. It occurs as a result of chemical imbalances in the brain and often runs in families. The mood changes associated with bipolar may result from stress, as the vulnerable part of the person's makeup is challenged (American Psychiatric Association, 2022). Following the DSM-5 criteria, to be diagnosed with bipolar 1 disorder, an individual must meet the above symptoms for a manic episode which can be followed by hypomanic or depressive episodes (American Psychiatric Association, 2022). According to American Psychiatric Association, "manic episode includes period of abnormal and continuous elevated, irritable mood, increased activity or energy, which can last at least 1 week and present most of the day, almost every day". During manic episode, the individual may have high self-esteem, lack of sleep, talk more often, have racing thoughts, easily distracted, like increase in social activities at work or at school, flight of ideas, sexual or psychomotor agitation, increased involving yourself in activities that have high painful impacts like buying without controlled, poor sex judgements, and poor business investments (American Psychiatric Association, 2022). The mood changes get so serious that the patient may have problems functioning socially and occupationally leading to hospitalization in order to prevent harm to thenself and others (American Psychiatric Association, 2022). Manic episode is not as a result of physiological effects of a substance like drug, medication, other treatment and a medical condition (Sadock et al., 2015). I chose this disorder as my priority diagnosis because of the patient's signs and symptoms. There is clear evidence that she is depressed because she is not able to work as she used to and feels down all the time. She is stressed, has ups and downs, has difficulty sleeping, low energy, lacks motivation and has hopeless periods known as depressive episodes.

Generalized Anxiety Disorder:

Generalized anxiety disorder is fear, worry, and a constant feeling of being overwhelmed. GAD is another common mental health disorders. About 20% of adults suffer from anxiety disorder every year. When a patient suffers from persistent, excessive, and unrealistic worry about everyday things it is known as generalized anxiety disorder (Locke et al., 2015). People with anxiety worry because of financial issues, problems in the family, health, and their future

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(Brahmbhatt et al., 2022). These issues can be unbearable and hard to control, and is often accompanied by psychological and physical symptoms. The main symptom of generalized anxiety disorder is persistent worry. People with GAD, feel distressed and have functional impairment. They experience physical symptoms such as sleep problems, restlessness, muscle tension,gastrointestinal symptoms, easy fatigue, irritability, poor concentration and bad headaches (Strohle et al., 2018).

The DSM list for GAD includes persistent anxiety and worry, most of the day and about a lot of things for atleast six months, difficulty controlling worry, presence of three symptoms like restlessness, fatigue, irritability, issues with sleep and poor concentration (American Psychiaric Association, 2022). Patients with GAD have issues with social life, and how to function physically (American Psychiaric Association, 2022). Although A.G has some of the symptoms mentioned above, she is alos worried about financial and family problems as mentioned earlier. She is also very worried about the sudden and unexpected death of her best friend. This persistent worry tends to affect her love relationship. She has times when she wants to stay alone and periods of sadness, she has crying spells and lacks motivation. This is an appropriate diagnosis for A.G because she sometimes has difficulty with her daily activities and when she thinks of her best friend it makes her anxious and more depressed. She lacks motivation and and her depression is affecting her love relationship. She becomes distressed and worries and thinks a lot which makes her more depressed. Besides the excessive worry, A.G reported lack of motivation, crying spells, low energy, and difficulty sleeping.

Separation Anxiety Disorder:

Separation anxiety disorder is intense fear of being separated from a loved one. It is a serious condition that can affect your quality of life, have a stressful effect on your and social interactions as seen with A.G. It is manifested by excessive worry, sleep problems, depression, other anxiety disorders and even thinking of the real or anticipated separation from a loved one (Manicavasagar & Silove, 2020). Risk factorsof SAD include loss of a loved one and diagnosis of a mental health disorder as an adult. Eventhough separation anxiety occurs developmentally, it manifests with inappropriate intensity. According to the DSM-5 criteria, the diagnosis of SAD has been extended to include adults. In adults, it has serious complications and can lead to poor

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functioning and quality of life, poor social interactions, and lack of intimate relationships (Manicavasagar & Silove, 2020). SAD can cause poor mental and physical health, social problems, and also poor academic performance. Despite the fact that SAD is common, it has often been underdiagnosed and undertreated. Following the DSM-5 criteria, separation anxiety is when an individual has many conditions like excessive distress before and during separation, too much worry about losing an attachment figure and things that can cause separation from the figure,and repeated nightmare about separation from the figure (American Psychiaric Association, 2022). According to American Psychiatric Association, to be diagnosed with SAD, the provider will perform a comprehensive examination following the DSM-5 criteria and the symptoms must be present for atleast 6 months in adults, must cause major impairment in normal functioning and cannot be explained by a different diagnosis (American Psychiaric Association, 2022).

