Indian J. Psychiat. (1981), **23** (1), 33—39

SOCIAL INTERACTION AND NEUROSES (THE FAMILY AND THE PRIMARY GROUP) : A PILOT STUDY[1]

B. B. SETHI[2], M. B. B. S., D. Sc. (Psych.) (Penn.), F. R. C. P., Dip. Am. B. Psych., F. A. P. A.
MUKUL SHARMA[3], M. D. (Psychiat.)
AJAI SRIVASTAVA[4], M. A.

SUMMARY

The present work examines the social interaction with the primary group of 30 neurotic patients and 30 matched controls. A comparison of the degree of family jointness in the two groups was also done keeping in view the nature of Indian family system and to find out the association, if any, it bears to social interaction. Evaluation instruments were Social Interaction Schedule (Henderson *et al.*, 1978) and Khatri's Scale to Measure Jointness of Families in India (1970). The findings indicate that neurotic patients do not have a deficient primary group, as far as the numerical size and the duration and type of interaction is concerned. However, the patients appear to be less active than controls in making contacts with members of their primary group outside their household. Further, our group of patients perceived their personal lives to be deficient in some respects. Patients and controls did not differ with regard to the degree of family jointness as measured on Khatri's Scale.

Recent researches in the field of social psychiatry have become particularly illuminating because of the development of refined techniques for evaluating the social environment. In this regard the work of Henderson and associates is particularly noteworthy (Henderson, 1974 ; 1977 ; Henderson, Duncan-Jones, McAuley *et al.*, 1978; Henderson, *et al.*, 1980). Their interest has been directed towards investigation of social bonds through the study of relationship between patients of non-psychotic disorders and their interaction with members of their primary group*. Primary group is considered important because it is a major source of 'support'; the presence of which acts as a buffer against adversity ; whereas a deficient support system probably contributes to neuroses. Some of the hypotheses proposed by Henderson (1977) were substantiated in a study (Henderson *et al.*, 1978) involving 50 patients with non-psychotic disorders and 50 matched controls where the findings indicated that neurotic patients have a deficient primary group in terms of numerical size and affective quality but not in the total duration of transactions.

Some studies from our country report an association between neuroses and nuclear family (Verghese and Beig, 1974 ; Veeraraghavan, 1978). Menon (1975) and Agarwal *et al.* (1978) found emotionally disturbed women belonged more often to nuclear families. Some reports have been in variance—with Dube (1970) and Vyas and Bharadwaj (1977) reporting preponderance of joint families in patients of hysteria. The controversy generates interest because traditionally Indian family has been considered a joint one, and should there be change from a joint family to a nuclear set-up and an association between neuroses

[1]Paper presented at the 33rd Annual Conference of Indian Psychiatric Society held at Ahmedabad in December, 1980.

[2]Professor and Head.
[3]Research Associate
[4]Psychiatric Social Worker.
Department of Psychiatry, K. G's. Medical College, Lucknow.

*Primary group is defined as being made up of all kin, nominated friends, work associates and neighbours (Henderson, et al., 1978).

and nuclear family, then various factors implied in the change need investigation from the point of view of etio-pathogenesis of neuroses. Possible factors may be related to the fact that a change from a joint to a nuclear family implies a reduction in a very vital component of an individual's social orbit and the observation that a joint family rather than a nuclear family is a better source of security and support to vulnerable individuals, especially in adversity (Sethi *et al.*, 1968 ; Sethi *et al.*, 1977).

It is apparent that the common theme of the two groups of work (Henderson's and family studies) is the concern with a commodity called 'support' and its source i.e. primary group in Henderson's work and family in Indian studies. It may be pointed out that since the primary group is defined as being composed of all kin, nominated friends, work associates and neighbours, the family automatically becomes a part of the primary group. The different spectrum of interest by the two groups of workers is probably a reflection of the cultural differences in the way we perceive our social milieu and the degree of importance given to various components of it. Family is the most important component of our social orbit, whereas in western countries it is probably not invested with such a severe emotion.

Finding a common base in the two groups of researches we decided to employ the Social Interaction Schedule devised by Henderson *et al.* (1978) and make an attempt to study the social interaction of neurotics in addition to their family jointness. The present is a pilot study and even though it has its own limitations, yet the results are revealing. The aims were:

(1) To study the social interaction in primary group of patients and matched controls.
(2) To find out if patients and controls can be differentiated on the basis of degree of family jointness (Khatri's Scale, 1970).

METHOD

Patient Sample : Comprised of a consecutive series of 30 neurotic patients diagnosed according to ICD-9 (WHO, 1977). Following were eligibility criteria :

(1) first contact with a psychiatrist in at least 12 months,
(2) currently being free of any medical disorder, and
(3) minimum education up to high school.

