Relating the Psychosomatic Viewpoint to Public Health Nursing

RUTH GILBERT, R.N.
Supervisor of Social Service, Psychiatric Service in the Community,
New Haven, Conn.

In recent years we have been able to bring ourselves to a broad concept of what can be called the psychiatric point of view and have made progress in relating this to our work as public health nurses. We did not always have this broad point of view both because the field of psychiatry and mental hygiene was, naturally, much less developed, and because we as nurses had not yet had time or experience to grasp the ways in which this point of view and body of information could be integrated into our nursing work. Until recent years psychiatrists were interested in precise diagnoses. We were all also spending a great deal of time—and probably having to spend it—with the help of the allied field of psychology, in recognizing and dealing with the more serious mentally defective, that is, the feebleminded or worse. In addition, in those days a great many people thought that "mental hygiene" consisted of a body of rules which could be learned, followed, and passed on to others who would then also follow them. Thus the world would shortly become a happier, more smoothly running place—in the eyes of those to whom these "rules" seemed good, at any rate.

Then we gradually learned better. As the result of a lot of hard work—investigation and treatment experience—it became apparent that in spite of individual differences, human beings, sick or well, are much alike under the skin with no sharp dividing line between the maladjusted and the "adjusted." We began to realize that those terms are to some extent sociological because the place and particular group in which an individual lives sets the standards for his behavior. We learned also that people’s behavior is not based on conscious, reasonable motives but is based in large part on unconscious motives, some of which can be clarified and understood by the individual himself and by others. We learned that diagnostic categories are not always precise or even of leading importance.

The public health nurse has learned that her tie-up with psychiatry is not alone for the purpose of recognizing major mental illness or intellectual inadequacy in her patients and securing appropriate help for these, though this continues to be important. She has learned that psychiatry can be of most help to her through aiding her to understand the feelings and resulting behavior of individuals, and therefore of families, so that she can gauge her work in these families accordingly, understanding better the differing needs of all these people and the methods of work which will be most helpful to each of them. Furthermore, the public health

* Presented before the Public Health Nursing Section of the American Public Health Association at the Seventy-third Annual Meeting in New York, N. Y., October 3, 1944.
nurse has learned to understand and use her own feelings and emotional reactions more accurately, and how to manage herself in relation to her patients. As illustration we can cite again the nurse's developing understanding of the so-called dependency relationship between herself and her patient. Years ago we were apt to foster such a relationship unthinking from a desire to "get things done" and to relieve symptoms of ill health as quickly as possible. When the evils of this were pointed out, we shied away from all dependency relationships with our patients. Now we are learning to individualize and to foster self-help when the patient is able to achieve this, but to accept dependency upon us by the inadequate individual who needs a dependency relationship temporarily or perhaps permanently.

Interestingly enough, we have learned our lesson sufficiently well through these years so that now we can begin to differentiate again between certain concepts and certain fields of work from the psychiatric point of view without losing sight of the whole field of human behavior. Some of these special aspects, within this larger field especially interesting to nurses, are, for example, the field of child development; at the other extreme, the better understanding of the aged. Psychiatry by itself is not responsible for this entire development. Psychiatry, psychology, physiology, sociology are increasingly making use of each other's findings and in many ways growing closer together.

Another example of a special emphasis within this broad framework is the material we are discussing this afternoon, namely that of psychosomatic relationships. We are considering the intimate tie-up of people's feelings—their emotions—with bodily symptoms and the balance of these two sets of factors. This is something in which public health nurses are interested, whether they include a "morbidity service" in their program which means that they spend considerable time in bedside nursing, or whether most of their time on duty is spent in direct health teaching with those presumably not ill.

The reason for the interest of those who do bedside nursing is obvious since they inevitably will find patients whose emotional difficulties are finding expression in bodily symptoms in the way which has been described to us by Dr. Dunbar.

