ORIGINAL ARTICLE

Culture and Somatization: A Psycho Social Perspective

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ABSTRACT

Culture shapes the perception and expression of distress. The occurrence of somatization varies across socio cultural groups and seems to be influenced by psychosocial factors. The study was conducted on somatization patients selected from outpatient unit of LGB Regional Institute of Mental Health, Tezpur, Assam. The data was collected in a period of three months from September to November, 2008. Subjects fulfilling the criteria of the study were evaluated for socio demographic variables and clinical presentation on semi structured proforma and thereafter the Bradford Somatic Inventory ¹, Satisfaction with Life Scale ², Multidimensional Scale of Perceived Social Support ³, WHO Wellbeing Index (1998) ⁴ and Perceived Stress Scale ⁵ were administered. Women have consistently been shown to report more somatic symptoms than men. Perceived social supports and perceived stress was found to have a significant positive correlation with life satisfaction. Wellbeing was found to be poor in the most of the patients and was found to have a significant positive correlation with perceived stress. Somatization is common in all ethno cultural groups and societies studied to date. The importance of demographics, psychosocial functioning, perceived stress, availability of social support was emphasized in the explanation of somatization tendencies among the subjects in the present study.

Key words: Culture and Somatization

INTRODUCTION

Culture and society plays a pivotal role in mental health, mental illness, and mental health services. Understanding

the wide-ranging roles of culture and society enables the mental health field to design and deliver services that are more responsive to the needs of racial and ethnic minorities. Culture is broadly defined as a common heritage or set of beliefs, norms, and values ⁶. It refers to the shared attributes of one group. Anthropologists often describe culture as a system of shared meanings. Cultural and social factors contribute to the causation of mental illness and it varies by disorder. Mental illness is considered the product of a complex interaction among biological, psychological, social, and cultural factors. The role of any of these major factors can be stronger or weaker depending on the specific disorder. The term “somatization” describes a presentation to communicate psychological distress in the form of physical symptoms. Somatic symptoms often occur in reaction to stressful situations and are not considered abnormal if they occur sporadically. Some individuals, however, experience continuing somatic symptoms, attribute them to physical illness in spite of the absence of medical findings, and seek medical care for them. Somatization may also co-exist with a medical disease, but when it does, the symptoms are out of proportion to the demonstrable medical findings. In the literature of medical sociology and anthropology, the term has been used to describe a pattern of illness behaviour, especially a style of clinical presentation, in which somatic symptoms are presented to the exclusion or eclipse of emotional distress and social problems ⁷.

Recent research, however, suggests that somatization is ubiquitous — although its prevalence and specific features vary considerably across cultures, the processes of focusing on, amplifying, and clinically presenting somatic distress are universal and somatic symptoms are the most common clinical expression of emotional distress worldwide^{8,9}. Epidemiological studies have used measures of somatization that are insensitive to culture-specific symptoms and modes of expressing distress. Kirmayer and Sartorius (2007)¹⁰ examined evidence that cultural and personal explanatory models can contribute to the pathogenesis, symptomatology, and chronicity of medically unexplained symptoms and functional somatic syndromes.

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In the contemporary world, culture involves flow of information, roles, and institutions that offer individuals multiple models for understanding illness. Beiser and Fleming (1986)¹¹ suggest that Southeast Asians are more likely to consider somatic symptoms rather than depressive feelings as legitimate reasons for consulting a physician. Samples from Southeast Asian clinics composed of depressed patients in the community but who also suffered concurrently from prominent somatic symptoms. An individual's report of bodily symptoms can be understood as encoding cultural models of sickness or idioms of distress. These cultural models supply individuals with a 'vocabulary' of symptoms; more than this, they also provide explanations for these symptoms and the associated suffering. As a culturally available idiom, somatic symptoms express discomfort and distress in ways that are intelligible within the individual's social milieu but may have different meanings to outsiders.

Somatization is a prevalent problem among individuals in cross-cultural transition and is associated with psychological distress; demographic characteristics such as gender, age, marital status, and duration of immigration; self-reported health problems; and immigrants' help-seeking behavior. Previous studies have suggested that the somatization phenomenon is influenced by demographic variables, such as gender, age, marital status, low educational and economic levels, rural residence, and minority ethnicity^{12, 13, 14}. Medical help-seeking in many cultures is organized around the presentation of bodily complaints rather than explicit mention of emotional disturbance or family conflict¹⁵. Thus the present study is aimed at assessing psychosocial functioning of the individuals with somatization. The study proposes to assess the social support, life satisfaction perceived stress and general wellbeing in individuals with somatization. It will further investigate the relationship between social support, life satisfaction and general wellbeing in individuals with somatization.

