

Causal illness attributions in somatoform disorders Associations with comorbidity and illness behavior

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Abstract

Objective: To compare causal illness beliefs between patients with unexplained physical symptoms and different comorbid disorders and to assess the association of causal illness beliefs with illness behavior. **Methods:** We examined a sample of 233 patients attending treatment in primary care. Inclusion criteria were “unexplained physical symptoms.” All patients were investigated using structured interviews and self-rating scales [Screening for Somatoform Symptoms (SOMS), Beck Depression Inventory (BDI), Beck Anxiety Inventory, and a 12-item instrument to assess causal attributions]. By means of factor analysis, the following illness attributions were considered: vulnerability to infection and environmental factors, psychological factors, organic causes including genetic and aging factors, and distress (including exhaustion and time pressure). **Results:** Most patients reported

multiple illness attributions. The more somatoform symptoms patients had, the more explanations in general they considered. Especially for vulnerability and organic illness beliefs, patients with somatoform symptoms had increased scores. Comorbidity with depression and with anxiety disorders was associated with more psychological attributions. Even when the influence of somatization, depression, and anxiety is controlled for, illness beliefs still showed associations with illness behavior. Organic causal beliefs and vulnerability attributions were associated with a need for medical diagnostic examinations, increased expression of symptoms, increased illness consequences, and bodily scanning. **Conclusions:** Multiple causal attributions can coexist demonstrating different associations with comorbid depression and illness behavior.

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Introduction

The way people think about illness and how they interpret illness-associated somatic symptoms seems to be a major determinant of health-care-seeking, illness-associated disability and coping behavior. In particular, this seems to be the case for the attribution of common somatic symptoms, such as abdominal pain, back pain, chest pain, or headache. These and other unexplained physical symptoms are key features of somatoform disorders in DSM-IV. Somatoform symptoms are common phenomena with base rates of above 30% for single symptoms [1]; the symptoms

are associated with substantial disability and significant costs for the health care system.

Current concepts of somatoform disorders emphasize the role of causal illness attributions [2,3]. It is assumed that patients with somatoform symptoms have a tendency to use organically oriented causal attributions for common somatic complaints. However, empirical approaches to evaluate this assumption are rare.

Robbins and Kirmayer [4] investigated attributions of common somatic symptoms using the symptom interpretation questionnaire. They revealed three dimensions of causal attributions, namely, psychological, somatic, and normalizing attributions. Sensky et al. [5] could demonstrate that causal attributions about common somatic sensations are associated with the frequency of general practice visits. The most striking difference between high utilizers and low utilizers of the health care system was found on the dimension of normalizing attributions: Frequent attenders reported less normalizing explanations for common bodily sensations than the comparison group.

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The cognitive representation of illness is typically conceptualized following Leventhal's self-regulatory model. Following his model, the Illness Perception Questionnaire (IPQ) was developed, which covers five dimensions: (1) "identity" of the illness comprises 12 symptom items; (2) the dimension "time line" includes items asking for the expected course (persisting, temporary, short-time); other dimensions are (3) "cause" of the symptoms (organic, psychological), (4) expected consequences of the illness, and (5) expected cure/control. These dimensions of the representation of illness seem to be stable features [6] and can predict other aspects of illness course and illness behavior [7].

To date, illness attribution is typically assessed two or three dimensionally. However, symptom attribution seems to be a multidimensional process with coexisting explanations for one and the same symptom. Therefore, we wanted to examine the multiplicity of causal illness attributions in somatoform disorders. We expected the following results:

- The more symptoms patients have, the more illness attributions they consider.
- Moreover, we expect that illness attributions are associated with comorbidity patterns: Patients with pure somatoform disorders are expected to show more organically oriented explanations for symptoms, while patients with somatoform and comorbid depressive disorders are expected to show more psychological explanations for the symptoms.
- Finally, we also wanted to address possible associations between illness attribution and several aspects of illness behavior. Therefore, it was necessary to assess illness behavior not as unidimensional, but as a multidimensional construct with aspects such as seeking diagnostic or treatment options, illness consequences, and others (see Ref. [8])

Methods

Subjects, design, and procedure

The first step was the acquisition of collaborating GP offices. From more than 200 contacted GPs, 25 accepted to participate in our study. GPs were instructed to approach all patients with at least two unexplained physical symptoms. Two hundred and ninety five patients (65% female; mean age 50.6 years; S.D.=15.4; range 17–82 years) fulfilled this criterion. The number of recruited patients per doctor ranged from 3 to 15. Patients with somatic disorders difficult to differentiate from somatoform disorders were not included. Most patients were married or living with a partner (66%) and about 45% had higher education. If patients agreed to participate, they were informed about the study, interviewed, and got the self-

rating scales (see below) either immediately in the GP office, at home, or in the university department. The final sample not only fulfilling inclusion criterion but also answering the self-rating scales was 233 patients (same age and sex distribution as sample above). During the following 6 months, the GPs were again interviewed to check whether the physical symptoms were still "organically unexplained." It is intended to analyze longitudinal data; however, in this manuscript we focus on cross-sectional data.

Assessment instruments

All patients were interviewed using a standardized interview instrument (International Diagnostic Check List, IDCL [9]) to get reliable and valid DSM-IV diagnoses. This interview guideline checks the criteria of the 30 most frequent mental disorders. Its reliability and validity is well established.

The Screening for Somatoform Symptoms (SOMS) [10] is a self-rating scale assessing 53 organically unexplained physical symptoms. In this study, we used the state version of the SOMS where subjects rated the intensity of the single symptom during the past 7 days on a five-point Likert scale. This scale has been validated not only for status diagnosis, but also for the assessment of change [11]. The SOMS state version results in two dependent variables, namely, the symptom count (sum of all positively answered symptoms) and the somatization severity index (means of all item answers). Reliability and validity indices of SOMS are satisfactory [10].

Illness behavior was assessed using the Scale for the Assessment of Illness Behavior (SAIB) [8], a 26-item scale assessing five factors of illness behavior (diagnosis verification, expression of complaints, medication and treatment, consequences of illness, and body scanning).

For the assessment of illness attributions, we modified a subscale of the IPQ [12] resulting in a 12-item scale (see Table 1) with a five-point Likert response format; the answers are scored from 0 to 4. This answer format allows to disagree, to agree, or neither-agree-nor-disagree answers to specific beliefs about the aetiology of the symptoms.

Further instruments were the Beck Depression Inventory (BDI) [13] and the Beck Anxiety Inventory [14].

Statistic methods

The first step was the definition of factors for causal illness attributions. Therefore, we planned to use principal component analysis with subsequent Varimax rotation. Afterwards, groups with different diagnoses will be defined and compared for causal illness beliefs; to control for possible age and sex differences, analysis of variance with age and sex as covariates will be used. To analyze associations between illness attributions and illness behavior, partial correlations will be computed eliminating

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