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Coping resources strained by illness or social stress Generalized anxiety disorder

Mental Health Nursing | Focused diagnosis-based template

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Clinical assessment

Subjective: Worries across daily situations with tension and difficulty sleeping.

Objective findings and required checks: Restlessness and impaired concentration; physical symptoms and risk require assessment.

Physical examination and investigations: Assess duration, triggers, function, physical causes, substance use and safety.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Generalized anxiety disorder: Persistent threat-focused thinking and physiological arousal can reinforce distress and avoidance.

Medical / surgical management

Use therapeutic listening, practical coping skills and prescribed psychological or medication treatment.

Illustrative drug and treatment study

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Medicine / treatment	Purpose	Nursing checks
Prescribed SSRI when indicated	Treat the assessed anxiety disorder	Monitor response, early adverse effects and follow-up
sedative review	Short-term medicines require careful indication	Check dependence, sedation and falls risks.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

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Focused nursing-problem template

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about stressors, strengths, support people and previous coping. Assess: Assess function, engagement and immediate safety needs.	Coping resources strained by illness or social stress. Possible factors: demands exceeding currently available support. Validate against the patient's assessment.	Short-term: At the next patient-specific reassessment: Chooses one feasible coping action and identifies a support person or service. Longer-term: Before the clinically approved transition or agreed follow-up: Has a realistic follow-up and support plan agreed with the care team.	1. Assess strengths and barriers collaboratively. Rationale: An individualized plan builds on resources the person can actually use. 2. Practice a simple coping strategy and divide tasks into achievable steps. Rationale: Small successes support confidence and participation. 3. Coordinate social, psychological or community support as indicated. Rationale: Practical barriers can limit recovery even when clinical treatment is available. 4. Use therapeutic listening, practical coping skills and prescribed psychological or medication treatment. Rationale: Persistent threat-focused thinking and physiological arousal can reinforce distress and avoidance. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Apply this template

Complete with verified data: assessment cues; supported actual problem or risk; measurable outcome and review time; selected authorized interventions and rationale; observed response and next action.

Subjective / objective cues: _____

Patient-specific target and review time: _____

Evaluation evidence and next action: _____

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Health education and continuing care

Practice coping skills, sleep routines and gradual engagement; explain treatment follow-up.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Chest pain, syncope, severe new physical symptoms or immediate safety concerns need appropriate urgent assessment.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Persistent threat-focused thinking and physiological arousal can reinforce distress and avoidance.
- Priority concerns: Coping resources strained by illness or social stress.
- Chest pain, syncope, severe new physical symptoms or immediate safety concerns need appropriate urgent assessment.
- Practice coping skills, sleep routines and gradual engagement; explain treatment follow-up.

Exam / viva: What assessment evidence supports this problem, and what measurable result would demonstrate improvement?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

Nursing Mental Health and Community Concepts, 2e - Open RN / WisTech Open, 2025
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Nursing Pharmacology, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2023
https://wtcs.pressbooks.pub/pharmacology2e/

B.Sc. Nursing curriculum and regulatory notifications - Indian Nursing Council
https://www.indiannursingcouncil.org/gazette-notification

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