

# SOMATOFORM DISORDERS

## DSM-IV

- 300.81 Somatization disorder
- 300.11 Conversion disorder
- 300.7 Hypochondriasis
- 300.7 Body dysmorphic disorder
- 307.xx Pain disorder
- 307.80 Associated with psychological factors
- 307.89 Associated with both psychological factors and a general medical condition
- 300.82 Undifferentiated somatoform disorder
- 300.82 Somatoform disorder NOS

Somatization refers to all those mechanisms by which anxiety is translated into physical illness or bodily complaints. The expression of physical symptoms suggests the presence of physiological disorder, but there are no demonstrable organic findings/known pathological mechanisms, or the symptoms are not fully explained by any physical disorder. That is, the symptoms are in excess of what would be expected from the history, physical examination, or laboratory findings. There does exist, however, positive evidence, or a strong presumption, that the symptoms are linked to psychological factors or conflicts. These disorders are more common in women than in men, with somatization disorder rare in men.

## ETIOLOGICAL THEORIES

### Psychodynamics

This disorder may represent an unconscious transformation of internal conflicts into physical symptoms that can be explained in terms of the ego's ability to control the sensory and motor apparatus, which may have specific meaning for the client.

Dependency is common in individuals with somatoform disorders, and fixation in an earlier level of development may be evident. Repression is the primary defense mechanism, as severe anxiety is repressed and manifested by the presence of physical symptoms.

### Biological

Although biological and neurophysiological influences in the etiology of anxiety have been investigated, no relationship has yet been established. However, there does seem to be a genetic influence with a high family incidence.

The autonomic nervous system discharge that occurs in response to a frightening impulse and/or emotion is mediated by the limbic system, resulting in the peripheral effects of the autonomic nervous system seen in the presence of anxiety. These manifestations of anxiety may be related to physiological abnormalities.

### Family Dynamics

The family contributes to these conditions by initiating, reinforcing, and perpetuating the behavior patterns. The children learn (overtly or covertly) that physical complaints are acceptable ways of coping with stress and obtaining attention, care, and gratification of dependency needs. The client may gain attention and meet these needs by overdramatization of the symptoms, resulting in overinvolvement of other family members in enmeshed behavior patterns. In the beginning, the client may exaggerate minor symptoms to prove she or he is really ill when others ignore reports of illness.

## **CLIENT ASSESSMENT DATA BASE**

### **Activity/Rest**

Fatigue  
General weakness

### **Circulation**

Heart rate may be elevated if symptoms mimic those of cardiopulmonary disease (similar to those experienced during panic attack)

### **Ego Integrity**

Preoccupation with imagined defect in appearance or markedly excessive concern with slight physical anomaly not better accounted for by another mental disorder (e.g., dissatisfaction with body shape/size in anorexia nervosa [body dysmorphic disorder])  
Evidence of severe psychological stress preceding onset/exacerbation of the physical symptoms (e.g., death of a loved one [conversion])  
Preoccupation with fear of having a serious disease (hypochondriasis)  
Use of denial; evidence that presence of the symptoms alleviates or promotes avoidance of the psychological conflict  
Feelings of anger, helplessness, powerlessness  
Report of issues suggesting unconscious secondary gain (e.g., attention of others, financial reimbursement, change in role expectations/responsibilities)

### **Elimination**

Urinary retention  
Constipation, diarrhea

### **Food/Fluid**

Two or more GI symptoms (e.g., nausea, vomiting, bloating, intolerance of several different foods, difficulty swallowing [somatization])  
Changes in eating patterns (loss of appetite/excessive intake)  
Weight loss/gain

### **Hygiene**

May neglect and/or report inability to perform basic ADLs  
Excessive concern/preoccupation with/or more imagined defects in appearance (body dysmorphic disorder)

### **Neurosensory**

Mental Status Exam:

