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Emotional Expressivity and Somatization Symptoms in Clinically Depressed Patients

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Abstract

Somatization might be defined as a process by which psychological, emotional pains and distress is expressed as physical symptoms without a known organic basis. This study aims to examining somatization symptoms among clinically depressed patients with White-American and Hispanic background. Participants diagnosed with major depressive disorder without psychotic features (DSM-V) completed self-report measures for somatization, depression, emotional expressivity (EE), and demographics. The findings suggest that patients low on emotional expressivity may tend to experience and report more bodily pains and complains than those who are emotionally expressive. No link between EE and depression was observed. Women scored higher on somatization then men in this study. In addition, Hispanics reported more somatization symptoms than their White American counterparts. The results of this study might contribute to provision of a clearer picture to distinguish between somatization syndrome and other actual physical conditions.

Keywords: Somatization; Depression; Ethnicity; Gender

Introduction

Somatization is defined as a tendency to experience and present psychological distress through somatic symptoms with no known organic basis, a phenomenon that can be spotted in diverse cultural groups reflecting a global distribution [1,2]. People with somatoform symptoms are usually first seen by general practitioners and primary care doctors who then possibly refer them to a psychiatrist. In a research conducted in a family clinic setting on a group of patients presented with pains and functional complaints, Maany [3] showed that they were subsequently diagnosed as depressed. The most common functional symptoms observed were fatigue, nausea, fainting and symptoms of irritable bowel syndrome. This might be supported by the evidence suggesting that social and physical pain sharing the same neurobiological and neural substrates [4].

Although, somatisation has been reported as common in all ethnic groups, the estimates of its prevalence have varied and the evidence for its underpinning factors has been inconsistent. The prevalence of somatization varies from 0.03% to 35% of all primary care attenders [2-7].

People with Eastern cultural backgrounds, however, tend to express emotional pains and distress through bodily complaints and ailments rather than through the use of psychological terms [8,9]. Hyphantis et al. [10] found that higher somatic symptom severity was associated with more introversion trait including features like being 'reserved', 'less talkative and sociable' and 'introspective'. The relationship between somatization and emotional expressiveness has been reported [11].

This study seeks to detect the level of somatization and its link with other factors such as level of emotional expressiveness and severity of depression in a primary care setting. We are also interested to examine somatization tendency varies across gender and ethnicity factors.

Method

Participants and procedure

The sample was composed of 81 outpatients from a primary care clinic (Community Health Centre, San Luis Obispo). A family physician interviewed participants using DSM-V diagnostic criteria for Major Depressive Disorder (MDD) [12]. They were included if they (a) were diagnosed with MDD without psychotic features, (b) had no comorbid mental disorders. They were given to an informed consent to read and sign, and were assured nonparticipation would not affect their treatment. A total of 97 patients were approached, of whom 81 (83.5%) provided the informed consent and agreed to fill out questionnaires.

The ethnicity of participants were White-American (n=46; 57%) and Hispanic (n=35; 43%). Table 1 depicts the demographic details of the sample in the two groups.

Measurements

To collect data, three self-report questionnaires and a demographic inventory were utilised.

The patient health questionnaire (PHQ-15) [13]

PHQ-15 is widely used as an open access screening instrument for somatization syndromes in different health care settings. The scale consisted of 15 items with 3-point Likert rating scale from 'Not bothered at all' (0) to 'Bothered a lot' [2].

The patient health questionnaire (PHQ-9) [14]:

This scale was used to measure major depressive disorder consisting of 9 items based on DSM-IV diagnostic criteria. A 4-point Likert scale from 'Not at all' (0) to 'Nearly every day' is used to rate each item [3].

Emotional expressivity scale (EES) [15]:

EES has been used to assess the extent to which people outwardly display their emotions. It consists of 17 items using a 6-point Likert rating from 'never true of me' to 'generally true of me' [1-6].

A demographic inventory including questions around ethnicity, gender, age, marital status and educational level were also used.

Demographic variables		White American	Hispanic
Gender	Male	19 (41.3%)	12 (34.3%)
	Female	27 (58.7%)	23 (65.7)
Age	18-34 yrs	17 (36.9)	24 (68.6)
	35-55 yrs	13 (28.3)	6 (17.1)
	Over 55 yrs	16 (34.8)	5 (14.3)
Marital status	Single	16 (34.8)	17 (48.6)
	Married/partnership	15 (32.6)	14 (40.0%)
	Divorced/widowed/separated	15 (32.6)	4 (11.4%)
Educational degree	High school/College	28 (60.9)	28 (80.0%)
	University	18 (39.1)	7 (20.0%)

Table 1: Descriptive data in white-american and hispanic groups.

Results

Demographic background of the sample

Table 1 indicates demographic details of two ethnicity groups. In both groups, females are more than males and majority of participants hold a high school/college degree. In terms of marital status, White Americans in this sample appeared to be more divorced, widowed or separated than the comparison group. Hispanic group were younger than White American.

Using SPSS 21, a 2×2 MANCOVA was performed with somatization (PHQ15) and depression (PHQ9) scores as dependent variables, ethnicity (White American, Hispanic) and gender (male, female) as between-group (fixed) factors, and emotional expressivity (EE) scores as covariate. The amount of somatization variation accounted for by emotional expressivity (EE) by the model (sum of squares) has increased from 218.29 to 364.10 units; this was trivial for the effect on depression (less than 2 units). Therefore, the results reveal that somatization is influenced by the effect of EE (F (1,76)=6.73, P =.01). Depression did not seem to be affected by EE (Table 2).