Nurses who are not doing a bedside program also find an understanding of psychosomatic relationships helpful—better to say necessary. Dr. Dunbar has brought to your attention the immense group of the chronically ill, and has pointed out that it is our job to help to interrupt this illness, when possible, before it has reached chronicity. I think we might say that there is a still larger group of individuals in our population of which the chronically ill individuals might be considered as the core. These are the people who have a smaller measure of general good health and well-being than could be the case, but whose condition is not sufficiently acute to bring them to the attention of a physician except perhaps sporadically and who rarely have consistent help in their difficulties. In this army of people are many individuals whose emotional problems are bearing poor fruit in the form of a lesser degree of somatic symptoms than some we have been discussing, but still to a degree sufficient to keep them "ailing." I think "ailing" is the word for this kind of individual, and I am sure you all know numbers of persons of this kind, and have been troubled to know how they could be helped.

Children may well belong in this group but for the moment it is adults whom I have in mind. The picture which rises most clearly to my mind,
and I believe yours too, is that of a mother with a number of children in one set or another of difficult circumstances, never really sick, but never really well. She does her work with difficulty, she has no joy in it and little in her family, and she has one or another or a series of somatic symptoms which never can be quite pinned down. It is possible that this woman may belong to the group we are discussing.

In News Notes of the September, 1944, number of Public Health Nursing magazine appears a rewrite of an article, Highlight and Shadow published in the Maternity Center Association’s Briefs. The article described the successes we have had in cutting down the maternal mortality rate. It goes on to say that a number of forces are at work which still militate against the safety of mothers and new-born babies. One of these is designated as “the tragedy of the under par.” The article goes on to say, “... True health is positive. It is the abundance of physical and spiritual vitality which enables a person to get the most out of living. Health is not an end in itself, it is only a means to an end.

“Many a mother is dragging through life with a tired, under par, unwilling body. Her contribution to her home, to the care of her children is at low ebb. She is able to do the necessary things but life may be a burden. The tragedy is that so many of these miseries and ailments are preventable and curable. It is only when a physical or mental breakdown occurs ... that the usual health facilities of the community are marshalled to protect these women. Notwithstanding much big talk about the importance of preventive care—the bulk of community health service is really emergency sickness service. If we accept the concept of positive health—the best possible health for everyone—then communities must recognize more fully the importance of preventing, discovering early and treating disease.”

Time was, some years back, when many public health nursing organizations initiated a program of “adult health supervision.” This program never has seemed to me to go very well though and, naturally, I say this with some hesitation. One reason for this may have been that we became increasingly involved in our programs for children about whose care there was an ever-growing and really helpful body of information for our use. However, the lack of success of many of these programs was not entirely that our attention was drawn elsewhere. Our attention could not have been diverted if we had had more understanding of ways in which we would be helpful to adults.

Our knowledge of the health needs of adults is increasing, however. Probably the widest gateway by which public health nurses are again and with greater understanding entering the field of adult health education is industrial nursing which, of course, has had tremendous augmentation during the war. We realize that the health or illness of industrial employees often is not only a matter of the individuals but relates also to the well-being of their families. Many of these adult employees are parents of children. Since we know that the illness of adults who form the emotional environment of children is very significant in the development of the child, we see again that whether or no our special interest as public health nurses has seemed to emphasize work with children, our work with adults is an essential part of our program. We need, then, to work as accurately and as thoroughly as we can with the great group of “ailing” adults, some of whom undoubtedly are showing psychosomatic symptoms in the sense described.

What can we do for them? How much can the public health nurse be expected to grasp and use of the theory of psychosomatic medicine? Is this a time-consuming method of working which may also add to our already large case loads?
First, we can say—and with some thankfulness—that the ultimate diagnosis is not ours to make. This is the job of the physician. It is not an easy job, and much work remains to be done in the field of psychosomatic medicine.

We can, however, take the definite step, if we have not already done so, of accepting without reservation that this specific relationship between the emotional and the physical or physiological exists, and acquaint ourselves with the commoner patterns of this expression of difficulty. Dr. Dunbar has helped to clarify this for us. If we do so accept and add to our information, it means that we are able to shed any clinging shreds of scorn or perhaps merely of impatience with the individual whose source of difficulty may lie as much in his own feelings as in the virus he has acquired from outside himself. When we remember our own “nervous indigestion” or similar physiological symptoms when we have been confronted with a situation which alarms us, we understand better.

Second, I want to add further to the suggestions Dr. Dunbar has given us for working with these individuals by pointing out that we can still further sharpen up our powers of trained observation of our patients. And I want to emphasize this point and to spend most of our remaining time in discussing it.

