# Healthcare for cases of somatoform disorders in the prison population

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**ABSTRACT:**

This study sets out to make a worthwhile contribution to healthcare personnel working in the prison sector by providing theoretical and technical knowledge to enable them to better understand and care for people in prison who suffer from these disorders.

As far as we know, the cognitive integration of a descriptive and comprehensive model, bearing in mind a theory of the observed phenomenon acts as an emotionally constraining factor for the anxieties we suffer in the therapeutic relationship with our patients. Consequently we also wish to contribute with this study to improving the emotional resources of personnel working in a context as anxiety-provoking as is a prison, while also pointing out the risks inherent to any theory that might be used to conceal clinical realities.

**Key words:** Somatoform Disorders; Mentally ill Persons; Prisons; Hospitals Psychiatric; Symptoms Psychic; Mental Health Assistance; Psychiatric Somatic Therapies; Behaviour Therapy.

Text received: August 2009

Text accepted: May 2010

## 1. INTRODUCTION

Deprivation of freedom, among all relational factors entailing mental suffering - together with the emotional states which such deprivation gives rise to- is considered a significant risk factor for the development of mental disorders.

One of the most humanly characteristic emotional needs —which is also key for mental development— is the search for relationships and attachment. Within such a gregarious and sociable species, withstanding life's vicissitudes within the context of psychosocial integration or exclusion processes, shape up attitudes, relational patterns and emotional conditions which include all the intermediate forms encircled in relationships with other human beings. These could comprehend on the one hand, all those feelings concerning the expression of healthy psychic experiences-tenderness, attention, care as well as emotional states encouraging confidence, gratitude, hope, satisfaction or integration. On the other hand, emotional experiences where the relationship is lead by exclusion, rejection, denial and abandonment will give rise to a range of attitudes of hostility, distrust and hopelessness which are frequently found in situations of metal suffering.

We firmly believe that any care intervention with people deprived of freedom should take this peculiar emotional situation into account as it will be present throughout the assistance relationship and will be expressed by means of submission, self-aggression,

deception and manipulation, violence or a demand for care and attention.

It is widely known that therapeutic relationships lead by attitudes of neutrality, respect, interest, care and attention have an important beneficial power. Such attitudes, which form part of all good practices, should be even more present when dealing with people with a limited exercise of autonomy and independence, as it occurs in the setting of prison healthcare.

If any attempt to comprehend psycho(patho) logical behaviors should consider its emotional nature, the analysis of the setting where such behavior is developed is even more necessary in order to establish genetic hypothesis, institute interventions and predict prognosis.

According to the contributions of dynamic, cognitive and systemic psychopathology, the setting is considered as an absolutely necessary element for any attempt to comprehend disruptive behaviors. It is also regarded as a pathoplastic factor which has an influence on the presentation of clinical symptoms, so that the same patient can present different symptoms depending on the healthcare setting where he/she is attended (primary care, hospital, …). We also know that the setting can act as a potential risk factor. We therefore believe that a psychopathological approach to the description of the prison emotional setting must be done, to some extent, due to its particular nature, so that we are able to integrate its character, its "culture".

## 2. WHAT IS SOMATIZATION?

Somatization is a syndrome of nonspecific physical symptoms that cannot be fully explained by a known medical condition and that is associated to substantial psychological impairment[1].

Somatization is a common phenomenon which does not inherently entail a clinical problem. A study on 14 frequent symptoms carried out on 1,000 patients in a primary care setting revealed that 74% of them had no medical explanation [2]. **Transitory somatization** can occur as part of an acute response to a great variety of significant life events. The term **somatoform disorder** refers to a situation of chronic somatization entailing significant deterioration of the person's functioning.

Bearing in mind a comprehensive view of the disease (see Figure 1), we must always take into account the existence of psychogenetic components and triggering stressors.

**Psychosomatic medicine** would deal with the study of the factors determining the appearance of a disease, especially of those diseases which have been traditionally associated to them as far as their etiology is concerned (peptic ulcer disease, Crohn's disease, ulcerative colitis, irritable bowel syndrome, migraine, hypertension …).

But yet there is a group of patients in whom frequent physical symptoms occur but an accurate disease is not discovered (there is a lack of exploratory and analytical evidence as well as of other complementary testing). Psychogenetic factors and environmental stressors are then pointed out as the main causes for the disease.

The particularity of these patients is that despite thorough explanations concerning the lack of evidence supporting a specific disease, they are not reassured and frequently pursue further consultation for the same problem. It is also characteristic that they find it difficult to relate their symptoms to some existing psychic impairment or a determined affective trauma.


Figure 1. López Sánchez. "Terapias de apoyo en pacientes psicosomáticos". Mirando personas. Granada 2004.