Moreover, after controlling the effect of EE, a significant main gender effect was obtained for somatization (F (1,76)=4.11, P=.04), that is, women (Mean=28.03, SD=5.58) tended to experience more somatization symptoms than men (Mean=25.58, SD=3.50) in this study. A marginally significant main ethnicity effect (F (1,76)=3.40, P =.06) were observed, showing that Hispanic patients reported higher level of somatization (Mean=28.46, SD=4.83) than their White American counterparts (Mean=26.07, SD=4.95). Figure 1 depicts levels of somatization across gender and ethnicity factors. No significant effect of either gender or ethnicity was found for depression.

Sources	DVs	SS	df	MS	F	Sig
Corrected Model	Somatization	364.10	4	91.03	4.20	.00
	Depression	112.35	4	28.09	.38	.82
Intercept	Somatization	57.90	1	57.90	2.67	.10
	Depression	450.45	1	450.45	6.08	.01
Emotional expressivity (EE)	Somatization	145.81	1	145.81	6.73	.01
	Depression	1.61	1	1.60	.02	.88
Gender	Somatization	88.96	1	88.96	4.11	.04
	Depression	17.73	1	17.73	.24	.62
Ethnicity	Somatization	73.57	1	73.57	3.40	.06
	Depression	8.71	1	8.71	.12	.73
Gender × Ethnicity	Somatization	.62	1	.62	.03	.86
	Depression	92.86	1	92.86	1.25	.26
Error	Somatization	1647.11	76	21.67		
	Depression	5633.87	76	74.13		
Total	Somatization	61493.00	81			
	Depression	65608.00	81			
Corrected Total	Somatization	2011.21	80			
	Depression	5746.22	80			

Table 2: MANCOVA details on dependent variables, covariate, and fixed factors.

Discussion

This study aimed to detect potential links between emotional expressivity (EE), somatization and depression. The findings support the idea that emotional expressivity influences somatization in clinically depressed patients. Specifically speaking, people low on emotional expressivity may tend to experience and report more bodily pains and complains than those who are emotionally expressive. We did not find any link between EE and depression. The link between somatization and emotional expressivity has recently been reported [11].

We also found that Hispanics compared with White American depressed patients showed higher level of somatisation. This effect might be owing to cultural differences. Research in clinical field show those patients with different cultural background experience different levels of somatization [9]. In some cultures, the person's response to a difficult life situation might be expressed in terms that are primarily physical [16-19]. There is evidence suggesting that people with Eastern cultural backgrounds are less emotionally expressive and tend to express their emotional pains through somatic symptoms [8,9]. It would seem that the more a culture encourages people to express and share their actual emotions, the less they tend to somatise and the less they present with somatic symptoms that may be traced to emotional

causes. On the other hand, the less a culture allows people to express their emotions and feelings freely and explicitly, the more they suppress such emotions and the more they show somatic (somatization) symptoms. With this in mind, one can conclude that an individual immersed in an Eastern cultural context expressing loss may go to a doctor and complain about 'physical aches and pains', such as headaches, backaches, muscular pains. In contrast, one from a Western background undergoing the same life event might present himself or herself as 'depressed'.

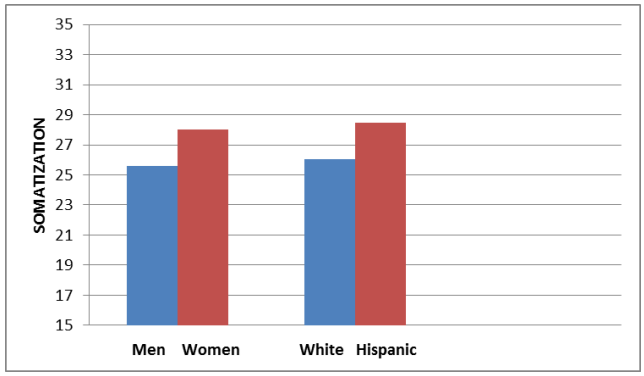

Figure 1: Mean somatization scores across gender and ethnicity groups.

One of the reasons that prevents people from expressing their mental illness (e.g., depression, anxiety etc.) and then seeking psychological help is stigma [20]. The stigma of this sort is prevalent in ethnic minorities that might be due to upholding social reputation or 'face saving' [9].

The present study, furthermore, reveals that women are more likely to somatise their emotional pains than their male counterparts. There is evidence that is in agreement with this finding. In a study in adolescents, Zwaigenbaum et al. [21] reported that high somatisers were more likely to be female. Ali et al. [22] found more somatic symptoms among women. However, there exists research evidence that challenge the effect of gender on somatization. For instance, Castro et al. [23] compared 137 males and 208 females, and concluded that gender does not have any significant impact on the expression of somatic symptoms.

Practitioners encounter a dilemma when seeing patients with physical symptoms that have no known organic basis. For instance, patients who attend primary care clinics for various reasons may present to their doctors a chronic multiple physical complaints that are not explicable medically. The symptoms may or may not be due solely to physical disease. Family practitioners working in a wide variety of health and welfare systems are familiar with this phenomenon. A large number of labels have been given to such patients by family practitioners that for instance include 'medically unexplained physical symptoms' and 'heart-sink patients'. Lack of distinction between somatization syndrome and other actual physical conditions might lead to misdiagnosis and subsequently malpractice. The results of this study might help practitioners to overcome this dilemma.

The conclusions drawn from the present study should be interpreted and generalized with caution due to its own limitations. Future studies need to take a larger clinical sample including comparable demographic subgroups in order to provide a more generalizable set of findings. To obtain more conclusive results on the impact of ethnicity on somatization, we need to test a range of depressed patients with diverse ethnical backgrounds. Currently authors are involved in a cross-cultural research on somatization and related factors in clinically depressed samples in the Middle East countries. The potential results would add to the present conclusion.

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