Aim and objective

- To investigate symptom presentation of individuals with somatization
- To assess the psychosocial functioning of individuals with somatization
- To assess social support, life satisfaction and general wellbeing in individuals with somatization
- To assess the perceived stress in individuals with somatization
- To investigate the relationship between social support, life satisfaction and general wellbeing in individuals with somatization

MATERIALS AND METHOD

The study was conducted on somatization patients selected from outpatient unit of LGB Regional Institute of Mental Health, Tezpur, Assam. The data was collected in a period of three months from September to November 2008. Samples of 63 subjects were selected.

Inclusion criteria

Subjects of both gender of age range between the 18 to 60 years and fulfilling the criteria of somatization disorder according to ICD 10 were included.

Exclusion criteria

Patients with any organic involvement, mental retardation, epilepsy and with co morbid mental disorder were excluded.

Tools used

1. Semi-structured clinical and socio-demographic data sheet
2. The Bradford Somatic Inventory¹
3. Satisfaction with Life Scale²
4. Multidimensional Scale of Perceived Social Support³
5. WHO (Five) Well-Being Index (1998 version)⁴
6. Perceived Stress Scale⁵

Procedure

Informed consent was taken from the patient as well as from the informant before eliciting relevant information and the nature and purpose of the study was explained. All the subjects were interviewed and were then assessed with the help of semi-structured clinical and socio-demographic data sheet. Thereafter, the Bradford Somatic Inventory¹, Satisfaction with life scale², Multidimensional Scale of Perceived Social Support³ (HO Wellbeing Index (1998)⁴ and Perceived Stress Scale⁵ were administered.

Analysis of data

The statistical package for social sciences (SPSS), version 14.0 was used for the analysis of the data of this study.

RESULT

The socio demographic characteristics of the subjects are summarized in table 1. Majority of the patients were female (93.7%), Muslim (93.7%), married (90.5%), illiterates (87.3%), house wife by occupation (93%), hailing from rural background (84 %) and belonging to nuclear family (66%). Majority of the patients were having income below 3000 (58.7%). Family history of mental illness was absent in the majority of the patients (93%). The mean age of patients was 42.4 years and duration of illness was found to be 3.8 year (table 2). Majority of the patients believe tension/stress (57.1) as the causation of their illness (table 4). The prominent symptom reported were severe headache (100 %) weakness (98%), abdominal ache (84%)

Table 1. Socio demographic profile of the entire sample

Variables		Subject	χ^2	df	p
		N=63			
Gender	Male	4	48.01	1	.000
	Female	59			
Education	Illiterate	55	83.24	2	.000
	Primary	1			
	Secondary	7			
Marital status	Married	57	41.28	1	.000
	Widow	6			
Occupation	Household	59	51.57	1	.000
	Agriculture	4			
Occupation of Spouses	Daily labour	18	29.77	4	.000
	Rickshaw puller	26			
	Agriculture	12			
	Housewife	3			
	Driver	4			
	Muslim	59			
Religion	Hindu	4	48.01	1	.000
Domicile	Rural	53	73.23	2	.000
	Urban	4			
	Semi urban	6			
Family type	Nuclear	42	7.00	1	.008
	Joint	21			
Monthly Income	Below 3000	37	27.81	2	.000
	3000-6000	23			
	6000-9000	3			

NS= non significant, S=Significant, df=degree of freedom

Table 4. Causations of the illness

Variable	Subject (n=63)	χ^2	df	p
Magical explanation	3	26.57	2	.000
Stress / tension	36			
No reason	24			

, hands or feet pins and needles (84%), heat inside the body (85 %), eyes painful or burning (85%), palpitation (85%), giddy or dizzy (88 %), head about to burst (77%), neck pain or tension (73%), stomach burning (79%), tired all the time (76 %)(table 3). Most of the patients have taken various modes of treatment consisting of doctors (77%) followed by homeopathy (46%), prayers (42%), Ayurvedic treatment (22%) and psychiatrist (16%) prior to coming to LGB Regional Institute of Mental Health