As far as our relationship with physicians developing their job in detention facilities, we know that inmates frequently present physical symptoms with no further evidence of a disease, entailing strong feelings of impairment and frustration. This is a highly prevalent concern in primary care settings – its prevalence has been estimated to be 9.2% (2), but it is thought to be even higher in detention

facilities due to the high prevalence of personality disorders (some studies reveal a comorbidity rate with personality disorders of around 62.9)[4] and due to high levels of stress exposure found in this setting. In a study on the analysis of demand in the facilities of Puerto I and Puerto II, a frequency of 18% was established[5].

## 3. CLASSIFICATIONS AND DIAGNOSTIC CRITERIA

Somatoform disorders were initially considered as provisional by the DSM-II, a consideration which the DSM-IV and the ICD-10 have preserved, yet with a greater validity that initially pretended.

The defining feature is "physical symptoms suggesting a physical disorder for which no organic cause is found or can be proved by means of known physiological mechanisms and for which there is a strong evidence or presumption of underlying psychological factors or conflicts".

There are several problems concerning the general concept of somatoform disorders:

- There are no clear operative definitions for the general category.
- Some types (particularly hypochondriasis and somatization disorders) are so lasting that they could be classified as personality disorders.
- Criteria are senseless for those cultures which do not share the Western presumption of the separation between the body and the mind.
- They have a high comorbidity with anxiety and depression.

We will initially describe the classification suggested by the IDC-10. We believe this is necessary to count upon a category work scheme which can be limited when applying it to everyday patients.

It includes the following disorders in the group of somatoform disorders (F45):

**SOMATOFORM DISORDERS**

| |
|---|
| Somatization disorder |
| Undifferentiated somatoform disorder |
| Hypochondriacal disorder |
| Somatoform autonomic dysfunction |
| Persistent somatoform pain disorder |
| Other somatoform disorders |
| Somatoform disorder, unspecified |

Table 1. Common symptoms in somatization disorder

| Systems | Symptoms |
|---|---|
| Gastrointestinal | Vomiting, nausea, flatulence, bloating, diarrhea, food intolerance |
| Neurological | Amnesia, swallowing difficulty, hoarseness, hearing impairment, blindness, blurred vision, muscular weakness, pseudo convulsion, micturition problems |
| Reproductive | Dyspareunia, dysmenorrhea, irregular menstrual cycles, hypermenorrhea, vomiting throughout pregnancy, stinging sensation in genitals |
| Cardiopulmonary | Breathing difficulties at rest, palpitations, chest pain, dizziness |
| Pain symptoms | Diffuse pain, limb pain, backache, joint pain, micturition pain, headache |

Diagnostic criteria for the somatization disorder:

**TRASTORNO POR SOMATIZACIÓN**

**SOMATIZATION DISORDER**

A. A history of at least two years complaints of multiple and variable physical symptoms that cannot be explained by any detectable physical disorders. (Any physical disorders that are known to be present do not explain the severity, extent, variety and persistence of the physical complaints, or the associated social disability). If some symptoms clearly due to autonomic arousal are present, they are not a major feature of the disorder, in that they are nor particularly persistent or distressing.
B. Preoccupation with the symptoms causes persistent distress and leads the patient to seek repeated (three or more) consultations or sets of investigations with either primary care or specialist doctors. In the absence of medical services within either the financial or physical reach of the patient, persistent self-medication or multiple consultations with local healers must be present.
C. Persistent refusal to accept medical advice that there is no adequate physical cause for the physical symptoms, except for short periods of up to a few weeks at a time during or immediately after medical investigations.
D. A total of six or more symptoms from the following list, with symptoms occurring in at least two separate groups:

Gastrointestinal Symptoms:

1. Abdominal pain
2. Nausea;
3. Feeling bloated or full of gas
4. Bad taste in mouth, or excessively coated tongue;
5. Complaints of vomiting or regurgitation of food;
6. Complaints of frequent and loose bowel motions or discharge of fluids from anus;

Cardiovascular symptoms:

7. Breathlessness without exertion;
8. Chest pains;

Genitourinary symptoms:

9. Dysuria or complaints of frequency of micturition;
10. Unpleasant sensations in or around genitals;
11. Complaints of unusual or copious vaginal discharge;

Skin and pain symptoms:

12. Complaints of blotchiness or discolouration of skin;
13. Pain in the limbs, extremities or joints;
14. Unpleasant numbness or tingling sensations

This definition of somatization disorder intends to distinguish between this disorder and persistent pain (and therefore defines the symptoms as malaise) as well as conditions with prevalent autonomic dysfunction. Moreover, hypochondriasis is defined as a different entity.