Fearfulness; preoccupation with belief of having serious disease; anxiety (symptoms associated with moderate to severe level) or *la belle indifférence* (lack of concern about loss of physical functioning)  
Depressed mood  
Amnesia  
Communication patterns: ruminating about physical symptoms  
May display loss of consciousness other than fainting (somatization)  
Apparent loss of or alteration in voluntary motor or sensory functioning that suggests neurological disease (e.g., blindness, double vision, deafness, paralysis, anosmia, aphonia, episodic seizure activity, and coordination disturbances [especially common in conversion disorder])

## **Pain/Discomfort**

Pain in 1 or more anatomical sites of at least 6 months' duration and of sufficient severity to warrant clinical attention (pain disorder); involving 4 different sites of function (e.g., head, abdomen, back, joints, chest, during urination/menstruation/sexual intercourse [somatization])  
Excessive use of analgesics with minimal relief of pain

## **Respiration**

Respiratory rate may be increased  
Shortness of breath without exertion

## **Safety**

May report suicidal ideations, inability to continue in current situation

## **Social Interactions**

Observed/reported impairment in social, occupational, or other areas of functioning  
Acute withdrawal from life activities, fear of being seen/scrutinized by others in public setting (body dysmorphic disorder)

## **Sexuality**

One or more sexual/reproductive symptoms other than pain, e.g., decreased libido/sexual indifference, irregular menses/excessive menstrual bleeding, erectile/ejaculatory difficulties, pseudocyesis (false pregnancy), somatization

## **Teaching/Learning**

Reports of physical symptoms of several years' duration beginning before the age of 30 (somatization)  
History of a past experience with true serious organic disease, in self or close family member (hypochondriasis)  
History of frequent visits to physicians (doctor shopping) to obtain relief/requests for surgery despite medical reassurance of absence of organic pathology or need for plastic surgery (e.g., facelift, liposuction)  
Failure to improve despite multiple approaches/therapies  
Expression of anger and frustration toward physicians for "inability to determine cause of physical symptoms"

## **DIAGNOSTIC STUDIES**

Virtually any diagnostic procedure (including exploratory surgery) may be performed as deemed appropriate to rule out organic pathology in light of the physical symptom(s) presented by the client.

**Urine and/or Serum Toxicology Screen:** Determines evidence of substance use/abuse

## **NURSING PRIORITIES**

1. Alleviate or minimize physical symptoms/chronic pain.
2. Promote client safety.
3. Resolve potentially dysfunctional areas of client/family dynamics.
4. Promote independence in self-care activities.
5. Provide information and support for lifestyle changes.

## DISCHARGE GOALS

1. Relief obtained from admitting physical symptom(s).
2. Client/family recognizes relationship between psychological stressors and onset/exacerbation of physical symptoms(s).
3. Stress management techniques used appropriately to prevent the occurrence/exacerbation of the physical symptom(s).
4. Level of function/independence increased.
5. Plan in place to meet needs after discharge.

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### NURSING DIAGNOSIS

### COPING, INDIVIDUAL, ineffective

#### May Be Related to:

Severe level of anxiety, repressed; personal vulnerability

Unrealistic perceptions

History of self or loved one having experienced a serious illness

Retarded ego development; fixation in earlier level of development; unmet dependency needs

Inadequate coping skills

#### Possibly Evidenced by:

Verbalized inability to cope/problem-solve

High illness rate, multiple physical complaints that are not fully explained by a known general medical condition

Decreased functioning in social/occupational settings

Narcissistic tendencies, with total focus on self and physical symptoms; demanding behaviors

History of “doctor-shopping”

Inappropriate use of defense mechanisms (e.g., denial of correlation between physical symptoms and psychologic problems); refusal to attend therapeutic activities

#### Desired Outcomes/Evaluation Criteria— Client Will:

Verbalize need for change within dysfunctional system.

Recognize correlation between physical symptoms and psychological problems.

Demonstrate adaptive coping strategies in the face of stressful situations, discontinuing use of physical symptoms as a response.

Report reduction of/relief from physical complaints.

