

Dover Behavioral Health  
Clinical Assignment  
2025

Student Name: Katelyn Milligan Date: 9/17/2025

Patient's Initials: John Age: 50's Sex: M

Psychiatric Diagnosis(es): Substance Abuse Disorder

Pathophysiology of the main Psychiatric Diagnosis:

Neuroanatomical Factors:	The prefrontal cortex (decision making, judgement) becomes hypoactive, this allows them to make poor decisions about taking drugs/alcohol. The amygdala is overactive allowing for stress that can initiate a relapse. The hippocampus stores drug smells and memories of getting high allowing for them to crave it. Drug use also disrupts hormones in the hypothalamus leading to the withdrawal symptoms they may experience.
Neurotransmitters:	Dopamine: Controls the reward pathway and substances like drugs or alcohol cause a big release of dopamine leading to the high. Glutamate: Involved in memories and learning, drugs alter the way glutamate works and allows powerful cravings for the substance. GABA: substances increase GABA producing the sedative effect that some give off. Endorphins: Opioids mimic endorphins which is a painkiller, this eventually leads to the dependence and withdrawal pain. Norepinephrine: Arousal, stress, stimulants cause a big release of energy and insomnia in those using substances.
Course/ characteristics of illness:	Substance abuse starts with the first time they take that substance, some people call this experimentation during young years of their lives and often do it because others around them are. The substance then can become a regular thing, first it could be every weekend, then every day after work and the brain begins to adapt to the high release of dopamine. It starts with missed responsibilities, and mild cravings. They then can start using it in dangerous situations like while driving, going to work high or drunk and start to lose control. They then can become dependent on it. They may have withdrawal symptoms if they stop the substance and at this point the goal is to get high. They then become addicted and will do anything even when harmful to get the high or drunk effect. The cravings are intense and can be triggered by events. Substance abuse is a relapsing disorder and even after long periods of being clean they could start again after any stressful event.

### Medications

Medication Name What is this for?	Classification & Action	Side Effects	Nursing Implications
Fluoxetine (Prozac) This medication is for major depressive disorder, OCD, panic disorder and sometimes anxiety.	SSRI (Antidepressant) It blocks the uptake of serotonin leading to increase serotonin availability leading to decreased depression, improved sleep, decreased anxiety.	GI disturbances like nausea, vomiting, diarrhea Insomnia Anxiety Weight changes Sexual dysfunction Suicidal thought Serotonin syndrome	Monitor for suicidal ideations especially at the beginning of therapy. Teach them to report signs of serotonin syndrome. Teach to not stop abruptly.
Suboxone Use to treat opioid use disorder and helps reduce withdrawal and cravings.	A mix of Buprenorphine and naloxone  Buprenorphine: Partially stimulates opioid receptors reducing cravings and withdrawal  Naloxone: Blocks opioid effects if misused and prevents euphoria.	Headache, nausea, vomiting, sweating, insomnia, anxiety drowsiness  Serious: Resp depression, precipitated withdrawal	Teach patient to put under their tongue not sublingually. Assess for opioid withdrawal before starting Monitor for respiratory depression Educate to use along with therapies.

### Mental Status Exam:

	Subjective Data	Objective Data
Appearance	“I am homeless, I don’t have access to a lot of things”	Hair messed up, dirt under fingernails, missing some teeth along with others decaying, yellowish sclera.
Behavior	“I don’t want to be here, nobody understands what I feel like here”	Shaking head while tech is talking, grimacing, pacing around leaving group then coming back, writing anxiously on paper.

Speech	“They do not get it, why would I come here and then another rehab, they are supposed to be helping me here”	Frowning, talking with others about issues, talking fast trying to get out what he has to say.
Mood	“Nobody cares how I really feel, thank you for listening to me”	Smiles when I restate and express understanding of how he feels, follows me into whatever room I go into.
Disorders of the Form of Thought	“He was crazy, he had a mental health illness”	Working through own mental health issue of addiction, and shows anxiety about it.
Perceptual Disturbances	None	None
Cognition	“I remember being in the military I had a good friend there, I also had a good friend at another home I was at.”	Good short and long term memory, told me a lot of stories about his past.
Ideas of harming self or others	“I was in a really low state before I came in here, yes I did have feelings of suicide”	Pass suicidal ideation

**Problem #1: Ineffective Coping**

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Priority Patient Goal:

1. Will demonstrate one positive coping mechanism while in withdrawal during my time of care like writing down feelings, talking to others with similar experiences.

Assessments:

- Mood in group settings, Vitals, withdrawal symptoms (tremors, nausea, sweating), use of journaling, openness about feelings, a plan for after discharge.

Top 2 Interventions with rationale:

1. Develop a RAPPOR by talking in a calm voice, make eye contact, and encourage to express how they feel while being fully engaged in what they have to say. Doing this will provide him a sense of safety and like he can full express how he feels without judgement.
2. Provide coping mechanisms by providing paper and a marker for journaling, working on crafts together at the day activities. This allows for him to get those anxious feelings out but in a healthy way instead of pacing around like he was doing before.

**Problem #2:** Knowledge Deficit

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Priority Patient Goal:

1. Will teach back resources on where to go and what to do after discharge during my time of care.

Assessments:

- If homelessness is going to still be an issue or if he has a place to go, resources that he does know of, who is support system is, openness to resources and readiness to learn, learning preferences, knowledge of why he became an addict, what addiction does to the brain, veteran resources.

Top 2 Interventions with rationale:

1. Explain clear and in simple terms what happens with substance abuse and withdrawal. This would be a good intervention because throughout my time, he kept asking me questions on why he ended up this way and addiction. He wanted to know the reason so by providing this information to him it may allow him to fully understand the effects on his body.
2. Provide resources of shelters, transportation, jobs, AA meetings and peers, doctors and a way to get his medication. Being homeless and not having a phone makes it difficult to find resources on his own, by giving them to him and him calling while here, it allows for him to get set up resources that way he has a plan in affect and does not have to struggle on his own.

Patient Teaching

List 2 teaching topics that you taught a client.

1. Educated on some of the reasons that people turn to addiction including depression, trauma, and genetics.
2. Educated on letting people know that he is down or needs help because that is the only way they are going to know and be able to help him.

## Growth & Development

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

In his 50's he should still be working in his lifelong career, maybe have kids and a family. Has a desire to reach out to the community and help others. They want a sense of purpose an accomplishment. The developmental stage for this would be Generativity vs stagnation.

2. Discuss any deviations of growth and development.

Deviations in this include not having a job, being homeless, no relationships, and finds fulfillment from substances instead of by helping others.

### **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.

I think I did well by asking direct questions to facilitate conversations like asking if he had suicidal ideations. I think I could have done better at getting the patient I researched to open up better, I felt like it was difficult to open her up because she was quiet but it is important to get those who are down to open up.