Control sample : was matched with the patient sample in the parameters of age, sex, occupation and marital status. As above, the minimum educational qualificaiton of each subject was fixed at High School. Thirty controls were obtained by requesting the patients to supply a list of their acquaintances closely matching them on the above parameters. Once a suitable person was obtained an interview was sought to detremine that the person had not suffered from a psychiatric disturbance within the past one year, or a medical disorder recently.

Evaluational instruments : were administered within 24 hours of first contact with the subjects and were as follows :

1. *The Social Interaction Schedule :* devised by Henderson and associates (1978) examines a person's interaction with members of his primary group and those outside it during the past one week. The schedule was suitably modified, abbreviated and adapted for our population. The schedule determines (i) the numerical size and composition of the person's household ; (ii) the respondents estimate of the number of persons he or she sees as 'good friends'. The interview then explores in some detail the respondent's interaction in the previous week with (i) his immediate household ; (ii) all others in his primary group, and (iii) persons outside the primary group.

Knowing that interaction between a person and others may be of different levels of intensity and affective quality, the in-

formation obtained through the interview is classified as follows :

Type 1 : Affectively intense interaction with one and only one other person. The latter may be within or outside the primary group.

Type 2 : may be of two forms : affectively intense interaction with more than one person ; or superficial interaction with one or more others, provided these are within the primary group, e.g. every day family interaction, talking with a group of kin or friends, or conversing superficially about inconsequential matters with a spouse.

The above information, which specifically attempts to find out the affective quality of a person's social transactions over the previous week is obtained by asking each respondent to recall the following :

(i) How many minutes or hours has been spent with each member of household, working systematically through each day of the week ?

(ii) The number and duration of contacts with persons in the primary group but outside the household, again for each day of the week.

(iii) Of the period of time spent with each person, what proportion was 'pleasant' (Type 1 and 2 positive) ; 'neither particularly pleasant or unpleasant' (Type 1 and 2 neutral) or unpleasant (type 1 or 2 negative).

The next stage of the interview identifies the respondent's principal attachment figure* and who else, in ranked order, are those persons with whom the respondent has affectional ties. For this the respondents were asked who of all persons they felt they needed most or to whom they felt closest and most attached. In descending ranked order, other attachment figures and their relationship to the respondent were recorded.

A series of questions then explored what comfort, help or support the respondent had obtained in the last one week from the principal attachment figures and from other attachments, including non-personal ones such as work, hobbies or religion. They were asked what, if anything they felt was missing from life at the moment, and whether this was of an interpersonal, personal or extrapersonal nature, that is, if it was in relationships with other persons, in some attribute of the subject himself, or in material such as housing or money.

2. *Khatri's Scale to Measure Jointness of Families in India* (1970) : was administered to the patients and controls. The scale consists of a questionnaire covering the following family variables : residence, pooling of income and financial help ; property and decision making. The results are scored and arranged in five categories : completely joint (I), very much joint (II), somewhat joint (III), slightly joint (IV), and not at all joint (V). The categories I and II fall approximately under the so-called joint family, category V corresponds to the nuclear type, and categories III & IV belong to the extended family (Venkoba Rao, 1973).

OBSERVATIONS

Table-1 compares the characteristics of the patient sample and the control sample and shows that they are well matched in the areas mentioned. No significant differences were found in comparisons of patients and controls on education, spouses' occupation, access to means of transport and channels of communication.

Table-2 shows the distribution of neurotic disorder according to ICD-9. Maxi-

*An attachment figure is one with whom the respondent has an affectionally close relationship. This is reciprocated to a greater or lesser degree. Strong affect, such as happiness or hostility, can be shared with such a person.

mum number of cases were of Anxiety State followed by Neurotic Depression and other categories.

TABLE-1—*Comparison of Patients and Controls on Matched Criteria*

		Patients	Controls
Age : (in yrs.)	upto—19	5	6
	20—29	21	21
	30—39	3	3
	40—49	1	0
	50 & over	0	0
Marital Status :	Single	19	17
	Married	11	13
	Separated/ Widowed	0	0
Occupation :			
	Student	16	15
	Service	9	11
	Business	1	1
	Housewife	4	3

TABLE-2—*Classification of Patients (ICD-9)*

ICD—9 Category	Number of Patients
Anxiety State	18
Neurotic Depression	5
Obsessive Compulsive Disorders ..	3
Hypochondriasis	2
Hysteria	2
Total ..	30

Table-3 compares the extent of social support available to patients and controls. Apart from percentages in the lower half of Table-3, the statistical significance of all comparisons has been assessed by 't' tests. Patients had significantly more household members as compared to controls. Patients also reported larger number of attachment figures, both in total or in Lucknow than the controls, but not to a significant extent. However, patients and controls, did not differ significantly with regard to the number of close relatives and good friends in Lucknow. During the week prior to interview patients reported significantly fewer contacts with members of the primary group outside the household and with persons outside the primary group. On subjective evaluation both the patients and controls considered their attachment support to be sufficient and did not report any deficiency in their inter-personal lives. However significantly more number of patients considered their personal life to be deficient in some respects.