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## **ACTIONS/INTERVENTIONS**

## **RATIONALE**

### **Independent**

Review laboratory and diagnostic results with the client in simple, easy-to-understand terminology. Answer any questions that may have arisen from discussions with the physician.

Show unconditional positive regard. Convey that you understand the symptom is real to the client, even though no organic pathology can be found.

Discuss possibility of and client's perceptions of behavior(s) as self-destructive. Determine suicidal risk as appropriate.

Be available to assist the client with basic dependency needs in the initial stages of the relationship. Recognize, however, that the client may be using maladaptive behaviors

Gradually decrease response to time and assistance required by the client as the trusting relationship becomes established. Encourage independent behaviors and respond with positive reinforcement.

Encourage verbalizations of honest feelings, including feelings of anger within appropriate limits.

Provide safe method of hostility release (e.g., pounding pillows). Help client to identify true source of anger and work on adaptive coping skills for use outside the therapeutic setting.

Withdraw attention if rumination about physical symptoms begins.

Help client identify symbols of hope in own life through exploration and discussion.

Explore past experiences with client and correlate appearance of physical symptoms with times of stress.

Client has the right to knowledge about own care. Honest explanation may help client to understand psychological implications. Anxiety is high, so learning is difficult, thus, explanations need to be kept simple and concrete.

Denial of the client's feelings is nontherapeutic and interferes with establishment of a trusting nurse/client relationship.

Limitations imposed by chronic "illness/disabilities" prevent client from full participation in life activities. In conjunction, multiple conflicts (e.g., medical, financial, family, legal) increase the likelihood of feelings of depression, helplessness, and hopelessness, which may in turn lead to substance abuse, dependence on pharmacological agents, and/or suicidal ideation necessitating additional therapeutic interventions.

To deny client this need at this time would result in an increased anxiety level and intensification of the physical condition to preserve the dependency role.

Positive reinforcement enhances self-esteem and encourages repetition of desirable behaviors. Doing things for oneself helps to develop independence and improves coping ability.

Verbalization of feelings in a nonthreatening environment may help the client come to terms with the unresolved issues.

Presence of depression and/or suicidal behaviors may be viewed as anger turned inward on self. When this anger is vented in a nonthreatening environment, the client may resolve these feelings, regardless of the discomfort involved.

Lack of response to maladaptive behaviors may discourage their repetition.

Encourages client to focus on reasons for wanting to change life.

Until denial defense is eliminated, change required for improvement will not occur.

Discuss possible alternative coping behaviors client may use in response to stress (e.g., relaxation techniques, deep breathing; physical activities, such as jogging, aerobics, brisk walks, housekeeping chores, sex). Offer positive reinforcement for use of these alternatives.

Discourage excessive sleep during the day, and encourage establishment of a routine pattern of sleep and activity with inclusion of customary bedtime rituals (e.g., warm baths, massage, warm/nonstimulating drinks or reduction of fluid intake, light snacks).

Report/investigate any new physical complaints.

### **Collaborative**

Provide information and recommendations regarding condition to other healthcare providers. Avoid suggesting that “the problem is all in the client’s mind.”

Administer medications, if indicated:

Antianxiety agents, e.g., diazepam (Valium), chlordiazepoxide (Librium), alprazolam (Xanax);

Antidepressants, e.g., amitriptyline (Elavil), imipramine (Tofranil), fluoxetine (Prozac), sertraline (Zoloft).

Because of high level of anxiety, client may require assistance in problem-solving and the ability to recognize available alternatives. Positive reinforcement enhances self-esteem and encourages repetition of desirable coping behaviors. **Note:** Stimulating activities/discussions should be avoided in late evening hours to prevent increasing level of anxiety, which could interfere with sleep.

Daytime sleep may be used as a defense to deal with pain/stressors. Ritualistic patterns and a realistic balance of activity and rest induce relaxation, promote inducement of sleep at appropriate times, and decrease interruptions of sleep. Obtaining quality sleep enhances client’s ability to deal with pain and develop new coping strategies.