We believe that it is clinically closer to establish a series of variables providing some dimensionality when diagnosing somatoform disorders. These would be the following:

1) Quality of the symptom: ranging from pain prevalence to neurovegetative symptoms.
2) Affected systems: affection of one or more systems (respiratory, digestive, cardiovascular, neurological, reproductive system).
3) Temporary evolution: ranging from the acute presentation (frequently within a reaction to a specific experience) to more chronic expressions.
4) Hypochondriasis: ranging from concern about the symptom to irrational belief of suffering a serious disease.
5) Primary-secondary: as the expression of another psychiatric disorder or not.

Along with this line of thought, Kirmayer and Robbins [6] refer to three overlapped yet conceptually different presentation patterns:

1) **Functional somatization**: high levels of somatic symptoms, medically unexplained by means of multiple physiological systems.
2) **Hypochondriacal somatization**: featuring corporal concern or fear of disease beyond what is expected due to a proven physical disease.
3) **Presentation somatization**: predominant or exclusive somatic presentation of a psychiatric disorder.

## 4. DIFFERENTIAL DIAGNOSIS

### Nonpsychiatric medical conditions

Diagnostic uncertainty is a frequent handicap when dealing with somatoform disorders, mainly due to the possibility of uncommon presentations of defined medical conditions with which we are not very familiar. There are many conditions which can lead to diagnostic mistakes concerning somatoform disorders, amongst which the following are outstanding:

- Multiple sclerosis
- Porphyria
- Epstein-Barr infection
- Systemic autoimmune diseases
- Endocrine disorders

### Psychosomatic disorders

Organic disorders classically related to psychological factors must not be mistaken with somatoform disorders, as they entail alexythimic personality or feature structures, operatory personality, etc. There is a proven impairment for such disorders affecting both emotional experiences and associated functioning disorders. There are a series of diseases for which a strong psychic component has been proven to contribute to their development (see Table 2).

### Conversion disorders:

Conversion symptoms are mainly expressed by means of the voluntary motor sensory system and there is a symbolization of an idea, an impulse or an unconscious affect.

### Factitious Disorders

Symptoms or injuries are deliberately presented in order to play the patient role and take advantage of the benefits this entails. They pursue continuous invasive explorations, and even surgery-hospitalization is continuing. They usually are familiar with medical terminology and can verge upon *pseudologia fantastica*.

Table 2. Classic Psychosomatic Disorders

| |
|---|
| Peptic ulcer disease |
| Crohn's disease |
| Ulcerative colitis |
| Chronic pancreatitis |
| Coronary disease |
| Hypertension |
| Paroxysmal supraventricular tachycardia |
| Collagenosis |
| Eczema |
| Baldness |
| Psoriasis |
| Hives |
| Bronchial asthma |
| Hyperthyroidism |
| Diabetes mellitus type 2 |
| Sudeck's Syndrome |
| Migraine |
| Neuralgy |

### Simulation:

The beneficial outcome is not derived from the role of patient but from something external and more specific, such as avoiding judgements or compromising situations or obtaining determined exchanges. One of the most frequent situations within detention facilities is the simulation of psychiatric symptoms to obtain benzodiazepines. The simulation of somatic symptoms is usually made due to nurse or hospital transfer.

## 5. CLINICAL MANAGEMENT OF SOMATIZATION

The great majority of patients with unexplained symptoms require nothing but an appropriate medical evaluation and reassurance. Nevertheless, recurrent or persistent symptoms usually entail difficult management. Therefore, controlling an exaggerate demand of healthcare and preventing iatrogenesis are more realistic objectives than recovery.

