UNIT 2 NURSING MANAGEMENT OF A PATIENT WITH NEUROTIC, STRESS-RELATED AND SOMATOFORM DISORDERS

Structure

2.0 OBJECTIVES

After reading through this unit, you will be able to:

- define Neurosis;
- identify different types of Somatoform Disorders and their manifestations;
- explain different types of Dissociative Disorders;
- describe Conversion Disorder and its Nursing Management;
- describe Obsessive Compulsive Disorder and its Management; and
- explain Post Traumatic Stress Disorder and Psychosomatic Disorder and its management.

2.1 INTRODUCTION

The term 'Neurosis' was first introduced in 1769 by William Cullen (1710-1790). Till later part of nineteenth century, anxiety disorders were conspicuously missing from the classification of psychiatric disorder. Mayer (1886-1950) included in his nomenclature a separate description of neurosis, psychoses, affective states, organic braindisease and sub normality. Sigmud Freud (1841-1925) developed a classification of neuroses; and his concepts of neuroses have formed the foundation of psychoanalytical thought.

Neurosis may be defined as a mild to moderately severe illness in the personality in which the ego function of reality-testing is greatly impaired, and in which the maladjustment to life is relatively limited. (Bimla Kapoor 2001)

In this unit you will read about different types of somatoform disorder, post traumatic disorder and psychophysiological disorder in specific to the classification under ICD-10.

2.2 SOMATOFORM DISORDERS

The term 'Somatoform Disorders' was introduced in the scientific literature by the American Psychiatric Association in the third edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM III). Though some of the disorders included in the group are known since centuries. It was included in ICD-10 in 1992. The various disorders included in the group have the central characteristic of having. physical symptom without organic basis as the presenting feature. The physical symptoms suggest a physical illness (hence somatoform) for which there are no demonstrable organic findings or known physiologic factors or conflicts.

2.2.1 Definition

Somatoform Disorders are reflected in physiological complaints or symptoms, are not under voluntary control and do not demonstrate organic findings. Faan and Goshan (1997) state "the patient converts his/her psychological distress into complaints pertaining to different parts of the body (for example, complaining of palpitation or pain instead of fear)

2.2.2 Types of Somatoform Disorders

Somatoform disorders are sub classified into the following categories. These include somatization disorder, conversion disorder, hypochondriasis, somatoform pain disorder, body dysmorphic disorder (dysmorphophobia), somatoform disorder.

1) **Somatization Disorder**

Somatization Disorder is characterized by presence of recurrent and multiple, frequently changing somatic complaints of several years duration, for which medical attention has been sought, but these apparently are not due to any physical disorder. The disorder usually begins in early adult life and runs a minimum duration of two years before the disorder is diagnosed.

2) Undifferentiated Somatoform Disorder

When physical complaints are multiples varying and persistent, but the complete and typical clinical picture of somatization disorder is not fulfilled, this category should be considered.

3) **Hypochondriacal Disorder**

Hypochondriasis is a term used to describe persons who presents unrealistic or 'exaggerated physical complaints. They become preoccupied with the fear of

developing or already having a disease or illness inspite of medical reassurance that such an illness does not exist. Minor clinical symptoms are of great concern to the person and often result in an impairment of social or occupational functioning. This disorder usually is accompanied by anxiety, depression and compulsive personality traits. It generally occurs in adolescence and usually becomes chronic, causing impaired social or occupational functioning.

It includes body dysmorphic disorder, dysmorphophobia (nondelusional), hypochondriacal neurosis, hypochondriasis, nosophobia.

4) Persistent Somatoform Pain Disorder

Somatoform Pain Disorder is characterized by presence of severe and prolong pain for which there is no adequate medical explanation. Although this may occur at any stage of life, but it is more frequently seen in adolescence or early adulthood and occurs more frequently in women.

2.2.3 Nursing Interventions

- Establish rapport.
- Assess the patient's insight regarding the reason for somatic complaints.
- Help the patient to identify stressors in life situations.
- Refer complaints to medical staff for evaluation.
- Minimize the amount of time and attention spent on the discussion of physical complaints.
- Present reality when possible (i.e. "Your x-rays do not show any lesions in your right lung").
- Encourage verbalization about feelings rather than physical complaints.
- If no serious illness exists, limit the amount of time spent in room to avoid reinforcement of the sick role.
- Explore alternative ways of coping with stress and anxiety such as relaxation techniques.
- Focus on realistic goals for self. Include significant others in the conversation (if able).
- Assess the patient's level of self-concept.
- Encourage verbalization of feelings regarding self-image.
- Have the patient list positive traits or attributes.
- Give positive recognition or feedback whenever he/she discusses issues other than somatic complaints.