Adults with SAD get anxious when they anticipate separation from their children, spouses,best friends and love partners. It's a normal to be concerned about your loved ones well-being. Individuals with separation anxiety get very anxious and even experience panic attacks, when loved ones cannot be reached (American Psychiaric Association, 2022). People with SAD are sometimes withdrawn socially, and sometimes become very sad and have poor concentration when away from their loved ones. Some symptoms of SAD are unknown fears that loved ones or yourself will be taken away or injured, refusal to leave the areas of loved ones, staying close to a loved one due to fear that something might happen to them, and depression or anxiety attacks related to any of the above topics (Manicavasagar & Silove, 2020). I chose this disorder as a differential diagnosis because A.G's depression got worsened after the sudden death of her best friend. Separation anxiety usually occurs after the loss of a loved one. People who have a diagnosis of separation anxiety disorder are often diagnosed with GAD like A.G. The diagnosis of separation anxiety came about when A.G lost her best friend suddenly in a car accident.She became depressed and has been struggling to deal with it. The death of her best friend was a sudden and unexpected situation. A.G's depression started with the poor relationship she had with her mother and some of her friends which worsened after her best friend died. SAD can be treated with group and family therapy.

Reflections:

Depression is a common psychiatric disorder that mostly leads to poor daily functioning and quality of life. Most people go through feelings and physical symptoms of stress when they deal with people or situations that are difficult. Individuals with diagnosis of depression go through disability due to their response to daily functioning. If not treated, these symptoms may prevent the patients from involving themselves in social and family relationships, catching up with job and school requirements, and participating in other activities of daily living. Depression is associated with the elevation or lowering of a person's mood or loss of interest in activities causing a significant impairment in daily life (Karrouri et al., 2021). There is no single cause of depression. For some people an upsetting or stressful life such as bereavement, divorce,illness, financial worries can be the cause. For this client, her main cause is the sudden loss of her best friend. Some people can experience the stress from school, other activities, and their job. I think that the biggest challenge most people face with depression, and their biggest accomplishment has been getting help for it. It has been known that the best treatment for depression is a combination of antidepressant medication and psychotherapy (Karrouri et al., 2021). I have learned a lot about depression from writing this assignment. This case presentation educated me on some new information that I can teach my community about mental health. There is an increased rate of mental health issues world wide. To minimize harmful effects, healthcare professionals have to make serious efforts to reduce mental health issues. Individuals with mental health problems have a high rate of suicidal thoughts and attempts.As the condition worsens, the risk increases. The case presentation allows us to address the patients concerns and their history so we can formulate a proper diagnosis and develop the best plan of care. Assessment is very vital because it gives the provider opportunity to gather relevant information about the patient. Knowing the social and cultural effects of a patient is very important as a healthcare provider because it can affect their condition and treatment outcome. Drug, alcohol use and suicide can be increased in people who are depressed.It can also cause problems in a relationship as seen in the case with A.G. She has the thought that her depression is causing problems with husband and children. She is not able to go work which is causing financial problems. Depression can affect the body, mood and thoughts making it difficult to control serious diseases. Looking at the client, she is feeling hopeless and depressed because of the poor relationship she had with her mother and some friends as well as sudden loss of her best friend. Due to her depression, she has lost the ability to feel pleasure in doing things that she has

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enjoyed in the past. She reported feeling sad all the time and having crying spells. She also reported lack of energy and motivation, she has poor psychosocial functions, difficulty sleeping and even if she sleeps it only last for few hours. She stays up worrying and thinking about not being a good mother. She feels hopeless and worthless, has feelings of negativity, and poor concentration (American Psychiatric Association, 2022). Following the DSM-5 criteria, people who have depression are most likely to have lack of concentration, energy and get upset easily. Depression affects an individuals thinking and response to things (American Psychiatric Association, 2022).

