SOMATIC NEUROSIS IN MIDDLE-AGED HINDU WOMEN

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SUMMARY

Somatization in neurotic disorders was noted as a significant complication in their lassification. Besides being an aspect of other neurotic disorders somatization becomes primary and chronic neurotic problem running true to type for several years in some atients. Recent evidence indicated that the syndrome "Somatic Neurosis" occurs not nly in Muslim women but in middled-aged women of other communities too. A group of 0 middle-aged women with somatic neurosis were compared with an equal number of ge-matched Neurotic Depressive patients. The former had significantly lower scores on Hamilton's Rating Scale for Depression and higher scores on the Intrafamily Interpersonal rust Scale. The groups, however, did not differ on Srole's Anomia scale scores. It was rgued that the good expressed interpersonal trust with specified family members in ontrast to the high anomia indexes, a particular dynamic in the family. The study points o the need for further study of this condition.

INTRODUCTION

It has been shown that the classical symptom-based typology of neurotic disorders 4, 8) is inadequate when transplanted in non-Western cultures (9). In an early paper on his topic Kleinman (9) illustrated the powerful shaping influence of culture on illness sing somatization among Chinese depressives as an example. It is clear not only that lepressive disorders present much more commonly with somatic symptoms (11) but hat neurotic disorders in general are somatized with a high frequency (1). The vast najority (88%) of a sample of patients presenting with somatic symptoms at the out- atient department of the National Institute of Mental Health and Neurosciences in Banga- ore, India, were found to be neurotics. Guatam (3) also noted that Muslims and women had significantly higher frequency of somatic presentation. The chronic neurotic syndrome of nultiple somatic symptoms seen in middle-aged Muslim women – "Somatic neurosis" - was briefly described by Janakiramaiah and Subbakrishna (6). It is now known that his syndrome is not confined to Muslim women. Over the years it has been increasingly ealised that the syndrome also occurs, but to a lesser extent, in other communities. ohn (7) found in his cross-sectional investigation of the phenomenology of neuroses, n urban and rural treatment settings, that the majority of 48 Primary Health Centre atients were female patients who were older than 36 years. Two-fifths had been given he diagnosis of "300.9 Neurosis NOS" which according to the International Classification f Diseases (12) is a category only to be used as a last resort. A similar proportion two-fifths) had an illness duration greater than two years. Moreover as somatic symptoms vere significantly more prevalent in the predominantly Hindu rural sample, this onfirms that the chronic polysymptomatic, undifferentiated "Somatic Neurosis" described arlier is found in groups other than Muslims.

The aim of the present study is to explore the interpersonal aspects of "Somatic Neurosis" in middle-aged Hindu women.

METHOD

Twenty Hindu women with "Somatic Neurosis" (6), in the age range of 35 to 50 years, attending the out-patient Department of the National Institute of Mental Health and Neurosciences, Bangalore, were compared with an equal number of age-matched Hindu women having an International Classification of Diseases (12) diagnosis of Neurotic Depression on the following: 1. Severity of Depression on Hamilton's Rating Scale (5); 2. the individual-group malintegration, as measured by the anomia scale of Srole (10); and 3. an intrafamily interpersonal Trust Scale. This Trust Scale was designed for the present study and is made up of 8 items (Primarily interested in his/her own welfare; There are times when he/she cannot be trusted; Perfectly honest and truthful with me; I feel I can trust him/her completely; He/she is truly sincere in his/her promises; He/she does not show me enough consideration; He/she treats me fairly and justly; and He/she can be counted on to help me), each of which was to be agreed or disagreed separately in respect of each of the significant others in the family. Each item was scored positively when affirmation of trust was given by the respondent. For testing the statistical significance of the differences between the two groups of patients an alpha level of .05 was adopted.

RESULTS

The Neurotic Depression group was significantly more depressed (mean = 24.8) than the Somatic Neurosis group (mean = 19.2) on Hamilton's rating scale ($t = 2.25$, $df = 38$, p .05). The duration of illness was, however, as expected, significantly longer (mean = 49.8 months) in the Somatic Neurosis group than in the Neurotic Depression group.

As the number of significant others varied considerably from patient to patient the mean score for them in respect of each patient was taken. The intrafamily trust scores and the anomia scores tended to dissociate in the Neurotic Depression group. Whereas both anomia scores and trust scores were high in the Somatic Neurosis group, only the anomia scores were high in the Neurotic Depression group. The groups did not differ significantly on anomia scores (with means of 3.5 and 3.4 respectively) while the Somatic Neurosis group scored significantly higher on the Trust Scale (mean = 4.8) than did the Neurotic Depression group (mean = 2.6) ($t = 2.7$, $df = 38$, p .05).

DISCUSSION

The findings support the view that somatic neurosis can be differentiated from neurotic depression by clinical methods and by the use of well-established psychological instruments. In the present sample Hindu patients with somatic neurosis were less depressed than matched neurotic depressives and somewhat less depressed than Muslim somatic neurotics reported on earlier (6).

An understanding of these cultural differences is important. Muslim patients were off medication at their first consultation whereas the patients in the present study had been taking some medicine or other. It is also possible that evident problems of poverty and overt inter-personal friction were more evident in the Muslim patients. It is o

terest that hysterical features were notable by their absence among the Hindu patients. onetheless the patients gave diffuse long-winded descriptions of their symptoms, and emed to link one symptom to another. Typically the patients admitted to giddiness/ :aviness of the head, burning sensations in various parts of the body, cold extremities ndered worse by touching water, generalized weakness and fatiguability. Most of ese symptoms persisted in some combination or other generally over the years. This)ndition of somatic neurosis is akin to the Somatization Disorder of DSM III (1) but :nnot be diagnosed so for two very important reasons.

Firstly, the disorder commenced after the age of 30, and secondly the number of mptoms complained of generally falls short of the required minimum of 14. The esent findings do however suggest that somatic neurosis is widely distributed. Its ilure to fit into official typologies may of course be a function of cultural variables in e distribution of commonly known disorders. We believe that somatic neurosis merits ore widespread recognition and that further research should be carried out in other areas.

The picture of good interpersonal trust given by the Somatic Neurosis group of ıtients in contrast to the Neurotic Depression group while having comparable levels of ıomia is interesting. Anomia as measured here is the fulfilment of the process of :socialization and indexes interpersonal malintegration. But this is in respect of people general and there is no hesitation in admitting to negative feelings towards them. The me seems to be carefully avoided when identified family members are brought into the cture. This appears to be an important indication of the covert interpersonal aladjustment and alienation from family people. It is by resigning oneself to the role nitations and by abdicating healthy role functions that peace of mind is gained. In ırticular decision-making is concentrated in the men folk. When the rearing of the)ung children recedes as an important responsibility, that little area of fulfilment shrinks. hen the constraints of interpersonal approvals and disapprovals become rigidly established ithin the family the assumption of a sick role serves to maintain the family homeo- atis as well as to offer a sense of importance to oneself in the family. There is no onder that these patients vigorously deny, till late in therapy, any emotional or inter- :rsonal problems. Once again these observations point to the need for further studies this area of interpersonal dynamics and the implications for the management of ıtients suffering from Somatic Neurosis

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