Freud explained that hysterical/conversion symptoms are caused by a conflict between the superego and some wish which is objected to by the superego. The repression is not, however, entirely successful and the wish, therefore, obtains disguised expression by its conversion or transformation into symptoms. In this discussed form, it escapes the censor of the super ego. Conversion Disorder may stimulate an astonishing variety of organic symptoms. These symptoms often change from time to time and with suggestions.

2.3 DISSOCIATIVE (CONVERSION) DISORDERS

There is normally a considerable degree of conscious control over the memories and sensations that can be selected for immediate attention, and the movements. that are to be carried out. In these disorders it is presumed that this ability to exercise a conscious and selective control is impaired, to a degree that can vary from day to day or even from hour to hour.

2 3.1 Definition

The common theme shared by dissociative (or conversion) disorders is a partial or complete loss of the normal integration between memories of the past, awareness of identity and immediate sensations, and control of bodily movements.

2.3.2 Psychodynamics and Etiology

In conversion disorder although the disturbance is not under voluntary control, the symptoms occur in organs under voluntary control, serve to meet the immediate needs of the patient, and are associated with a secondary gain. Patients with conversion disorder benefit by primary and secondary gain. Primary gain is obtaining relief from anxiety by keeping an internal need or conflict out of awareness. Secondary gain is any other benefit or support from the environment that a person obtains as a result of being sick. Example of secondary gain are attention, love, financial regard and sympathy.

The term 'la belle indifference' is used to describe patient reaction such as indifference to the symptoms and displaying no anxiety. This is because the anxiety has been relieved by the conversion disorder. The conversion symptoms serve the purpose of non-verbal communication of the stress or suffering and also function as non verbal means of controlling or manipulating others. An emotionally charged feeling or idea, blocked from expression by personal or cultural restraints is expressed in the form of conversion symptoms. Patients with more frequently recurring conversion symptoms have been reported to have significantly higher number of problems in their private life.

Age of onset for conversion disorder is usually'adolescence or early adulthood but it may occur for the first time during middle age or in later maturity. Conversion disorder is two to five times more common in woman than in man.

2.3.3 Types of Dissociative Disorders

The different types of dissociative disorders in the following text

1) Dissociative Amnesia

The main feature is loss of memory, usually of important recent events, which is not due to organic mental disorder. The amnesia is usually centered on traumatic events, such as accidents or unexpected bereavements, and is usually partial and selective.

2) Dissociative Fugue

Dissociative fugue has all the features of dissociative amnesia, plus an apparently purposeful journey away from home or place of work during which self-care is maintained. In some cases, a new 'identity may be assumed, usually only for **a** few days but occasionally for long periods of time and to a surprising degree of competeness.

3) Dissociative Convulsions

Dissociative convulsions (pseudoseizures) may mimic epileptic seizures very closely in terms of movements, but tongue-biting, serious bruising due to falling and incontinence of urine are rare in dissociative convulsion, and loss of consciousness is absent or replaced by a state of stupor or trance.

2.3.4 Management

The management of dissociative disorder is in two phases:

Symptoms Removal

Prompt elimination of the symptoms is important to prevent the secondary gains from reinforcing it and making it chronic. The patient should not be told that there is nothing wrong, but should be reassured that the symptoms are going to disappear quickly and completely. After detailed examination, a suggestion may even be made that it had already started improving. Mild sedation, relaxation exercises, hypnosis and anxiolytics may be used. If no response is seen, pentothal interview or abreaction may be used which has both diagnostic as well as therapeutic value.

Dealing with Psychosocial Stresses

If the precipitating factor is transient and unlikely to recur, this phase of treatment is brief. If the stress is persistent, psychotherapy is required for longer period of time. Secondary gain should be cut to minimum.

