Chapter-VII

DISCUSSION
The results obtained in the present study supports many recent findings that predicts the fact that certain psychological correlates do exist in Somatisation disorder (SD) (Smith, Follick & Ahern 1985, Sharpe & Bass 1992). Significant differences were obtained in the State Anxiety (SA) and Trait Anxiety (TA) results of the three groups supporting previous studies (Merskey & Spear 1967, Tyrer 1976, Kellner 1988). Both the patient groups (SD and CD) showed higher levels of anxiety than the normal controls, with the SD group showing highest mean state and trait anxiety levels than the CD group. Spielberger (1966, 1972, 1985) considers anxiety to be a personality trait and appraisal of threat according to his model is a function of one's level of TA. The personality trait of anxiety leads a person to be anxious and illness prone. Spielberger's model also asserts that if an individual frequently experiences state anxiety than s/he has a strong trait anxiety as well. This model also supports Barlow's notion (1988) of the "anxious personality" – being more vulnerable to triggers that produce acute anxiety and consequent illness. Question may arise as to what could be the possible role of TA in somatisation? Since SD patients had the highest TA score it would be that their perception of distress is influenced by and large by the TA as because anxiety leads to behavioural changes which induces biochemical changes (Pfeffer 1984). Our present findings suggest that "anxious personality" predisposition is more vulnerable to SD, a contention which supports Barlow's notion (1988). Contradictions prevail in the findings that studied the association between
anxiety and somatic symptom manifestation (Arntz et al. 1991, Beidel et al.'s 1991) studies show that though anxiety is accompanied by an increase in the incidence of somatic symptoms and pain complaints, a clear empirical basis for the proposition that anxiety increases pain is not available.

When the role of another psychological factor i.e. depression is taken into consideration to deduce its influence in symptom somatisation numerous researchers (Katon et al. 1982, Viinamaki, Koskela & Niskanen 1993) have shown a consistent positive correlation between depression and somatisation (Betrus, Elmore & Hamilton 1995) studies reveal depressed people usually report significantly more physical complaints. In this study on the BDI scale both the patient groups obtained significantly higher scores than that of the normals. Again SD group showed significantly highest level of depression compared to the CD group. The present findings thus reveal that loading of depression has an impact on somatisation of symptoms, so much so that higher the depression higher is the manifestation of somatisation. Depression is claimed to be one of the most common causes of somatisation (Katon, Kleinman & Rosen 1982) and these SD patients adopt depression as a non-verbal message and communicates the psychological stress of depression in the form of physical symptoms (Ayorinde 1977) or it might be the fact that depression is present in their mental makeup and with the onset of the disorder, it gets fully incorporated in the mind-body system (Vassend, Watten, Myhrer & Syvertsen 1994). The
notion of a "somatisation trait" is given (Escobar 1987, Escobar, Burnam, Karno et al. 1987) and since this is prominent in these patients, they tend, when depressed, to report primarily physical symptoms. Even though correlational studies between depression and somatisation are common because they occur together in various proportions, those patients who complain mainly of somatic symptoms i.e. the SD patients mask the under-lying affective state that contributes to somatisation and this continues to remain a mystery for nonpsychiatric physicians who because of their training tend to focus on bodily complaints thereby labeling the disease to be "physical" in its genesis (Lipowski 1987). Psychodynamically, Pilowsky (1978) refers to somatisation as a defense mechanism, involving the turning away from unacceptable thoughts and situations towards a focus on physical problems and thus consequently the patient manages to deflect attention from current problems. The patient avoids blaming himself for such predicaments and so avoids some depression. Hence, seen this way, it seems that somatisation may have an adaptive function in protecting the patient from a more severe disorder. Though studies show depression to be an important precursor for the development of somatic symptoms, contradictions have been found in the studies undertaken. Some authors (Garron & Leavitt, 1983, Kerns et al. 1983 and France et al. 1987) show that psychogenic pain and depression exist as a separate phenomena and despite their capacity for mutual influence they are best seen as independent processes.
Since both the results on the STAI as well as the BDI reflect high scores in the patient groups with the SD group scoring highest, complications arise by the coexistence of anxiety and depression in a large proportion of patients (McNair & Fisher 1978, von Zerssen 1986). Hence no conclusions can be drawn as to which factor i.e. anxiety or depression is crucial to somatic symptom formation but it can be said that both these psychological factors have equal importance and have a key role to play in the etiology of somatisation disorder.