Table 2. Age and duration of illness

Variable	Mean	Std. Deviation
Age	42.4	5.9
Dur of illness	3.8	1.4

Table 3. Relative frequency of symptoms

The Bradford Somatic Inventory (BSI) Symptom	Subject (n=63)	(%)
1 Severe headache	63	100
2 Stomach fluttering	25	39
3 Neck pain or tension	46	73
4 Skin burning	21	33
5 Head constriction	43	68
6 Chest pain	23	36
7 Dry mouth	32	50
8 Misty vision	35	55
9 Stomach burning	50	79
10 Weakness	62	98
11 Head hot or burning	35	55
12 Sweating a lot	33	52
13 Chest pressure	27	42
14 Abdominal ache	53	84
15 Choking sensation	22	34
16 Hands or feet pins and needles	53	84
17 Total body ache and pains	41	65
18 Heat inside the body	54	85
19 Palpitation	54	85
20 Eyes painful or burning	54	85
21 Indigestion	49	77
22 Trembling and shaking	46	73
23 Urine frequency	14	22
24 Low back trouble	42	66
25 Stomach swollen or bloated	49	77
26 Head heavy	48	76
27 Tired all the time	48	76
28 Leg pain	36	57
29 Nausea	36	57
30 Head about to burst	40	77
31 Breathing difficulty	14	22
32 Tingling all over	37	58
33 Constipation	44	69
34 Bowel frequency	16	25
35 Palms sweating	31	49
36 Throat lump	15	23
37 Giddy or dizzy	56	88
38 Bitter taste	27	42
39 Whole body heavy	42	66
40 Urine burning	35	55
41 Buzzing in ears or head	27	42
42 Heart weak or sinking	25	38
43 Excessive winds or gas	28	44
44 Hands or feet cold	22	34

(table 5). Most of them found no improvement in their help seeking experience or on prior treatment (table 6). Family perceived social supports were high for patients, when compared to that of others areas of perceived social support (Societal perceived social support and Friends perceived social support) (table 7). In satisfaction with

Table 5. Mode of treatment prior to attending LGBRIMH

Variable	Subject (n=63) n(%)
Prayers	27 (42.9)
Doctors /physicians	49 (77.8)
Psychiatrist	12 (19)
Faith healing	11 (17.5)
Homeopathy	29 (46)
Ayur Vedic Medication	14 (22.2)
Meditation	1 (1.6)

Table 6. Experience of help seeking

Variables	Subject (n=63)	χ^2	df	p
Improvement in symptom	11	12.87	3	.005
Deterioration in symptom	13			S
No improvement	28			
Static	11			

Table 7. Mean and SD of areas of Perceived Social Support

Variables	Mean	S. D.
Family perceived social support	12.82	4.65
Societal perceived social support	9.39	4.320
Friends perceived social support	5.36	1.40

Table 8. Life satisfaction in the individuals with somatization

Life satisfaction	Subject (N=63) n (%)
Extremely satisfied	4 (6)
Satisfied	09 (1)
Slightly Satisfied	26 (41)
Neutral	03 (4)
Slightly dissatisfied	15 (23)
Dissatisfied	06 (9)
Extremely Dissatisfied	-

Table 9. Relationship between Perceived Social Supports, Life satisfaction and Perceived Stress

Variable	Perceived social support
Perceived social support	1
Life satisfaction	.688**
Perceived stress	.010

Table 10. Wellbeing in individual with somatization

Wellbeing (N=63)	Subject n(%)
Poor wellbeing	56(88.8)
Good wellbeing	7(11.1)

Table 11. Relationship between Wellbeing, Perceived Social Supports, Life satisfaction and Perceived Stress

Variable	Perceived social support	Life satisfaction	Perceived stress
Wellbeing	.031	.091	.332**

**P<0.001

life scale most of them were slightly satisfied (41%) with their life (table 8) and Perceived social support and Perceived stress has a significant positive correlation with life satisfaction at 0.01 level (table 9). Well being of somatization patients was found to be poor in most of the patients (88%) (table 10) and well being was found to have significant positive correlation with Perceived stress at 0.01 levels was found (table 11).

DISCUSSION

Culture influences symptom presentation and help-seeking behaviour. Culture influences many aspects of mental illness, including how patients from a given culture express and manifest their symptoms, their style of coping, their family and community supports, and their willingness to seek treatment. We found that in the present study, subjects belong to a particular place and location, majority of them are staying on the banks of river Brahmaputra, which is perennially flooded. This leads to encroachment of land and displacement of the population, adding stress in their life. These people staying near the river side are considered to be migrants, majority of them profess the

**P<0.001

faith of Islam, and have a unique style of dialect prevalent in the Mymensingh district of Bangladesh, and having rituals and preference of food as per their own tradition and culture. These findings suggest a high probability of somatization syndromes in immigrant patients and tendency to somatize more than other ethnic groups. Most of the people belong to lower socio economic status and are illiterate and poor. Our results indicated that majority of the female gender (93%) were suffering from somatization. Previous studies observed a significant increase of somatization among women and reported the possibility of physiological differences between males and females as a cause for it (Nakao et al., 2001). Accordingly, gender differences in brain function, hormones and reproductive processes were considered as possible factors related to the increased risk to complain for somatic symptoms in women. The occurrence of somatization varies across socio cultural group and seems to be influenced by environmental stressors. Barskey (1983) observed that somatization is more common among those who are less educated, of lower socio economic status, of rural background, and among ethnic groups that discourage the direct expression of emotional distress. In the present study also we found that majority of the patients were illiterate, belonging to rural background and belonging to lower economic status, facing financial difficulties and hardship and having trouble in affording basics of life to a large extent were suffering from somatization. Patients stated that tension/stress as the causation of their illness or problem, economic difficulty was listed as the major stressor in the present study. In somatization disorder, the body serves as a medium for expressing social and emotional distress. In fact, in order to deal with the accumulated stress, tension and conflict, family members will frequently activate the socially acceptable pattern of somatic complaints (Sluzki, 1987). In the present study also it was reported that most of the patients are not having satisfying family life in terms of family care and concern, adequate spousal relationship and need fulfilment. Perceived social supports and perceived stress was found to have significant positive correlation ($p=0.01$) with life satisfaction. Life satisfaction has been found to moderate the effects of stress on symptoms of psychological distress. Poor well being was found in the majority of patients and significant positive correlation with Perceived stress was found. Subjective well-being has been related to an individual's ability to deal effectively with stressful life circumstances. Patients who suffer from medically unexplained symptoms experience a lower level of life satisfaction (Noyes et al., 1995). Support from family and other social network may