2.3.5 Nursing Interventions

- **a** Nurses must remember that the physical symptoms are quite real to the patient with a dissociative disorder. The patient should not be told that there is nothing wrong, but should be reassured that the symptoms is going to disappear quickly and completely. After detailed examination and reviewing the laboratory reports a suggestion may even be made that it has already started improving.
- Firm and kind attitude is required along with understanding, tolerant and non-judgmental attitude. Do not give much attention to the patient's symptoms but try to find out patient's psychological needs.
- **Ignore the symptoms but attend the patient.**
- Denial of the clients feelings is non therapeutic and interferes with establishment of trusting relationship. Identify gains that the physical symptoms are providing the client of increased dependency, attention from other problems etc. Initially, fulfill the client's most urgent dependency needs, but gradually withdraw attention from physical complaints.
- Explain to client that any new physical complaint will be referred to the physician and avoid giving further attention to them.
- Encourage client to verbalize fears and anxieties. Discuss possible alternative coping strategies that client may use in response to stress, e.g. relaxation exercises give positive reinforcement for use of these alternatives. Help client identify ways to achieve recognition from others without resorting to physical symptoms.

Check Your Progress 1

1) List different types of Somatoform Disorder.

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2) Fill in the blanks:

i) A person who presents unrealistic or exaggerated physical complaints is suffering from.....

ii) A person suffering from severe and prolonged pain for which there is no adequate medical explanation is suffering from.....

iii) Disorder characterized by the symptoms relating to organs or systems under autonomic innervations and control is called.....

iv) A psychological condition where.there is partial or complete loss of normal integration between memories of the past, awareness of identity, /and immediate sensations, and control of bodily movements is called.....

3) Encircle T if the statement is True and F if the statement is False:

i) Patient suffering from Conversion Disorder should be told that there is nothing wrong with him. (T/F)

ii) Anti anxiety drugs are used to treat Conversion Disorder. (T/F)

iii) Firm and kind attitude is required while managing patients with Conversion Disorder. (T/F)

iv) The patient suffering from Conversion Disorder should be ignored by nurses (T/F)

2.4 OBSESSIVE COMPULSIVE DISORDER (OCD)

OCD is another common neurotic disorder seen in the hospital.

2.4.1 Definition

Obsessive Compulsive Disorder is the disorder characterized by two main clinical features, namely recurrent obsessions or compulsions (or a combination of both, that are severe enough to cause marked distress or significant impairment).

Obsessions are defined as unwanted, intrusive, persistent ideas, thoughts, impulses, or images that cause marked anxiety or distress. The most common ones include repeated thoughts about contamination, repeated doubts, a need to have things in particular order aggressive or horrific impulses, sexuality and violence.

Compulsion is defined as unwanted repetitive behavior patterns or mental acts (example praying, counting, repeating words silently) that are intended to reduce anxiety, not to provide pleasure or gratification. They may be performed in response to an obsession or in a stereotyped fashion. The individual recognizes that the behavior is excessive or unreasonable but, because of the feeling of relief from discomfort that it provides, is compelled to continue the act. The most common compulsions involve washing of clothes and cleaning, counting, checking, hand washing, etc.

2.4.2 Psychodynamics and Etiology

Psychoanalytical theorist propose that individuals with obsessive compulsive disorder have weak, underdeveloped egos (for any of a variety of reasons unsatisfactory parent child relationship, conditional love or provisional gratification) The psychoanalytical concept views clients with obsessive compulsive disorder as having regressed to developmentally earlier stages of the infantile super ego, the harsh, punitive characteristics, which now reappear as part of the psychopathology. Regression to the anal phase combined with the use of specific ego defense mechanisms (isolation, undoing, displacement, reaction formation) produces the clinical symptoms of obsessions and compulsions.

2.4.3 Signs and Symptoms

Some of the common obsessions include repeated thoughts about contaminations repeated doubts, need to have things in symmetry, aggressive or horrific impulses and sexual imaging. Some of the common compulsions include ritualistic washing and cleaning, repeated counting, repeated checking, arranging things in symmetry, repeatedly requesting or demanding assurance, buttoning unbuttoning, etc.

2.4.4 Management

Pharmacotherapy

Drugs that have been used successfully in alleviating the symptoms of obsessive compulsive disorders are clomipramine and the Selective Serotonin Reuptake Inhibitors, for example Fluoxetine (Fludac), all of which are believed to block the neuronal reuptake of serotonin, thereby potentiating serotonergic activity of the central nervous system.

Behaviour Therapy

Classical Behavior Therapy Techniques have been used in the successful treatment of OCD. These include procedures such as systematic desensitization, flooding, modeling response prevention, thought stopping etc. Cognitive Behavior Therapy also is found to be effective in OCD.