It can be said first that nurses in general do a good job in their observation of patients. We as a group are rather dutiful people, prone to spend considerable time and effort in getting rid of our possible deficiencies. Our powers of observation are, on the other hand, one of our assets, and we can take pride in this and use it further. We are trained from the outset to observe the somatic symptoms of the patient precisely, and the better nurse we are, the more accurately and fully do we note those symptoms. Public health nurses in addition to noting such signs and symptoms are trained and experienced in observing the patient’s way of life. The phrase, “way of life” conveniently covers a big field. Examples of what we observe here are: type of employment, wages, reactions to employment; type of home, standards of housekeeping, standards of home-making (a very different thing); family relations including the recognizable capabilities and inadequacies of the various members of the family, the way they get on together, the way the children are trained, nurtured and are, or are not, given security, the goals an individual or a family may have, the peaks which he or the family as a whole has reached or the slumps into which they have fallen; as time goes on, something of the background of the individual. It is no mere manner of speaking to say that the nurse perhaps more than any other professional person acquires an intimate contact with the family which enables her to have much of this information. In some instances when her services are not desired, she does not acquire this information easily or perhaps at all. Also, when a public health nurse serves a very large rural area she cannot have the intimate personal contacts which develop between the nurse in an urban district and her patient. Nevertheless, basically it is true that the nurse knows or can know her patient’s way of life.

To state what I have just said more precisely, the nurse has carried over in her public health nursing work her skill in observation of the patient’s somatic symptoms to some degree of skill in observing three things, namely, the patient’s circumstances, the patient’s own characteristic adequacies and inadequacies, and third—a combination of the other two—the patient’s characteristic reactions and behavior.

This fits into our subject of psycho-
somatic relationships in the following way. All living might be described as a surmounting of obstacles. A successfully surmounted obstacle means that we have been big enough to "get over it." This depends on how big the individual is relative to the obstacle. The circumstances which surround the individual, some of these of course of his own creating, are his particular obstacle. Of these circumstances the nurse is able to observe a great deal that is of importance in understanding the reactions of the patient.

You have, of course, often watched a baby just able to walk as he approaches some ponderous object in his path—perhaps a big chair—which he cannot climb over in his present state of development, nor is he yet capable of knowing that he can move around the chair. He cries in angry frustration. So with the adult patient of whom we have been speaking. He is living along with the obstacle—not as clearly defined and obvious as the chair—which he does not know how or is not able to surmount. His response may be somatic symptoms since as a socially disciplined person he may repress the emotional explosion of the infant. Our point is, that to a considerable extent the nurse can observe both the patient and his difficult circumstances as she did the baby and the chair which blocked his progress.

I want to make briefly five points about the way in which these observations can be carried out if they are to be skilled, helpful ones.

In the first place, the nurse's study of the circumstances of an individual or family is best done as a series as far as this is possible. (One observation does not make a summary.) Even if a nurse returns to the same family only infrequently, she can seek to reinforce her knowledge of the same points previously observed. If we see on the occasion of one visit that a mother is embroiled in incompletely housework, with the familiar picture of confusion present, and with irritation apparent in her handling of small children; if we often find her with vague complaints of "stomach trouble," headache, backache, etc., for which she does not consult a physician; is this then true on our next visit? is it different in any degree and precisely how is it different? As you know, we may find that the circumstances we saw on the occasion of the first visit are characteristic; we may find that those circumstances were the exception. Repeated observation of the same facets of family life, if we are in a position to make them, give us a true picture. Naturally we do this, all of us, to a certain extent. But we could carry this out more consistently and purposefully.

A second point is allied to the above. There is great value in observation of an individual or family at other times than during crises. True, an individual handles a crisis in the way in which his whole life has prepared him to do this. But we know, for example, that many neurotic individuals may rise to great courage and effectiveness at a time of extreme danger or difficulty whereas that same individual when confronted with the daily smaller difficulties of living may be a burden to himself and others.

Third, a nurse cannot make accurate observations if she is at the time emotionally aroused herself. I remember a very good public health nurse who came into a home just after a small baby had fallen from his bed, and found the mother absent. She was frightened and angry at the apparent neglect of the baby. Her impression of the total situation she later found was not entirely just, and her relationship with the mother suffered because of what she said under stress of her own feelings when the mother returned.