have moderating or mediating effect on the stress experienced by the ethnic grouping. Family perceived social supports were high for patient, when compared to that of other areas of perceived social support (Societal perceived social support and Friends perceived social support) in our study. Ethnic groups are more likely to rely heavily on the social support of the extended family for assistance with personal problem rather than on friends, neighbour (Al-Isa, 1995). In the study of South East Asians refugees, it was found that having social support and confiding relationship tended to modify the effect of the migration trauma experiences on mental health. The results indicate that social support, particularly perceived social support from the migrant ethnic community plays a significant role in predicting mental health outcomes. Social support, social relationship and various psychosocial factors are associated with Perceived Quality of Life. Subjective QOL has been found to be associated with social support invariably among subjects in clinically stable phase or recovering from a severe episode (Michalak et al., 2006).

Limitation

Before concluding, some of the methodological limitation of this study has to be considered. First, the study had relied on the hospital population than the community sample. Second, the study was limited by a small sample size.

Conclusion

Culture shapes the perception and expressions of distress, variation in the expression of physical symptoms have been observed across cultures. The importance of demographics, psychosocial functioning, social support, life satisfaction, general wellbeing and perceived stress was emphasized in the explanation of somatization tendencies among social, psychological and cultural variables.

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RULES FOR THE AWARD

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1. All the members of Indian Psychiatric Society, Eastern Zonal Branch will be eligible to compete for the award.
2. The award will be for the best paper presented in the annual conference of Indian Psychiatric Society, Eastern Zonal Branch
3. The intending competitors will have to apply to the Chairman, Awards sub-committee with four copies of complete paper by a deadline to be fixed up by the Executive committee of Indian Psychiatric Society, Eastern Zonal Branch.
4. There will be a minimum gap of 45 days between the last date so fixed up and the corresponding conference.
5. All the four copies of the written text should be typed in double space on one side of paper. The first page of the text should contain only the Title of the paper, Names of the author and authors if any and the place of research. These particulars except the title should not be reflected anywhere else in the paper. The Chairman of the Awards Sub-committee will detach the first page and forward the remaining text to the judges.
6. The evaluation of the papers will be in two parts:
 - a) The written text: 75 marks
 - b) The oral presentation : 25 marks
7. The evaluation of written text will be by three judges as decided by the awards sub-committee. Each of the judges will evaluate the paper out of 25 marks and communicate the result to the Chairman confidentially. The sum total of the marks awarded by the three judges will form the written text marks in respect of the paper.
8. In theoretical evaluation the relevant review, objectives, methodology, presentation of data and discussion thereon will be adjudged.
9. The best three papers as per evaluation of written text will be considered for oral presentation in the Annual Conference of Indian Psychiatric Society, Eastern Zonal Branch. In case of tie, it will be decided by further comparative evaluation by the Chairman, Awards Sub-Committee.
10. The Chairman, Awards Sub-Committee will communicate to the selected authors about the date and time of presentation under intimation to organizing Secretary of the corresponding Conference.
11. The oral presentation of the selected three papers will be adjudged by three judges appointed for the purpose, by the Chairman, Awards Sub-committee from among those attending the Annual Conference. In case the Chairman, Awards Sub-Committee is not attending the Annual Conference, he can forward the result of written text evaluation confidentially to the Organizing Secretary who would act on his behalf.
12. The Oral presentation has to be made by the author or one of the authors, all of whom must be members of IPS, Eastern Zonal Branch. Time allowed for presentation will be 8 minutes to be followed by 2 minutes for discussion.
13. All the three judges of oral presentation will evaluate out of a total of 25 marks and the average will be taken for consideration. The awardee will be decided on the basis of total of written and oral evaluation.
14. All the papers so presented will be eligible for BPSS Award but for this only the evaluation of Oral presentation will be considered.