Psychotherapy

Supportive psychotherapy, short term psychotherapy or classical psychoanalysis can be carried out in appropriately chosen patients.

2.4.5 Nursing Intervention

1) Establish trust and one to one relationships.
2) Observe for signs of increasing anxiety and intervene before the patient resorts to ritualistic behavior if possible.
3) Remove patient from any situation that stimulates or increase behaviour.
4) Allow time for rituals if already established - do not hurry up the patient.
5) Encourage the patient to participate in planning activities after allowing time for ritualistic behavior to decrease.
6) Support any positive decision made by patient.
7) Plan diversional activities.
8) Spend time with patient and anticipate needs
9) Discuss thoughts and behavior with the patient. Explore conflicts in relation to ritualistic behavior.
10) Communicate your expectations of the patient's recovery.
11) Set priorities and time for other tasks to be done (like eating, personal hygiene etc.)
12) Encourage the patient to develop new interests outside self.
13) If patient has washing/hand washing rituals provide good quality soap and in winter provide warm water.
14) Protect the patient from being ridiculed by others.

2.5 REACTION TO SEVERE STRESS AND ADJUSTMENT DISORDERS

This category differs from other diseases as it includes disorders identifiable not only on grounds'of symptomatology and course but also on the basis of one or other causative influences — an exceptionally stressful life event producing an acute stress reaction, or a significant life change leading to continued upleasant circumstances that result in an adjustment disorder.

2.5.1 Types of Reaction to Severe Stress and Adjustment Disorders

1) Acute Stress Reaction

A transient disorder of significant severity which develops in an individual without any other apparent mental disorder in response to exceptional physical and/or mental stress.

2) **Post-traumatic Stress Disorder**

This arises as a delayed and/or prolonged response to a stressful event or situation (either short- or long-lasting) of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone.

3) Adjustment Disorders

States of subjective distress and emotional disturbance, usually interfering with social functioning and performance, and arising in the period of adaptation to a significant life change or to the consequences of a stressful life event.

2.5.2 Post Traumatic Stress Disorder (PTSD)

PTSD is an intense sustained emotional response to a traumatic experience or natural or man made disaster.

I) **Definition**

PTSD is defined as the development of characteristic symptoms after exposure to a traumatic life experience capable of psychologically harming most people.

2) Etiology

Traumatic events capable of causing PTSD are : .

- Natural disasters such as earth quakes, floods etc.
- Accidental human made disaster example nuclear plant accident, auto. crashes, industrial accidents, air plane crashes etc.
- Intentional human made disasters such as prolonged military combat, rape, assault, armed robbery, physical and/or psychological abuse.

3) Signs and Symptoms

Characteristic symptoms of PTSD includes re-experiencing the traumatic event, a sustained level of anxiety or arousal, or a general numbing of responsiveness. Nightmares of the event are common. Some individuals may not be able to remember certain aspects of the trauma, and symptoms of depression are common. In the case of a life threatening trauma that one has to face along with other survivors often describe painful guilt feelings about surviving when others did not. The full symptoms must be present for more than one month and cause significant interference with social, occupational and other areas of functioning.

4) Management: Pharmacotherapy

Tricyclic antidepressants like amitryptiline and imipramine have been effective in treatment of PTSD. Benzodiazepines are also widely used for its treatment.

5) Nursing Intervention

- Counseling : Clients should feel that s/he is being accepted. Communicate interest in the client by helping him describe his experience, and promote self care.
- Be non judgmental about client's shameful and horrified perceived experience.
- Help the client grieve. Let them express their feelings to the losses even if there are intangible losses such as sense of safety and threat of loss of life.
- Help the client discuss the losses that have occurred and changes that have resulted from the trauma.

- Redirect client's anger and energy towards physical activity.
- Protect the client and others from physical harm
- . Help them overcome symptoms of chronic anxiety.
- Teach them new coping strategies.
- Help the client recognize the relationship of symptoms to traumatic events.