Although physical symptoms have been used as a way of coping by the client, the possibility of organic pathology must always be considered to prevent jeopardizing client safety/well-being.

Understanding the client’s psychological needs and symptoms may promote a team approach for healthcare. Research suggests a regular schedule of brief medical appointments/examinations every 4–6 weeks at preset times (not on demand), with the avoidance of laboratory tests, surgeries, and hospitalizations (unless absolutely necessary) can enhance the client’s sense of well-being and actually reduce annual medical costs.

Psychopharmacological treatment is usually not indicated unless anxiety/depression is prominent.

Antianxiety medications have a calming effect on the client, masking the feelings of anxiety, which may minimize physical response. Careful monitoring of use of antianxiety agents is important because of high addiction potential. **Note:** Sedative side effects may induce sleep during day, thereby interfering with client’s sleep at night.

Antidepressant medication may elevate the mood as it increases level of energy and decreases feelings of fatigue. **Note:** Potential for suicide increases as energy level improves.

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**NURSING DIAGNOSIS****May Be Related to:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—  
Client Will:****PAIN, chronic**

Severe level of anxiety, repressed

Low-self-esteem; unmet dependency needs

History of self or loved one having experienced a serious illness

Multiple reports of severe/prolonged pain

Guarded movement/protective behaviors; facial mask of pain; fear of reinjury

Altered ability to continue previous activities; social withdrawal

Changes in weight, sleep patterns

History of seeking assistance from numerous healthcare professionals; demands for therapy/medication

Acknowledge relationship between psychological problems and onset/exacerbation of pain.

Demonstrate techniques to interrupt escalating anxiety/pain.

Verbalize noticeable reduction/relief of pain.

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**ACTIONS/INTERVENTIONS****RATIONALE**

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**Independent**

Note and record duration and intensity of pain. Assess factors that precipitate onset of pain. Observe and report any new or different pattern of pain behavior to physician.

Convey to client your belief that the pain is indeed real, even though no organic pathology can be found.

Provide nursing comfort measures with a matter-of-fact approach that does not provide added attention to the pain behavior (e.g., back rub, warm bath, heating pad).

Assist client with activities that distract from focus on self and pain.

Use distractors to facilitate initiation of discussion of unresolved psychological issues (e.g., open expression of feelings such as guilt, fear about life events).

The correlation of these factors provides client with information to become aware of cause/effect relationship and to gain control of outcome. **Note:** Changes in pain necessitate evaluation to rule out development of organic pathology.

Denying or belittling the client's feelings is nontherapeutic and interferes with the development of a trusting relationship.

May serve to provide some temporary relief of pain for the client. Secondary gains from solicitous behavior may provide positive reinforcement and can actually prolong use of maladaptive behaviors.

Helps the client to focus on adaptive behavior patterns and serves as a transition to higher levels of therapy.

Unresolved psychological issues must be dealt with before maladaptive patterns can be eliminated.

Help client connect times of onset/exacerbation of pain with times of increased anxiety.

Identify specific situations that cause anxiety to rise, and demonstrate techniques to interrupt the pain response (e.g., visual or auditory distractions, guided imagery, breathing exercises, massage, application of heat or cold, relaxation techniques).

Provide positive reinforcement when client is not focusing on pain.

### **Collaborative**

Review ongoing assessments by physician and laboratory/other diagnostic studies.

Administer medications as indicated, e.g.:  
Aspirin, ibuprofen (Motrin, Advil);

Low-dose antidepressants, e.g., amitriptyline (Elavil), doxepin (Sinequan), phenelzine (Nardil);

Anticonvulsants, e.g., phenytoin (Dilantin), carbamazepine (Tegretol), clonazepam (Klonopin);

Sedative medications at bedtime, e.g., triazolam (Halcion).

Refer to chronic pain clinic.