Though research work has been reported on the contribution of psychosocial stress, including life events, for the manifestation of somatic symptoms (Hönnmann & Schepank 1983) contradictions prevail in the reported findings (Rabkin & Struening 1976, Cohen 1979). In the Indian context (Kala et al., 1986 and Sharma et al., 1985) have correlated life events with psychological disturbances. The present findings reveal that both the patient groups experienced significantly higher stressful experiences than the normals. Interestingly, in the present study results show that in the SD group, stressful life experiences occur most in their lifetime, however in the past one year, the number of stresses experienced by them is the least. It is not the number of stressful events but the duration of life experiences which is most important in causing SD, an association between stressful life events and somatisation (Katon, Ries & Kleinman 1984) has been reported earlier with particular reference to severe life stress during early childhood (Reister, Tress,
Psychodynamically, this may be explained by the fact that the accumulated stress of the individual experiencing SD throughout his lifetime makes him satiated, hence the past year of stressful experiences seem to have a minimal effect, or it may be explained (Ford 1983) as a method of denial, a displacement or rationalisation or an attempt at conflict resolution instead of dealing with an intolerable stressful situation.

A certain amount of cognitive involvement seems to be present in the CD patients in the manifestation of somatic symptoms. The cognitive style of a somatic defence adopted by the SD patient is not utilized by a CD patient. In the CD group the conversion symptoms represents a compromise between the unconscious need to express ideas or feelings and a fear of expressing them (Engel 1970) and hence there is a constant participation of the patients and the symptoms are produced by a conscious enactment of ideas of illness (Hurwitz 1988).

Somatisation has been viewed differently by various research workers. In some cases somatisation is seen as a coping response to stressful life events (Ben-Sira, Aviram, Stern & Shoham 1978, Quartesan, Venturi, Moretti, Lupparelli et al. 1985), Leavitt et al. (1979) study reveal an association between social stress and non-organic pain. Another study show stressful life events to be a significant factor in the development and maintenance of somatic symptoms (Leavitt, Garron & Bielianskas 1979), whereas Leavitt et al's
(1979) study suggested that mere occurrence of stressful life events does not predispose the development of somatic symptoms. Since somatic complaints and pain are highly personal so there is a difficulty in objective analysis of the relationship between pain and other variables including significant life occurrences. Interestingly, Merskey & Spear's study (1967) reveal that of the various emotional disturbances, anxiety and depression have been found to be significant in precipitating pain syndrome, Garron & Leavitt's (1983) study reported the contrary. One of the reasons for such inconsistency in the reported findings is that all these studies were totally based on self-report index of the patients, which is subject to criticisms for obvious reasons. None of these studies employed objective physiological index of anxiety and depression.

In sum, our present knowledge regarding the impact of stressful life events, anxiety and depression onto somatic symptom manifestation is as yet unclear.