TABLE-3—*Indicators of Social Support*

	Means		
	Patients	Controls	p
Number of household members	6.1	5.0	0.05
Number fo close relatives in Lucknow ..	3.1	4.3	N.S.
Number of good friends in Lucknow	3.0	3.6	N.S.
Number of primary group contacts (outside household) in past week ..	3.3	6.9	.001
Number of contacts with persons outside primary group in last week	2.9	7.9	.05
Total number of attachment figures	3.9	3.5	N.S.
Number of attachment figures in Lucknow ..	2.3	1.7	N.S.
	Percents		
	Patients	Controls	p
Attachment Support considered sufficient	80	80	NS
"What do you feel is missing from your life" ..			
Interpersonal ..	—	—	.001
Personal ..	70	26.7	
Extrapersonal/Social	—	—	
Nil ..	30	73.3	

Table-4 compares patients and controls on summary measures of hours spent in social interaction. The upper half of the Table summarizes the hours spent in interaction with other household members, with members of primary group outside the household and with persons not in the primary group. Patients in our sample

TABLE-4—*Mean hours of social interaction in last week : Summary Measures*

	Patients	*Controls*	*p*
Total interaction with household ..	28.9	32.5	N.S.
Total interaction with primary group (excluding household) ..	15.8	10.6	.001
Total interaction with persons not in primary group ..	5.1	4.7	N.S.
Total interaction with principal attachment figure	11.2	12.3	N.S.
Total type of 1 positive interaction ..	24.6	20.5	N.S.
Total type 1 neutral interaction ..	1.2	1.6	N.S.
Total type 1 negative interaction ..	4.9	1.4	N.S.
Total type 2 positive interaction ..	9.8	15.9	N.S.
Total type 2 neutral interaction ..	4.7	8.8	N.S.
Total type 2 negative interaction ..	4.6	0.1	N.S.

reported spending significantly more time in interacting with members of primary group outside household, but apart from this their total hours of interaction did not differ significantly from the control. Patients and controls did differ with regard to the time spent with their principal attachment figure. The lower half of Table-4 compares patients and controls on different types of interaction. These comparisons represent totals for interaction with household members, other primary group members and others outside the primary group combined. We did not find any difference between the two samples as far as types of interactions were concerned.

Table-5 depicts the degree of family joitness of the patients and controls as evaluated on the Khatri's scale. The two samples did not differ to a significant extent in this regard.

TABLE-5—*Degree of Family Jointness* (*Khatri*, 1970)

	Patients	*Controls*	*p*
(*a*) *Degree of Jointness* :			
I—Complete ..	1	3	N.S.
II—Very much ..	6	5	
III—Somewhat ..	8	12	
IV—Slightly ..	8	6	
V—Not at all ..	7	4	
(*b*) I & II (Joint Family)	7	8	N.S.
III & IV (Extended Family)	16	18	
V (Nuclear Family)	7	4	
(C) I-IV (All degrees of jointness) ..	23	26	N.S.
V (Not at all Joint)	7	4	

DISCUSSION

These findings when considered as a whole, indicate that neurotic patients do not have a deficient primary group, as far as the numerical size and the duration and type of interaction is concerned. However, the patients appear to be less active than controls in making contacts with members of their primary group outside their household. Further, our group of patients perceived their social lives to be deficient in some respects.

The findings of the present work differ in some respects from that obtained by Henderson and co-workers (1978) who observed that neurotic patients reported deficiency in their primary group in terms of numerical size and affective quality of interaction. Our patients did not report a deficiency in the primary group on these two parameters. However, the finding that patients and controls do not differ in the total duration of transaction with their primary group was the same in the two studies. On subjective evaluation our patients reported that "something was missing in their personal lives", but found their interpersonal lives to be adequate whereas Henderson *et al.* (1978) found that their patients report having deficient interpersonal relationships.

The results of our study and the differences from that obtained by Henderson and associates (1978) requires careful interpretation keeping in view that the pattern of social transactions may be quite different in the two cultures.

There is a possibility that our patients gave an account of primary group interaction which was incorrect, in the sense that it was not what had truly happened in the previous week. We do not consider this to be a possibility as far as the total duration of interaction is concerned, but it is our impression that patients reported greater positive interaction than neutral or negative interaction. This may be because of the value Indians place on their family and their reticense in openly discussing their family problems. Thus, for reasons of social desirability the patients may be reporting positive interactions rather than negative interactions or even neutral ones.