Client's ability to connect pain to times of increased anxiety helps to decrease denial and is the first step in resolution of the problem.

Use of techniques described may help to maintain anxiety at manageable level and prevent the pain from becoming disabling.

Positive reinforcement, in the form of the nurse's presence and attention, may encourage a continuation of these more adaptive behaviors by the client.

The possibility of organic pathology needs to be ruled out.

ASA and other nonsteroidal anti-inflammatory agents have minimal side effects and low addiction potential and are useful in treating episodic exacerbations of chronic pain.

Helps combat depression, may enhance sleep, reduce level of fatigue, and promote feelings of well-being.

Studies suggest short-term use may be of some benefit in treating neuropathic and neuralgic pain while other therapeutic interventions are initiated.

Level of repressed anxiety/physical symptoms may interfere with obtaining quality sleep, which has a negative impact on energy level and coping ability. Sedatives should not be used for longer than a 3-week period, as they eventually interfere with, rather than promote, sleep.

May be helpful to learn ways to manage residual pain on a long-term basis.

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### **NURSING DIAGNOSIS**

#### **May Be Related to:**

#### **Possibly Evidenced by:**

### **BODY IMAGE disturbance**

Severe level of anxiety, repressed

Low self-esteem; unmet dependency needs

Preoccupation with real or imagined change in bodily structure and/or function that is out of proportion to any actual abnormality that may exist

Negative feelings about body/self

Fear of negative reaction or rejection by others; change in social involvement

**Desired Outcomes/Evaluation Criteria—**

**Client Will:**

Verbalize realistic perception of bodily condition.

Express positive feelings about body.

Function independently and interact socially without experiencing discomfort.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Ascertain client’s perception of own body image. Acknowledge that disability is real to the client, even in the absence of evidence of organic pathology.

Information about the way in which the individual views self aids in choosing appropriate interventions. Denial of client’s feelings is nontherapeutic and impedes the development of trust.

Help client to see that image is distorted and out of proportion to reality of actual change in structure and/or function. Correct inaccurate perceptions in a matter-of-fact, nonthreatening manner.

Recognition that a mis perception/distortion exists is necessary before client can accept reality and reduce significance of impairment.

Encourage verbalization of fears and anxieties associated with identified stressful life situations. Discuss ways in which client may respond more adaptively in the future.

Verbalization of feelings with a trusted individual may help the client come to terms with unresolved issues. A plan of action formulated with assistance and at a time when anxiety is low may prevent later dysfunctional response by client.

Encourage and give positive feedback for independent self-care behaviors, while gradually withdrawing attention from dependent behaviors.

Lack of attention to maladaptive behaviors discourages their repetition. Positive reinforcement enhances self-esteem and promotes repetition of desirable behaviors.

**Collaborative**

Administer medications as indicated, e.g.:  
Antidepressants, e.g., clomipramine (Anafranil), or selective serotonin reuptake inhibitors, e.g., fluoxetine (Prozac).

These psychoactive drugs increase the amount of serotonin available for uptake by brain cells, which tends to lessen the individual’s bodily preoccupations and lifts their spirits.

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**NURSING DIAGNOSIS**

**SELF CARE deficit (specify)**

**May Be Related to:**

Paralysis of body part

Inability to see, hear, speak

Pain, discomfort

**Possibly Evidenced by:**

Inability to bring food from a receptacle to the mouth; obtain or get to water sources; wash body or body parts; regulate temperature or flow of water

Impaired ability to put on or take off necessary items of clothing, obtain or replace articles of clothing, fasten clothing, maintain appearance at a satisfactory level

Inability to get to toilet or commode (impaired mobility); manipulate clothing for toileting; flush toilet or empty commode; sit on or rise from toilet or commode; carry out proper toilet hygiene

**Desired Outcomes/Evaluation Criteria—**

Display willingness to participate in ADLs.

**Client Will:**

Demonstrate techniques/lifestyle changes to meet self-care needs.

Perform self-care activities independently within level of ability.

