Dover Behavioral Health
Clinical Assignment
2025

Student Name: Kevin Juarez Date: 9/9/25

Patient's Initials: J.F Age: 51 Sex: M

Psychiatric Diagnosis(es): Severe Substance Use Disorder (opioids), Suicidal Ideation

Pathophysiology of the main Psychiatric Diagnosis:

Neuroanatomical Factors:	Dsfunction in the VTA, NAc, and prefrontal cortex. VTA initiates dopamine release, NAc reinforces drugseeking behavior & decesion making becomes impaired through prefonlal cortex. Amygdala & hippocampus contribute to emotional reactivity and memory linked cravings. The insula drives compulsive use.
Neurotransmitters:	Dopamine increases during intoxication which leads to the intense feeling of euphoria. Dopamine & serotonin decrease during withdrawal. leading to depression & anhedonia. Agitation, anxiety, & brain damage is caused by increased Glutamate levels. GABA decreases, leading to reduced feeling of calmness.
Course/ characteristics of illness:	Chronic relapsing condition with cycles of intoxication, withdrawal, and craving. High risk of overdose, impaired functioning, & co-occuring mood disorders. Suicidal ideation often emerges during withdrawal or relapse due to neurochemical imbalance & psychosocial stressors.

Medications

Medication Name What is this for?	Classification & Action	Side Effects	Nursing Implications
Fluoxetine (Prozac) Antidepressant	SSRI: blocks serotonin reuptake to increase serotonine levels in brain. Relieves depression, reduces OCD, bulimic behavior	insomnia, anxiety, nausea, sexual dysfunction, weight changes	Monitor suicidal thoughts especially early in treatment, educate it may take 4-6wks, avoid abrupt discontinuation. Assess for serotonin syndrome.
Sertraline (Zoloft) Antidepressant, anxiolitic OCD adjunct.	Blocks reuptake of serotonin at CNS neuronal presynaptic membranes. ↑availability in brain. Relieves depression. ↓ OCD behavior & anxiety.	GI upset, drowsiness, dry mouth, sexual dysfunction, serotonin syndrome	Monitor mood and anxiety levels, assess for serotonin syndrome, educate on adherence and delayed onset of action.

Fluoxetine: OCD, Depression, bulimia, panic disorder

Sertraline: Depression, PTSD, panic disorder, social disorder.

Mental Status Exam:

	Subjective Data	Objective Data
Appearance	"Im just chillin today".	51 yo thin male. Clean white layered outfit (2 joggers, shirt, undershirt), socks & sandals. Hygiene intact (did his laundry). Tattoo sleeves seen on both arms.
Behavior	"Im pissed off - today is going to be a bad day".	Pacing in and out of room and during AT meditation. Fidgeting with stress ball.
Speech	" that came out a little slow".	Speech clear, fluent, mildly slowed at times. Able to read four paragraphs aloud. Joked about speech pace.
Mood	"Today is going to be a bad day". "Tired and anxious".	Mood irritable early in morning after breakfast. Affect reactive and congruent. Improved throughout day with peer interaction and music.
Disorders of the Form of Thought	N/A	Thought process logical and goal directed, No derailment or tangentiality noted. Attribute mood to cafeteria staff chang
Perceptual Disturbances	Did not report hallucinations/paranoia/ delusional beliefs.	Intermittently responded to internal stimuli (looking away/distracted) when not engaged with external tasks. Actively involved in structered activites or social interaction.
Cognition	Stated, "Its because its a different lady, the lunch lady loves me!".	AOx4. No short term memory impairment noted. Able to follow group activities and recall events.
Ideas of harming self or others	"No, I don't think about that".	Denied suicidal or homicidal ideation. No plan or intent. Cooperative with safety screening.

Problem #1:
Risk for suicidal self-injurious behavior.

Priority Patient Goal:

1. Will continue to deny SI and demonstrate use of atleast one coping strategy by end of my shift.

Assessments:

- Reassess suicidal thoughts, plan, intent. Monitor mood changes, especially after peer/faculty/environmentall stress. Observe engagement in therapeutic activities and peer interaction.

Top 2 Interventions with rationale:

1. Maintain safety precautions and therapeutic millieu to ensure continued safety and early detection of mood shifts continuously.
2. Encourage participation in structered group activites and peer support to reinforce protective factors and reduce isolation.

Problem #2:
Impaired mood regulation

Priority Patient Goal:

1. Will demonstrate behavorial stability by participating in atleast one structured activity without signs of agitation (pacing, verbal outbursts).

Assessments:

- Monitor for signs of escalating agitation or emotional dysregulation
- Evaluate effectiveness of coping tools and peer interactions.

Top 2 Interventions with rationale:

1. Encourage participation in structered, calming activities (music, mindfullness) to promote emotional regulation during every moment of agitation.
2. Reinforce use of physical tools (stress ball, coloring, reading) to support behavorial stability.

Patient Teaching

List 2 teaching topics that you taught a client.

1. Cognitive engagement through leisure activity. Taught how to play Sudoku to support focus, problem solving, and provide a healthly distraction from stress.
2. Social Reintegration. Helped a patient move from isolation to group interaction through shared activity, promoting connection and trust.

Growth & Development

1. Discuss norms of growth and development for your patient, including development stage.

His role as a father and his voluntary admission with support of wife suggest a level of generativity, insight, and willingness to engage in treatment. His participation in group activities, peer support, and music sharing reflects a desire for connection and contribution. Generativity vs stagnation.

2. Discuss any deviations of growth and development.

His difficulty with mood stability, pacing, and verbal outbursts suggest difficultly managing stress and maintaining Psychological stability. This should be better handled with due to a normal expected emotional maturity at his age.

Self-Evaluation: Answer the following question.

1. What is your personal perception of your performance during your clinical day? What did you do well? What could you have done better? Give specific examples.

During my clinical day, I felt anxious since I didn't know what to expect. Despite that, I believe I performed well in introducing myself to the group and practicing active listening. I made a conscious effort to sit besides patients and engage with them as equals, which helped build trust and comfort. For example, a patient who was active in groups but often sat alone during activity therapy. I gently encouraged him to participate by offering pencils, asking if he wanted to work on the questions together, and eventually taught him to play sudoku which he was reluctant at first to accept. He acknowlegded this to the group that "he sat next to me like nothing". which I feel shows that my presence helped him feel accepted. While I was quiet and didn't ask too many questions, I stayed observant and made sure everyone felt included and not judged. I could improve by being more assertive in initiating therapeutic conversations.