The patients had numerically a richer household than controls but had the same number of supports outside household. Thus there was no deficiency in primary group of patients. Controls reported more contacts with persons of primary group outside household and outside primary group which means that the controls were more active than patients in making social contacts outside household. Here it would be worthwhile to mention the finding of Post (1962) who examined the 'social orbit' of 40 psychiatric out-patients at the Maudsley Hospital and found that these patients were largely restricted to their families in their social contacts, 8 of the 40 having no social contacts beyond exchanging the time of the day with unrelated persons. Post had the impression that his sample was much more family centered than the general population.

The patients perceived their personal lives to be deficient in some respects. This finding appears to be more at a psychological level than a social level. Taking a holistic approach—social and genetic factors being equal the psychological factors are of major importance in the development and/or perpetuation of neuroses. Cassel (1974) observes that there are two devices which cushion people against adversity : the organisms' capacity to adjust physiologically and psychologically and the availability of 'group supports' for the individual. Thus we may consider that since the patients did not have a deficient primary group (i.e. group support) and interpersonal relationship, their self perception of something missing in their personal lives may be reflecting their impairment at a psychological level. Of course we have not examined the factor of adversity which may well be quite an important contributory factor.

The degree of family jointness as measured on the Khatri's Scale was of the same degree in patients as well as controls.

CONCLUSIONS

The data in this study suggests that patients and healthy individuals have an equally rich social orbit. However, patients lack the capability to utilise it as effectively as healthy individuals. The patients are also more family centered. However, before categorically subscribing to this view, we would like to confirm our findings on a larger sample. We would also like to study this aspect in a survey sample. Some necessary modifications need to be made in the social interaction schedule to make it more suitable for our cultural setting. The work is being continued in this direction.

ACKNOWLEDGEMENT

We are grateful to Dr. Scott Henderson for supplying us the Social Interaction Schedule devised and developed by the National Health and Medical Research Council Social Psychiatry Research Unit at the Australian National University, Canberra.

REFERENCES

AGARWAL, A. K.; MEHTA, U. K. ; & GUPTA, S. C. (1978). Joint Family and Neurosis (A study of wives of male neurotics). Indian J. Psychiat., 20, 232.

CASSEL, J. C. (1974). Psychiatric epidemiology. In : The American Handbook of Psychiatry, Vol. 2 (Eds. : S. Arieti and G. Kaplan). pp-401-10. New york : Basic Books Inc.

DUBE, K. C. (1970). The study of prevalence and social variables in mental illness in a rural and urban community in Uttar Pradesh, India. Acta. Psychiat. Scand., 46, 327.

HENDERSON, A. S. (1974). Care-eliciting behaviour in man. J. Nerv. Ment. Dis., 159, 172.

HENDERSON, S. (1977). The Social Network, Support and Neurosis (The function of attachment in adult life). Brit. J. Psychiat., 131, 185.

HENDERSON, S., DUNCAN-JONES, P., McAULEY, H. AND RITCHIE, K. (1978). The Patients' Primary Group. Brit. J. Psychiat., 132, 74.

HENDERSON, S., BYRNE, D. G., DUNCAN-JONES, P. SCOTT, R. AND ADCOCK, S. (1980). Social Relationships, Adversity and Neurosis (Study of associations in a general population sample). Brit. J. Psychiat., 136, 574.

KHATRI, A. A. (1970). Manual of the scale to measure jointness of families in India. Ahmedabad : B. M. Institute.

MENON, M. SARADA (1975). Psychiatric disorders in women. Ker. J. Psychiat., III, (8), 48.

POST, F. (1962). The Social orbit of Psychiatric patients, Jour. Ment. Science, 108, 759.

SETHI, B. B. (1968). Changing patterns of culture and Psychiatry in India. Am. J. Psychother., 22, 46.

VENKOBA RAO, A. (1973). Affective illness in First Degree Relatives Parental Loss and Family Jointness in Depressive Disorders. Brit. J. Psychiat., 122, 601.

VEERARAGHAVAN, V. (1978). A comparative study of different types of neurosis in relation to certain etiological and demographic variables. Indian J. Psychiat., 20, 81.

VERGHESE, A. AND BEIG, A. (1974). Neurosis in Vellore town—An epidemiological study. Indian J. Psychiat., 16, 1.

VYAS, J. N. AND BHARADWAJ, P. K. (1977). A study of Hysteria—An Analysis of 304 patients. Indian J. Psychiat., 19 (4), 71.

WORLD HEALT ORGANIZATION (1977). Manual of the International Statistical Classification of Disease, Injuries and Causes of Death. Ninth revision. Vol. IX. Geneva.