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**ACTIONS/INTERVENTIONS**

**RATIONALE**

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**Independent**

Assess degree of impairment; note level of disability as well as areas of strength.

Establishes client needs and identifies individual potentials.

Encourage client to perform ADLs to own level of ability. Intervene only when client is unable to perform.

Loss of function may be related to unfulfilled dependency needs. Intervening when client is capable of performing independently serves to foster dependency in the client.

Convey a nonjudgmental attitude as nursing assistance with self-care activities is provided. Remember that the physical symptom is real to the client and is not within the client's conscious control.

A judgmental attitude interferes with the nurse's ability to provide therapeutic care for the client, provoking defensiveness that blocks client's willingness to look at own behavior/dynamics.

Provide positive reinforcement for ADLs performed independently.

Enhances self-esteem and encourages repetition of desirable behaviors.

Encourage client to discuss feelings regarding the disability and the need for dependency it creates. Help the client to see the purpose this disability is serving.

Self-disclosure and exploration of feelings with a trusted individual may help client fulfill unmet needs and come to terms with unresolved issues, thus eliminating the need for maladaptive physical responses.

Involve family members in care at level of their ability/willingness.

Feelings of anger toward the client may interfere with ability to provide care in a therapeutic/nonjudgmental manner.

**Collaborative**

Refer to occupational/physical therapy, community resources/supports.

Involvement with these programs provides role models, enhances client's self-esteem, promoting ability to care for self.

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**NURSING DIAGNOSIS****May Be Related to:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—  
Client Will:****SENSORY/PERCEPTUAL alterations (specify)**

Psychological stress (narrowed perceptual fields caused by anxiety, expression of stress as physical problems/deficits)

Poor quality of sleep

Presence of chronic pain

Reported change in voluntary motor or sensory function (e.g., paralysis, anosmia, aphonia, deafness, blindness, loss of touch or pain sensation)

*La belle indifférence* (lack of concern over functional loss)

Verbalize understanding of emotional problems as a contributing factor to alteration in physical functioning.

Identify adaptive ways of coping with stress and community support systems to whom she or he may go for help.

Demonstrate recovery of lost function.

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**ACTIONS/INTERVENTIONS**

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**RATIONALE****Independent**

Identify gains that the physical symptom is providing for the client (e.g., increased dependency, attention, distraction from other problems).

Assist client with ADLs with which the physical symptom is interfering.

Allow client to be as independent as possible without focusing on the disability. Intervene only when client requires assistance.

Encourage client to participate in therapeutic activities to the best of ability. Do not allow client to use disability as an excuse for nonparticipation. Withdraw attention if client continues to focus on physical limitation. Reinforce reality as required while ensuring maintenance of a nonthreatening environment.

Encourage client to verbalize fears and anxieties. Help client recognize that physical symptom appears at times of extreme stress and is a way of coping with that stress.

Helps provide focus on “actual” problem, enhancing appropriateness of interventions and problem resolution.

Promotes general well-being, meets comfort and safety needs without undue attention.

Encourages client to begin to assume responsibility for self. Giving attention to the use of the maladaptive response reinforces secondary gain, such as dependency.

Gently confronting reality of client’s abilities while minimizing attention to problem helps client begin to accept own responsibility.

May be unaware of relationship between physical symptom and emotional stress.

Help client identify positive coping mechanisms that can be used when faced with stressful situations.

Explain/review assertiveness techniques and use role-play to practice use.

Identify SO(s), other support systems that can provide assistance to the client.

### **Collaborative**

Monitor ongoing assessments, laboratory findings, and other data.

Client has been accustomed to using maladaptive coping to retreat from reality and needs to begin to change to more realistic ways of dealing with problems.

Enhances self-esteem and minimizes anxiety in interpersonal relationships.

Satisfactory supports can help client cope with overwhelming stress.

Assures client that possibility of organic pathology is clearly ruled out. Failure to do so may jeopardize client safety.