In the present study, the findings with regard to SMSP have indicated a lowered self-appraisal by the patients compared to NC. The patient groups showed low self-esteem. Question arises how self-esteem would be associated with somatisation? Low self-appraisal is an outcome of lack of affection, regards and severe punishment during the formative stage of life (Hamner & Turner 1990). People with low self-appraisal have need for social support, dependency (Celani 1976, Ezeilo 1983, DeSouza, Othmer, Gabrielli & Othmer 1985) with
a feeling of self-depreciation (Ninan & Kapur 1989, Lionells 1995). As their basic demands remain unfulfilled, they have no other way but to somatise their complexes and conflicts. However, contradictory findings are also available (Gannon & Pardie 1989, Schüssler 1992) where SD patients showed active, problem related coping behaviours and lower level of depression. This may be due to the fact that these patients possess a higher self-esteem than the others. The study reveals an internal inconsistency because it is apparent that within the patient groups there are differences in levels of self-esteem with some achieving a higher self-esteem and showing good adjustments while those possessing a low self-esteem exhibits adjustment problems. Intragroup differences have also been obtained for the CD group. The hysterics usually have dependency needs (Ninan & Kapur 1989) and they have an immature way of relating to others, they use their personality to convince others into serving their needs and are constricted in the means and mechanisms of independent self-striving (Lionells 1995). They communicate their helplessness through hysterical symptoms thereby facilitating an environment in which attention, support and acceptance is gained from others (Celani 1976).

The difference obtained between the three groups in self-perception is also reflected in their locus of control beliefs. Previous clinical studies on locus of control have concluded that pessimistic belief systems and external locus of control result in developing functionally based somatic disorders
(Wickramasekera 1986) and psychiatric disturbances generally have an external locus of control (Steinhausen 1982). The concept of external locus of control and its association to somatisation is tenable. Since external subjects usually use more emotion-directed coping behaviours, mistrust others, and project their failures onto others and use fewer problem-directed coping behaviour, they are the ones who seek social support and its unavailability results in depression and health problems (Schill, Ramanaiah & Toves 1982).

In the present study both the patient groups show a marked degree of externality. Externals are usually considered to be vulnerable to life stress and have high levels of neuroticism (Horner 1996). Since SD patients have low-self-appraisal it is likely that they would have a need for appraisal from others and that might make them perceive others as more powerful. Accordingly symptom manifestation in SD cases is perceived as due to others power. This once again suggests that SD patients lack “individual” control and somatisation of symptoms may be a reflection of their need for social support and dependency. Inspite of having similar levels of “individual” control, CD group on the other hand, attributes their symptom manifestation onto “chance” control which indicates that they too have a need for affection and sympathy from others, but with a desire to maintain their rigidity in controlling the situation the way they want it. Therefore the mode of operation in fulfilling the basic need appears to vary between the SD and CD groups.
The normal subjects showed internality in this study. Internal locus of control is considered to be crucial in decreasing depression and increasing life satisfaction. Internals are considered to be more task and achievement oriented (Landau 1995), possess an optimistic explanatory style and are less at risk and more able to prevent health problems (Peterson & DeAvila 1995). In this study as well the results indicate that the NC group has lower levels of depression and high levels of self-esteem, and that external locus of control beliefs and low self-concepts results in psychological maladjustments (Kliewer & Sandler 1992).

The psychological factors mentioned earlier affects the psycho-biological mechanism of the body as well (Sainsbury & Gibson 1954). Stress results in increased hypothalamic-pituitary-adrenal activity with a decrease in resistance and irreversible physiological damage (Selye 1950). Generally, in SD distressing emotions are associated with increased autonomic arousal (Flor et al. 1985, Kirmayer, Robbins & Paris 1994). In addition, these patients exhibit emotional instability and a tendency to suppress their affect (Pennebaker 1985). This suppression influences physiological functioning and leads to increased autonomic activity (Bucci 1997). The CD group on the other hand, use histrionic emotional display in addition to the emphasis of expression of affect (Lionells 1995). Wickramasekera (1986) also considers through his research studies that autonomic lability and consequent emotional instability to be a high risk factor to develop functionally based somatic disorders. Since the patients show a
proneness to be highly reactive to stressors (Zalewska 1995) and are also emotionally disturbed (Wise & Rosenthal 1982) they show higher arousal and greater susceptibility to illnesses and health problems compared to the normals. Hence difference revealed in the personality makeup of the various groups is thus reflected in their arousal levels also.