Nursing people with psychosomatic illness

Nursing and medical staff can feel frustrated in their attempts to help patients with problems of a psychosomatic nature. Lack of success can also compound the patient's problems, making the prospect of effective treatment even less likely. The author considers the assessment of such patients in hospital, and looks at short and long term nursing interventions as well as the therapeutic goals that can be appropriate.

Somatization is defined as 'a tendency to experience and communicate somatic distress and symptoms unaccounted for by pathological findings, to attribute them to illness and to seek medical help for them' (1). Somatization disorder comes under the umbrella of somatoform disorders, along with hysterical conversion disorders and hypochondriasis.

The separation of mental and physical activity has lost clinical relevance and a view that acknowledges both in any human process has emerged (2). We may recognize the tendency to somatize in our friends, family members, and in ourselves. It is a potential which can range from minimal to high expression.

Extensive investigation

Somatic presentation in general practice and psychiatric settings may include headache, dizziness, chest pain, gastrointestinal disorders and insomnia (3). Patients are commonly referred to outpatient departments where they are subject to extensive investigation. This is costly in terms of resources and for the patients, who continue to be distressed as vital psychological and psycho-social issues remain unaddressed.

Over-investigation may convince patients that a disease process actually exists, or that the investigation itself is causing disease (2). This uncertainty can lead to feelings of resentment and anger, and patients may behave in a way that attracts pejorative labels such as 'doctor shopping' or 'crock' (4).

Patients may somatize above and beyond their physical illness. Psychiatric nurses and nurses who work in primary care and hospital settings have a responsibility to be aware of this. Educated practice, however, will enable the nurse to prevent inappropriate intervention, and fulfil his or her role as patient advocate as described by the United Kingdom Central Council (5).

Assessment Assessment will involve the nurse in establishing the following information:

- Previous patterns of illness. Heightened sensitivity to the problem of somatization can help nurses elicit a more purposeful and skilled nursing history. Previous patterns of illness may reveal characteristic symptoms or an array of complaints that arise during periods of stress or adversity, for example, changing jobs or ending relationships (2). Patterns of parental illness, particularly those that have involved changes in the ability of the parent to care or those that required hospitalisation, may have had a profound impact on the child. What patients say and their perceptions of illness are important if the nurse is to build up a picture of the patient's model of illness, rather than impose his or her own.

- Learned behaviours. Patients often have ideas about what has precipitated an illness. They may have been given inappropriate advice and translated it into a rigid, fixed routine to avoid future illness. Inpatient status provides a unique opportunity to observe such behaviour. When caring for patients it may be helpful to consider the time of presentation and the configuration of symptoms with which they present. The way they refer to their problem, and the words they use, may illustrate areas in their lives that are causing or contributing to somatization (6). The symptom itself may hold symbolic meaning and should be explored, if the patient is willing.

- Context of advantages. How has the patient's life been affected by the symptoms? What are the disadvantages that he or she suffers, and what are the potential or realised advantages that may exist?

Information on the patient's receipt of financial benefits and allowances are an integral part of this assessment. Somatizing, by definition, is an unconscious act and this part of the assessment requires tact and diplomacy.

- Relationships with others. Family relationships, friends and work life can be explored with emphasis on the nature and quality of contact between individuals who feature in the patient's
Patterns of parental illness can have a profound effect on the child, and may contribute to the model of illness formed later in life. Visiting time also provides a window through which the nurse can observe the patient’s interaction with others. It is worth noting the patient’s attitude to his or her visitors and the degree of reciprocity involved. Do visitors treat the patient as if he or she were moribund, speak in hushed tones and bring in food specially prepared for ‘the invalid’, or are relationships strained and uncomfortable? Is the patient visited at all, and if so, by whom?

Interviews with informants from as wide a range as possible will enable the team to clarify the situation. Consent should be obtained from the patient when involving others, but initial reluctance is often overcome with an adequate explanation of the reasons for such actions. Friends and relatives may remember more clearly than the patient when previous episodes of stress provoked a similar response, and can give an account of the patient under normal conditions. Information from the general practitioner should always be sought (7).

Nursing care and interventions A working relationship between patient and carers is pivotal to success. Nursing interventions are varied and are rich with possibilities for imaginative innovation. Despite findings that show nurses have difficulties in caring for ‘neurotic’ patients, the problems that these patients face provide an opportunity for freedom and flexibility in practice (8). Once recognised, this is both liberating and rewarding. In my experience, nursing contracts have not been useful.