Furthermore, a fourth point, we can
never forget that our observations may be colored by our own standards of individual behavior or family life, and so may be inappropriate to the situation observed and therefore an inaccurate basis for helping that individual. Perhaps this can well be briefly pointed up by the old couplet,

"I beat her; she beats me—
We love each other tenderly."

A fifth point relative to the observation of the patient's way of life has to do with the specific accuracy of our observation, and also with our recording of this. Let me give you an example of what I mean.

The nurse writes on her record regarding a home visit made because of an upper respiratory infection on the part of a child. TPR are indicated in the usual place on the record form. For the running record the nurse writes,

"Pt. being kept in bed. General care and throat irritation given and mother instructed in these. Apartment dirty, dishes unwashed, mother seemed tired and disheveled. Return visit in two days."

You will agree with me that the nurse missed a trick there—that either she did not observe accurately, or failing to realize the importance of this observation in understanding the situation and planning, did not sort out her impressions clearly. Because, on further discussion with the nurse who made this visit—and it was a "good" visit—one finds that the observation actually was as follows:

"Pt. being kept in bed. General care and throat irritation given and mother instructed in these. She handles equipment well, child reacts well to her. Three room apartment dirty, windows unwashed, corners not dug out and clothing stacked on chairs. Remains of breakfast are doughnuts and coffee. Mother looks thin, posture and color bad, hair dry, lacks upper dentures. Housedress torn as well as dirty. Mother said, 'I never get anything done.' Return visit in two days."

I hope you do not think that we have strayed from the subject of psychosomatic medicine in relation to nursing, because I do not think we have. We have been saying that since somatic symptoms on an emotional basis are the result of an individual's unsuccessful struggle with his circumstances, the nurse must put her best powers of observation to work on both the individual and the circumstances.

All right—now we have this careful, accurate information as the result of our observation. What are we to do with it?

Some of this material should be brought to the physician speedily and in as much detail as he will accept. How else is he to gain knowledge of it in many instances?

But this is also true: We shall have found that the process of observation and the process of treatment are not two separate things. The nurse finds that as she understands the situation better, at that time she and the family find ways of improving it, some of which may help a great deal, some a little. This is a cumulative and dynamic process which except in very difficult cases results in some progress if the nurse is resourceful. Often she need not rely solely on her own resourcefulness but can call on other community agencies when this is appropriate and when such agencies exist.

Again—still speaking of how the nurse shall use the results of her observation—here is a ticklish point which we can raise as a question but which each one of you will have to think through for herself. How far can the nurse take the responsibility of deëmphasizing somatic symptoms when her knowledge of the total situation indicates that emphasis on the somatic symptom by referral of the patient for physical examination may imprint the pattern of physical illness more deeply? I am referring here to patients not
already under the care of a physician and who belong to the "ailing" group described. Let me give you briefly a case in point and you can decide for yourselves whether you think the nurse proceeded wisely.

A public health nurse was called into a home by a young mother who had heard that the nurse could give help in budgeting, especially in buying food for a balanced diet. This woman's husband had been in the armed forces four months. He had taken all responsibility for buying during the five years of the marriage. There were three children. The mother complained of dizzy spells. The nurse noted that this dizziness always occurred in connection with some budget problem. Well, a good many of us become a little dizzy when we confront the budget. Seriously, however, what is the nurse to do about this dizziness? Should she at once suggest physical check-up? There is no family physician in this instance. Dizziness began after the husband went into the Army. Further inquiry led the nurse to feel that she would at least postpone suggestion for physical examination in order not to emphasize the somatic symptom while at the same time attempting to give all the help she could give—and get—regarding the family circumstances.

Two questions frequently are raised—or felt, though not expressed—about this more analytical way of working. First, is it not time-consuming? On the contrary, I think we may say with some assurance that it is time-saving. If you have a map, even though the map lacks some details, you get where you wish to go much more quickly than would be the case were you steering by more vaguely seen, though somewhat familiar, landmarks. In other words, precision gives our work direction and thus speeds it up. We make fewer unproductive, scattered visits when we are more keenly alive to the situation and what we are trying to do in it.