1. **Active listening to the impairment expressed by the patient** by means of attention and an **empathetic attitude**, standing in someone else's shoes. If the patient feels that he/she is not being listened to or not paid attention to, frustration and symptoms will increase. We must tell the patient that we accept that the symptoms are true. It is a good idea to make questions or repeat what the patient is saying with different words (paraphrasing), as well as summarising what is being said. Sometimes they express vague and imprecise ideas, greater accuracy is then recommended.
2. **A quick yet appropriate exploration** of the affected system should always be done (eg. abdominal palpation when the patient refers digestive malaise). Even if somatisation is suspected beforehand, due to clinical features, and exploration is thought to be unnecessary, it is extremely important for the patient and it is part of the therapeutic effort ("recovery starts with an appropriate exploration"). Some time should be preserved to thoroughly comment on any negative results.
3. If there is evident secondary gain, **simulation should then be considered**. The relation will be pointed out without concurring in any confrontation. The most usual reaction is repeated denial of such gain and an increase relating symptoms in an attempt of manipulation. We will then need to stick to our previous appreciation and explain that there is no evidence of a disease entailing specific limitations or changes. The interview will then be finished.
4. When the existence of a somatisation disorder has been already established, with gains derived from the role of patient, generally concerning a dependant personality and operative thinking, the consultation will be completed by means of appropriate information on the disorder. We recommend that a comparison or metaphor be used so that the following message is understood: **not all corporal symptoms inherently entail the existence of a disease.** The body has a means of expressing itself through symptoms when mental suffering occurs and mainly through the somatic way with is constitutionally weaker. It is characteristic that patients show indifference when stress is pointed out as the source of symptoms. The ability of relating external circumstances to the inner status will depend of the intellectual capacity and introspection skills of the patient. This ability indicates a *somatization oriented support therapy*. In this case, the most direct stress source is that of imprisonment and what it entails. In the following paragraph we will refer to the intervention means recommended for these patients.
5. It is recommended that patients who over-pursue consultation agree to a scheduled calendar of periodic brief consultation. (for example one very 4-6 weeks) where complaints will be attended and the next indications will be followed:
   - Tests and diagnostic exams will be avoided unless indicated by the disease's signs
   - Unnecessary medication will be reduced
   - We will be patient, quick changes shouldn't be expected
   - The patient's attention will be focused on a single professional
   - Worsening or new symptoms must be understood as part of emotional communication
6. If depressive symptoms are observed somatisation can be a depressive equivalent. It is indicated to try **antidepressant** therapy, selective serotonin reuptake inhibitors (SSRIs) in the first place. It is recommended to start off by lower doses than the recommended ones to avoid initial secondary effects and progressively increase the dosage. If appropriate response occurs, therapy must be instituted for at least 6 months due to the high risk of relapse, and indefinite administration could be justified for as long as imprisonment takes

place. If inappropriate response is observed after one month of therapy, it will be switched to another SSRI or to a serotonin-norepinephrine reuptake inhibitor (SNRI). According to our experience, failure of the first therapy attempt entails a poor response to the rest of pharmacological strategies detailed in the guidelines for the treatment of resistant depressions. Antidepressants have proven to be somewhat effective in the treatment of primary hypochondriasis concerning atypical facial pain, even without depressive symptoms.

Tricyclic Antidepressants (TCAs) have proven more effectiveness evidence in the treatment of pain predominant symptoms than SSRIs.

7. If there is a strong anxiety component, **anxiolytic** agents are then indicated, and if there is muscle contraction, of muscle relaxants. The problem frequently found in this setting is the coexistence of addiction problems, which could lead to an escalated demand of the dosage on account of the patient. In these cases, alternative therapeutic agents would be indicated: gabapentin and pregabalin. Nevertheless, for anxiety disorders antidepressants are also indicated: SSRIs in the first line and according to the same scheme as with depression. Benzodiazepines are highly efficient for digestive somatisation (irritable bowel syndrome) and chronic use is frequent among patients.

## 6. INTERVENTION MEANS

We consider that any technical intervention- whether indication of psychoactive drugs or cardio-respiratory exploration- should create an emotional setting capable of restraining the aforementioned paranoid anxieties inherent to the setting, by means of a "good care" which should lead all human relationships; even more in a healthcare environment.

A "therapeutic environment" should be attempted, emotionally comfortable and by promoting and implementing respect attention and empathetic care.

Relaxation techniques, whether individual or collective, have been implemented with a good response in Primary Care settings as part of the common treatment of this type of disorders. These techniques should contribute to improve care provided in detention and correctional facilities; the strategy, which could be named as: "relaxation on exchange of psychoactive drugs", is already being implemented by Mental Health teams and a good response has been achieved.

Cognitive behavioural therapy is a feasible and efficient treatment. The more outstanding are those proposed by Goldberg and collaborators [7],

Also known as reattribution therapies and based upon the patient's transformation of the physical attribution concerning a corporal sensation into a psychological attribution. There are a series of intermediate steps proposed for this change. We have somewhat referred to these therapies in the previous paragraph concerning the clinical management of somatization.

Moreover, "Expressive Therapies" by means of painting, drawing, modelling, etc enable the spontaneous and cathartic expression of mental contents which can further encourage establishing a therapeutic dialogue about what is being expressed. These have proven useful in the treatment of somatoform disorders; the implementation of such techniques can be made both individually and on a collective basis for later group analysis.

The development of expressive corporal playschemes and sport activities – ranging from soccer to chess- both individual and collective, on a regular basis, enhance a satisfactory relation towards the body and encourage a better development of the abilities of refrain and delay.

Participation in reading and debate groups, supervised outings to concerts, exhibitions, civic acts... contribute to improve the "awareness", a basic therapeutic objective when dealing with these disorders.

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