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### **NURSING DIAGNOSIS**

#### **May Be Related to:**

#### **Possibly Evidenced by:**

#### **Desired Outcomes/Evaluation Criteria— Client Will:**

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### **SOCIAL INTERACTION, impaired**

Inability to engage in satisfying personal relationships

Preoccupation with self and physical symptoms; altered state of wellness, chronic pain

Rejection by others due to focus on self/physical symptoms

Preoccupation with own thoughts; repetitive verbalization about self/physical symptoms

Seeking to be alone; uncommunicative, withdrawn; no eye contact; sad, dull affect

Absence of supportive significant others(s)—family, friends, social contacts

Spend time voluntarily with others in group activities.

Interact with others without apparent discomfort.

Demonstrate interest in others, while discontinuing use of statements that focus on self/physical symptoms.

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### **ACTIONS/INTERVENTIONS**

#### **Independent**

Spend time with client after setting limits on attention-seeking behaviors. Withdraw presence if ruminations about physical symptoms begin.

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### **RATIONALE**

The nurse's presence conveys a sense of worthwhileness to the client. Lack of reinforcement of maladaptive behaviors may help to decrease their repetition.

Increase amount of time/attention given during times when client is not focusing on physical symptoms.

Describe client's interpersonal behaviors objectively. Emphasize how the focus on self/physical symptoms discourages relationships with others.

Assist client in learning assertiveness techniques, especially the ability to recognize the difference between passive, assertive, and aggressive behaviors and the importance of respecting the human rights of others while protecting one's own basic rights.

Encourage attendance in group activities after client is interacting appropriately in the 1:1 relationship. Accompany the client the first few times.

Provide positive feedback for any attempts at social interaction in which the client's focus is on others rather than self/physical symptoms.

This separates the person from the behavior and increases feelings of self-worth as unconditional acceptance is experienced by the client without need for the physical symptoms.

Client may not realize how own behavior is perceived by others/results in alienation.

Use of these techniques enhances self-esteem and facilitates communication and mutual acceptance in interpersonal relationships.

As a trusted individual, the nurse provides objective feedback about client's behavior in the group. Subsequent discussion and role-play on a 1:1 basis may help prepare client for future group encounters and may promote success with this endeavor.

Positive feedback enhances self-esteem and encourages repetition of desirable behaviors.

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**NURSING DIAGNOSIS****May Be Related to:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—  
Client Will:**

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**KNOWLEDGE deficit [LEARNING NEED] regarding  
condition, prognosis, and treatment needs**

Strong denial defense system

Severe level of repressed anxiety

Preoccupation with self and pain

Lack of interest in learning

Verbalization of denial statements, such as, "I don't know why the doctor put me on the psychiatric unit, I have a physical problem."

History of "doctor shopping" for evidence of organic pathology to substantiate physical symptoms

Lack of follow-through with psychiatric treatment plan

Verbalize understanding of psychological implications of physical symptoms.

Report relief from physical symptoms.

Demonstrate more appropriate coping mechanisms to employ in response to stress.

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## **ACTIONS/INTERVENTIONS**

## **RATIONALE**

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### **Independent**

Ascertain client's level of knowledge regarding effects of psychological problems on the body. Be aware of degree to which denial defense controls client's behavior.

Knowing what information the individual already has provides a base that is necessary to develop an effective teaching plan for the client. Strong denial system needs to be penetrated before learning can begin.

Assess client's level of anxiety and readiness to learn.

Effective learning does not take place when level of anxiety is moderate to severe. Client's narrowed focus precludes attending to external cues.

Explain purpose and review results of laboratory/diagnostic testing, as well as aspects of the physical examination.

Client has basic right to knowledge about care. Objective knowledge about physical condition may help to break through the strong denial defense.

Have client keep 2 separate records: (1) a diary of the appearance, duration, and intensity of physical symptoms and (2) a journal of situations that the client finds especially stressful.