The second question often asked is: Does not this mean that the nurse takes on extra work—makes more visits—before she has, as we still sometimes say, "corrected" the problem situation? This, too, can be answered in the negative. We need to remind ourselves that we are sometimes justly accused of being perfectionists. "Correction" is a relative matter, and has limits. Granted the limitations on the nurse's time and on the ability of the patient to improve, within these limitations we can put our time to the best possible use.

One cannot and probably should not tie off a discussion of adult health in these days without specific mention of the returning men and women of the armed forces and the adjustment problems which will then confront us. However, it seems that for our purposes here at the moment we should not make a special category of these individuals. They seem to constitute a special category because their numbers are legion. Our degree of responsibility for these men and women depends somewhat on the stage of development of the area in which we work. Hopefully we need not assume the sole responsibility for solving or even steering problems of adjustment of men and women discharged from the armed forces. This is a community responsibility which is best assumed by coordinated community effort including businessmen, the legal profession, the religious leaders, and others, as well as physicians and the group known as welfare agencies of which we are one part. If such coordinated community activity is not under way in our community, I think it is our responsibility to aid in getting this in motion. It is inevitable, however, that we shall come in contact with many discharged veterans, some of whom will need the services of the nurse. Basically their problem is no
different from the situations we have been discussing. We shall need to observe them and their circumstances and the way they behave in these circumstances, in a manner no different from that described. True, their circumstances may often be unusual and poignant and related to war experience. But no two people have the same set of circumstances, be they civilians or members of the armed forces.

I want to turn now to one brief illustration of this same kind of situation in a different age group—namely the school age child. Having established to a certain extent some of the ways in which we as nurses are concerned with emotionally based somatic symptoms, we can use an illustration at this point to bring more of our case load into this same focus.

The small boy I have in mind was referred to a child guidance clinic by the school nurse in the large city school which he had been attending. He was 10½ years old at the time of referral during the summer and expected to enter the fifth grade this fall. The nurse in referring this child said that in recent months he had developed a series of fears and anxieties in regard to going to school, then with regard to going to Sunday School, and finally was afraid to leave his home except in the company of his mother. Along with this he had physiological disturbances such as vomiting and diarrhea. When first seen by the psychiatrist he appeared rather small for his age, friendly, but definitely tense and fidgety. He had a marked stammer. In response to a question he said that he liked school. He seemed to get on quite well with other children and had what might be called normal interests for a boy of his age in that he formerly did well at active games and wanted, when he grew up, to join the Navy and be on a P.T. boat. A series of interviews with this child and also psychological study were planned. The mother was much interested in having this done. She was worried about his fears and somatic symptoms but had few "complaints" to make about his behavior otherwise. He did quarrel excessively with his brothers and sisters. She was concerned, however, as to how to get him back to school this fall. Of this she said, "He will wait until the last minute and then go through what he did before—the nausea and diarrhea."

Psychological study showed this boy to be of adequate intelligence and ready for his fifth grade placement as far as school achievement was concerned. However, psychological study as well as interviews with the psychiatrist showed that this child seemed to feel misunderstood at home and dissatisfied with his abilities. He seemed afraid to stand on his own feet and still wanted to lean heavily on his mother.

The mother appeared at the clinic as tired and harried. Material from the school nurse's knowledge of the home brought the psychiatrist the information that she had for years managed her family of five children with the greatest difficulty, that she was over-precise in her housekeeping standards, and was never able to live up to these, that her husband was working long hours and was nervous and irritable. She had observed that the child had been somewhat lost in the shuffle in that, falling as he did in the middle of the group of children, he was neither baby nor older child. He had not been helped to take responsibility at home. In fact, as a supposedly somewhat sickly child, he had been protected from small household tasks. Yet his fumbling attempts to stay on as a baby were not well received by his parents either. He had always been a child whose stomach yielded up easily. Afraid, not ready to stand on his own feet, with the vomiting already "natural" to him, his pattern of somatic symptoms under pres-
sure of new situations was readily established. His stammering was also seen to be of emotional origin. Interpretation to the family and to the school; the successful meeting of the new situation at the clinic by this child over a period of time, gave him enough added security so that now he is able to take his hand out of his mother's. At the present time he is doing quite well in school and is not showing the symptoms for which he was referred to the clinic.

Carrying this discussion one step further in the chronological age groups, I would like to give you in closing one further illustration which has to do with an infant.