As a clinician, what I would do differently is talk to family members more often about the patients daily functioning to know if it is affecting her life more seriously and also find out the best treatment regimen so as to come up with a good treatment plan. Also I would ask the patient how depression affects their day-to-day life, find out what their triggers are and what helps the situation or makes it worse. Knowing their experience, could help empathize with their feelings. I would also educate A.G on what to do when she feels depressed like to exercise, eat healthy food and drink plenty of water, talk and express themselves to someone, not to think about problems, be positive and thinks about good things. I will also educate and encourage her to belong and participate in support groups and group therapy because she will learn techniques that will help reduce her feelings of depression. Depression is a broad topic that involves all of us causing people to reflect.

Conclusion:

Since depression causes poor quality of life and daily functioning, the goal of treatment during the first phase is to help the patient get to the state of remission and later return to their baseline level of functioning (Karrouri et al., 2021). According to the World Health Organization, depression is known to be the second-leading cause of disability in the world and is estimated to be the first by 2030 (Karrouri et al., 2021). Depression can lead to suicidal thoughts and mortality. Psychotherapeutic interventions are used world wide to treat people who have depression, psychosocial problems, interpersonal issues, and intra-psychic conflicts (Karrouri et al., 2021). The psychotherapeutic approach that is chosen for any case depends on the symptoms exhibited by the patient. For individuals with depression, psychotherapy helps the

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patients mood to be controlled and monitored, their functioning improved, their symptoms well known, and their behavior be mastered so they can be able to cope with stressful events (Karrouri et al., 2021). The treatment of depression is challenging. Thus, finding the best treatment option for every patient is the best way to achieve short and long-term effect. The 3 best treatments for depression are antidepressants, psychotherapies, and somatic approaches. It is obvious that the client is suffering from depression because she has most of the physical symptoms which occurs most of the time as she mentioned.When you think of depression, you think of low energy, lack of pleasure in doing things, poor concentration, poor sleep pattern and crying spells.Medications, psychotherapy and changes to lifestyle can help ease depression.

Case Formulation and Treatment Plan:

The three differential diagnosis I chose need a professional like a PMHNP to develop a treatment plan. Mental health conditions affect people in different ways. A treatment plan that can be effective for one person, may not be effective to the other. The treatment of mental health disorders has to be manage by someone who is a licensed and experienced mental health provider inorder to have a better outcome. Mental health treatment includes psychotherapy, medication or a combination of both. The main cause and symptoms of a mental health problem should be treated. For example a person who is depressed from a sudden incident can receive psychotherapy and be treated with SSRI medications like Lexapro which can treat anxiety and depression. Lexapro helps restore serotonin in the brain, increases energy level, increases your feelings of well-being and helps decrease nervousness. A patient taking this medication should be educated on the life threatening side effects like heart conditions, birth defects, serotonin syndrome and increased risk for suicide. The patient should be educated not to stop taking the medication abruptly because of withdrawal symptoms that can have serious effects. The patient should also be educated not to mix OTC medications with their medications without asking the their provider. Education should be provided to the patient not to consume alcohol and other illicit drugs due to their condition. According to the case study, the client has been depressed from poor relationship with her mother and some of her friends as well as the sudden death of her best friend. Her symptoms exhibit poor social functioning and poor coping skills, thus it will be advisable for her to continue group psychotherapy. Medical assistance should be provided to the patient , education on medication management shoud be provided. The patient shoukd be

educated to keep up with all her medical and psychiatric appointments. Transportation should be provided to and from her appointments. The patient should be assisted with problems that are related to her daily functioning.

The patient will continue the group psychotherapy weekly that runs 4-5 hours a day. The patient will also have family therapy at least once a week.She will have scheduled appointments with the psychiatrist for medication management and continued psychiatric care since she mentioned discontinuing her medication and doesn't like taking medication.Transportation will be provided to and from the group psychotherapy program as well as psychiatric appointment. Medication management will be provided. The patient should be educated that the emergency crisis support hotline can be called at 855 521 1317, emergency services can be called and instruction is provided to the patient to go to the nearest emergency room or dial 911 if they become suicidal or homicidal.

Treatment Plan

She will continue to attend group psychotheray and family psychotherapy weekly. She will follow-up with her provider in one week for occasional back pain and any other medical conditions. Patient will be educated on the importance of taking medication including side effects and she will be encourage to practice stress management techniques.

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PRECEPTOR VERFICIATION:

I confirm the patient used for this assignment is a patient that was seen and managed by the student at their Meditrek approved clinical site during this quarter course of learning.

Preceptor signature: [illegible]

Date: 7/10/2023

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