Comparison of these records may provide objective data from which to observe the relationship between physical symptoms and stress. Guided therapeutic writing is also a useful tool for monitoring the client's safety and response to interventions.

Help client identify needs that are being met through the sick role (e.g., dependency needs, attention seeking, or cover-up for painful conflicts in life situation).

Client usually does not realize that the physical symptoms are fulfilling unmet needs. Recognition needs to be achieved before change can occur. Role-play can relieve anxiety by helping client anticipate responses to stressful situations.

Help client recognize and accept more adaptive means for fulfilling these needs. Practice through role-playing. Demonstrate/encourage use of adaptive methods of stress management (e.g., relaxation techniques, physical exercises, meditation, breathing exercises, autogenics).

These techniques may be employed in an attempt to relieve anxiety and discourage the use of physical symptoms as a maladaptive response. Additionally, exercise therapy need not be aerobic or intensive to stimulate release of endorphins and enhance client's sense of general well-being.

Incorporate occupational/recreational therapy activities in treatment plan to help client learn adaptive coping mechanisms.

Daily activities can provide opportunities to learn/practice specialized techniques for coping with stress (e.g., decision-making, problem-solving, housekeeping, art/plant therapy, bowling, volleyball, weight lifting).

Encourage participation in Outdoor Education Program, e.g., wall/rock climbing, hiking, caving.

Involvement in activities that challenge physical and psychological abilities can help the client learn to become more self-aware and confident and increase self-esteem.

Include family/SO(s) in learning opportunities, assisting them to understand underlying reasons for client's behavior.

Having understanding support from significant other(s) can help client to accept reality of situation and make required changes.

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**NURSING DIAGNOSIS****May Be Related to:****Possibly Evidenced by (Actual):****Desired Outcomes/Evaluation Criteria—  
Client Will:****SEXUAL dysfunction, actual/risk for**

Perceived or actual loss of bodily structure or function

Preoccupation with physical symptoms; total focus on self/chronic pain response

Fear of contracting a serious disease

Alterations in relationship with SO

Actual/perceived limitation imposed by condition

Change in interest in self/others; sexual indifference

Lack of pleasure/pain [dyspareunia] during intercourse

Inability to achieve or maintain erection

Desire to achieve greater satisfaction in sexual role

Identify underlying stressors that contribute to the dysfunction.

Discuss concerns/perceptions with partner.

Demonstrate techniques to control stressors.

Verbalize achievement of sexual functioning at a mutually desired level.

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**ACTIONS/INTERVENTIONS**

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**RATIONALE****Independent**

Obtain sexual history, including previous pattern of functioning and client's perception of current problem.

Determine pattern of drug use, including type, amount, and frequency of use.

Identify stressors in client's life. Explore correlation of stressful situations to onset of sexual dysfunction.

Be aware of pathophysiology that could negatively affect sexual functioning, e.g., hypertension, diabetes.

Provide education regarding sexual functioning and alternative methods of fulfillment, as client indicates need and desire for this type of information.

Identifies individual need(s) in order to focus therapeutic interventions

Certain types of drugs can interfere with sexual functioning, e.g., alcohol, tranquilizers, narcotics, antihypertensives, antidepressants.

Recognition and acceptance of psychological implications (progression beyond the denial defense) need to occur before positive change can be effected.

Organic pathology as an etiological factor needs to be considered in problem-solving when setting goals and identifying appropriate interventions.

Client may have misinformation about normal bodily functioning that may interfere with sexual fulfillment. Alternative methods may help to meet a need until desired level of functioning is attained.

Include SO in sessions as appropriate.

Input from client's sexual partner will have a significant influence on client's progress. The couple should be treated as a unit. An absence of mutual trust and unwillingness to discuss each other's needs interferes with the goals of remediation.

### **Collaborative**

Refer to appropriate resources, such as clinical specialist, professional sex therapist, or family counselor.

May require individuals with a greater degree of knowledge and expertise in this specialty area to achieve resolution of persistent problem(s).