In the short term, the following techniques can be used successfully:

- Team approach. Roles within the multidisciplinary team need to be well defined. It may be necessary for the ward doctor to be the recipient of the symptom complaint so the remaining team members can focus on other areas with the patient. The nurse, for example, can then reject symptom discussion and encourage the patient to re-establish old friendships.
- Being realistic with assurances. The value of reassurance is doubtful with people who have a chronic somatization problem. In most cases, it will further entrench the problem. Patients have already been advised ‘to pull yourself together’, or ‘not to worry, we’ll soon have you sorted out’, and more reassurance will only convey the nurse’s lack of awareness of the problem. It is more appropriate to make explicit to the patient that you are offering help, but cannot make promises or predictions about outcome. In some cases it may be part of the management plan to maintain a degree of therapeutic pessimism to facilitate change in the patient.
- Changing the agenda. Building a relationship will take time. It is likely the patient will have had difficulty in making and sustaining relationships. Practical activities, like shopping, provide an easier and more natural opportunity to talk than a contrived scenario where the patient is expected to supply material for discussion. Patients who have somatic problems often find it difficult to express themselves and the more the nurse can facilitate this process the better. Informal contact with the patient may help complete your picture of the person, and may help you understand the way in which he or she...
understands and conceptualises the illness.

Longer term, the introduction of psychological explanations for physical symptoms is a crucial phase and will require patience and sensitivity. The patient's willingness to explore the problem within a new framework dictates the pace at which progress is made. If the problem is long-standing, the patient has probably organised life around the illness, and the prospect of relinquishing the symptoms may be more traumatic in the short term than that of living with constant illness.

A more rewarding mechanism must be found to replace symptoms that perform a clear function for the patient. Any disturbance of what may have been a state of equilibrium for a considerable length of time can lead to a sudden decompensation. The nurses caring for the patient must be alert to an increase in distress and to the subsequent risks involved. The patient may withdraw from treatment, return to somatizing or a non-accepting stance, or act in an impulsive way. Any suicidal threats should be evaluated carefully by the team.

Absorbing new ideas and information is difficult at the best of times, particularly if it has the effect of making the patient anxious. A repertoire of easily understandable explanations is essential (9).

In order to convince the patient of an alternative explanation for the pain, it is necessary to recognise which explanation resonates with the patient, is the most acceptable and will be congruent with the knowledge and experience of that pain (3). The aim is to help the patient examine the full range of possibilities for the existence of pain, rather than to shift his or her position from a purely organic model to that of a psychological one. It is useful to write things down for the patient's review later on.

Simple diagrams may also be helpful to demystify the situation and increase the patient's understanding, and in some cases it is possible to evoke symptoms deliberately in order to demonstrate their relationship to physiology; for example, overbreathing (3).

Health diaries can be used to show the link between stressors and symptoms. If necessary, the nurse can help the patient to structure the diary so that minimum writing is necessary. This is important for those who feel uncomfortable with reading and writing and may be put off by what is a powerful tool for increasing insight when utilised appropriately.

Diaries have an advantage in that they often enable patients to make the links for themselves, allowing them to regain a sense of control over their illnesses, having relinquished that control to the doctors and nurses who have undertaken investigative procedures in the past. They also provide material for the nurse and patient and may point to problems outside the hospital setting, such as family dynamics, that may be inaccessible to a ward-based team.

Once stressful situations have been identified and the patient has begun to accept an alternative explanation, diaries can be used to monitor and evaluate the effect of relaxation. Patients who are going on weekend leave and who anticipate a difficult time at home can be encouraged to participate in role play situations with their nurses in order to explore the alternative ways in which the expected problems can be dealt with. If patients (or nurses) feel apprehensive about this, brainstorming exercises are equally useful.

Feedback for the patient is important. Non-verbal behaviour in discussions between the nurse and patient can indicate areas of tension or difficulty. This should be brought to the patient's attention to help identify the problem area, and as an illustration of how psychological processes can affect bodily symptoms. Discussing difficult topics can bring on symptoms, but if this situation arises, it should be exploited to the full.

The nurse's words

The nurse's words are a vehicle for influencing change in how the patient perceives him or herself. Resist referring to a patient's 'illness'; speak instead about the degree of disability or handicap he or she has experienced.

The shift from the illness/sick/medical model to one of disadvantage/handicap maximises the opportunity to speak about issues such as adaptation and change, autonomy and adjustment, in which the patient can be active, rather than in terms of illness and cure with connotations of helplessness, passivity and stasis.

Somatizing behaviour may reveal problems that are difficult for ward nurses to work with, such as an unhappy marriage or financial problems, but the aim should be to direct the patient to the appropriate agency or undertake work with the patient in hospital with an acceptance of the limitations of any hospital-based intervention.

Reasonable therapeutic goals have been defined as gradual improvement over long periods of time; small units of change that are useful; prevention of further deterioration and helping the patient to lead a fuller life within the constraints of the problem and to reduce the distress it causes (3).