During the past summer a nurse went to a home in her semi-rural district used as a foster home by a state child-placing agency. The foster mother in this home was a warm hearted woman who had an imposing record of good care of infants, placed in her home by the state, who needed special care and "building up." A new foster child had come to this home since the nurse's last visit. She was shocked when she looked at the baby. He was five months old, resembled a new-born in size. His color was bad, he was emaciated and dehydrated. His movements were feeble. This child had come to the foster home from an institution where he had spent the five months of his life—an institution which had tried its utmost to bring this baby along to growth and vigor. Repeated physical examinations revealed nothing specifically wrong with this infant as a basis for his condition. There was no particular lack of tolerance of the formula on which he had been placed and which was still the ordered feeding in the foster home. The nurse returned to this home five weeks later after an absence when another nurse was in touch with the home. She did not recognize the baby. He was filled out, rosy, active. Here we undoubtedly have an example of a baby who was dying, and whose somatic symptoms were due to emotional starvation in a baby who could not cope with that deprivation. The foster mother had not changed the baby's routine, but she had obviously administered the routine as a mother to her child.

I give you this illustration, not because the nurse herself had a hand in working through this problem, but because it shows as clearly as any illustrative material I know the tie-up between the somatic and the psychic in this age group. When we have constantly in mind that the reactions of the adults we have been discussing stem in large part from the kind of nurturing and training experiences they have had as infants, we realize what an important job the nurse has in this connection. Probably you have read Dr. Margaret Ribble's *The Rights of Infants* which develops this material in relation to the new-born and infants in a highly specific way, and which is fresh and necessary material for every nurse.

**SUMMARY**

We have been discussing psychosomatic medicine as it relates to public health nursing in the following manner. We recognize this as the tie-up between the physiological and the emotional. Often we see the somatic symptoms first. As nurses we can benefit our patients by observing not only the somatic symptoms but the circumstances of the patient and family and their reactions to this to a certain extent on the basis of their own adequacy or inadequacy. This approach may be especially useful in working with the immense number of "ailing" adults who usually do not have consistent help. We can sharpen our observation of these patients. This process stimulates and directs our concurrent work
with patients, and reporting of our observations aids the physician. This approach is applicable to all our work. It is not an additional demand upon our time. On the contrary, it is a time-saver but it does call on our skill, resourcefulness, and our background of information.

---

**National Health and Welfare Retirement Association**

The formation of a National Health and Welfare Retirement Association, Inc., was announced in January by Gerard Swope, Chairman of the Board of the new corporation, who described it as a major advance in the field of social welfare. The Association is a non-profit organization created to extend retirement pensions and life insurance coverage to the workers in private, social, health and welfare agencies throughout the country who are not now covered by Federal Social Security.

Pointing out that these workers have pioneered many advances in health, child care, rehabilitation, and social legislation without thought of reward, Mr. Swope said that few of them had been paid in a manner which would permit them to retire upon reaching old age after their service to the community. To provide them with the equivalent of at least the minimum social security benefits which government and industry normally extend to the wage and salary earner is the goal of this Retirement Association.

The Association has recently been authorized by the New York State Superintendent of Insurance after several years of study by a committee of the National Organization of Community Chests. The study resulted in the formulation of a plan of reinsurance by a well known mutual life insurance company which guarantees the benefits of the plan. Under this scheme social, health and welfare workers may enjoy minimum old age security, enabling the agencies to continue to attract better grades of personnel. Under the plan employees of the participating organizations normally may retire at the age of 65, with the option of retiring after 55. Participants will be eligible to receive annuities for past service and for future service based on individual salaries. A death benefit amounting to approximately ten months' salary is provided for each participant during the initial years of the plan's operation. After the tenth year the death benefit will be equal to the accumulations of the contributions of the employer and the employee.

Employees are said to be able to continue their benefits even if they change their jobs, since membership in the plan can be transferred from one private agency to another or from one community to another. Active enrollment will begin in February. Organizations eligible to join the plan include hospitals, settlement houses, visiting nurse associations, family welfare societies, and health and welfare workers in all fields. Sixty trustees have been elected, including outstanding leaders of industry, welfare and civic affairs. The Association has its offices at 441 Lexington Avenue, New York 17, N. Y. Homer Wickenden is the new executive.