2.6 PSYCHOPHYSIOLOGICAL/PSYCHOSOMATIC DISORDERS

- Psychophysiological/Psychosomatic responses to anxiety are those in which it has been determined that psychological factors contribute to the irritation or exacerbation of the physical condition. Psychosomatic theory holds that emotional change are persistent or frequent, then pathological. Physical factors can help to maintain or aggravate the disease or to trigger relapses. It is also assumed that physical conditions induced in this way will improve if the psychological disturbance improves either spontaneously or as a result of psychological treatment.
- Somatoform disorders are characterized by physical symptoms without organic pathology. Lack of evidence of organic pathology in Somatoform disorder is the major difference between somatoform disorder and psychophysiological disorder.
- Peptic ulcer, Irritable Bowel Syndrome, dermatitis, low back pain, asthma, essential hypertension and migraine headache are the few examples of psychosomatic disorders.
- The medical problem is treated before focusing on the emotional needs exhibited by the patient. Anti anxiety agents, anti-depressants or sedatives-hypnotic agents may be prescribed. Other treatment prescribed may include bio-feedback and relaxation exercises.

Nursing Management

- Nursing interventions should be holistic health care approach by treating the patient's physical, psychological and spiritual needs. Nurses can assist the patient to identify positive or alternative coping mechanisms.
- Help the patient identify support systems such as a close friend, family member or professional counsellor.
- Teach the patient relaxation and deep breathing exercise and shavasana, etc.

Check Your Progress 2

1) Define the following:

i) Obsession

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ii) Compulsion

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iii) Obsessive Compulsive Disorders

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iv) Post Traumatic Stress Disorder (PTSD)

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v) Psychosomatic Disorder

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2) True or False

i) Patients with OCD have weak underdeveloped egos. (T/F)

ii) Patient suffering from OCD get the benefit in the form of primary gain and secondary gain. (T/F)

iii) Antipsychotic are the most effective drugs to treat OCD. (T/F)

iv) Nurses should allow time to patients suffering from OCD to perform rituals. (T/F)

3) Traumatic events capable of causing PTSD are:

a) .....

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b) .....

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c) .....

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2.7 LET US SUM UP

In this unit, you have learnt about neurosis, somatoform disorders, dissociate disorders, obsessive compulsive disorder, post traumatic disorder and psychophysiological/psychosomatic disorder. Somatoform disorder can be sub classified into seven categories viz. Somatization disorder, conversion disorder, hypochondriasis, somatoform pain disorder (psychalgia).

The treatment and management of conversion disorder is discussed. A brief summary of dissociative disorders including amnesia, fugue, multiple personality and depressionalisation disorder, their treatment and nursing management is also discussed. You have also learnt about the obsessive compulsive disorder and it management including nursing intervention. Post-traumatic Stress Disorder and Psychophysiological disorder (Psychosomatic Disorder) have also been briefly described. Knowledge attained in this unit will help you to identify these disorders and provide comprehensive nursing care to the patients suffering from these disorders.

2.8 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1) Somatization Disorder.
Undifferentiated Somatoform Disorder
Hypochondrical Disorder
Persistent Somatoform Pain Disorder

2) i) Hypochondriasis.
ii) Persistent Somatoform pain disorder (Psychalgia).
iii) Somatoform Autonomic Dysfunction.
iv) Conversion disorder.

3) i) F
ii) T
iii) T
iv) F

Check Your Progress 2

1) i) Obsessions are defined as unwanted, intrusive, persistent ideas, thoughts, impulses, or images that cause marked anxiety or distress. The most common ones include repeated thoughts about contamination, repeated doubts, a need to have things in particular order aggressive or horrific impulses, sexuality and violence.

ii) Compulsion is defined as unwanted repetitive behavior patterns or mental acts (example praying, counting, repeating words silently) that are intended to'reduce anxiety, not to provide pleasure or gratification. They may be performed in response to an obsession or in a stereotyped fashion. The individual recognizes that the behavior is excessive or unreasonable but, because of the feeling of relief from discomfort that it provides, is compelled to continue the act. The most common compulsions involve washing clothes and cleaning, counting, checking, hand washing, etc.

iii) Obsessive Compulsive Disorder is the disorder characterized by two main clinical features, namely recurrent obsessions or compulsions (or a combination of both, that are severe enough to cause marked distress or significant impairment).

iv) PTSD is an intense sustained emotional response to a traumatic experience or natural or man made disaster.

v) Psychophysiological/Psychosomatic responses to anxiety are those in which it has been determined that psychological factors contribute to the irritation or exacerbation of the physical condition.

2) i) T
ii) F
iii) F
iv) T

3) i) a) Natural disasters
b) Accidental human made disasters
c) Intentional human made disasters,