SOMATIC NEUROSIS IN MIDDLE-AGED HINDU WOMEN
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SUMMARY

Somatization in neurotic disorders was noted as a significant complication in their classification. Besides being an aspect of other neurotic disorders somatization becomes primary and chronic neurotic problem running true to type for several years in some patients. Recent evidence indicated that the syndrome “Somatic Neurosis” occurs not only in Muslim women but in middle-aged women of other communities too. A group of 20 middle-aged women with somatic neurosis were compared with an equal number of age-matched Neurotic Depressive patients. The former had significantly lower scores on Hamilton’s Rating Scale for Depression and higher scores on the Intrafamily Interpersonal Trust Scale. The groups, however, did not differ on Srole’s Anomia scale scores. It was argued that the good expressed interpersonal trust with specified family members in contrast 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 this topic Kleinman (9) illustrated the powerful shaping influence of culture on illness using somatization among Chinese depressives as an example. It is clear not only that depressive disorders present much more commonly with somatic symptoms (11) but that neurotic disorders in general are somatized with a high frequency (1). The vast majority (88%) of a sample of patients presenting with somatic symptoms at the outpatient department of the National Institute of Mental Health and Neurosciences in Bangalore, 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 multiple 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 realised that the syndrome also occurs, but to a lesser extent, in other communities. John (7) found in his cross-sectional investigation of the phenomenology of neuroses, in urban and rural treatment settings, that the majority of 48 Primary Health Centre patients were female patients who were older than 36 years. Two-fifths had been given the diagnosis of “300.9 Neurosis NOS” which according to the International Classification of 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 were significantly more prevalent in the predominantly Hindu rural sample, this confirms that the chronic polysymptomatic, undifferentiated “Somatic Neurosis” described earlier 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
interest that hysterical features were notable by their absence among the Hindu patients. Nonetheless the patients gave diffuse long-winded descriptions of their symptoms, and emed to link one symptom to another. Typically the patients admitted to giddiness/haviness of the head, burning sensations in various parts of the body, cold extremities rendered worse by touching water, generalized weakness and fatigability. Most of these symptoms persisted in some combination or other generally over the years. This condition of somatic neurosis is akin to the Somatization Disorder of DSM III (1) but cannot be diagnosed so for two very important reasons.

Firstly, the disorder commenced after the age of 30, and secondly the number of symptoms complained of generally falls short of the required minimum of 14. The present findings do however suggest that somatic neurosis is widely distributed. Its failure to fit into official typologies may of course be a function of cultural variables in the distribution of commonly known disorders. We believe that somatic neurosis merits 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 patients in contrast to the Neurotic Depression group while having comparable levels of anomia is interesting. Anomia as measured here is the fulfilment of the process of desocialization 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 picture. 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 particular decision-making is concentrated in the men folk. When the rearing of the young children recedes as an important responsibility, that little area of fulfilment shrinks. hen the constraints of interpersonal approvals and disapprovals become rigidly established within the family the assumption of a sick role serves to maintain the family homeo-

REFERENCES


