Causal symptom attributions in somatoform disorder and chronic pain

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Abstract

Objective: Somatoform disorders (SFD) are defined by symptoms that lack medical explanation. This study examined the type and pattern of patients’ causal attributions using a new semistructured interview technique. Methods: The Causal Attributions Interview allows to assess and weigh 15 common explanations of physical symptoms. Attributions given by 79 patients with SFD were compared with those obtained from 187 chronic pain patients. Results: The test–retest reliabilities of the interview-elicited attributions were satisfactory to good. SFD patients attributed most of their symptoms to mental/emotional problems (46.9%) and somatic disease (41.1%), while the pain sample preferred physical overloading/exhaustion (56.1%), daily hastiness/time pressure (41.7%), somatic disease (39.6%), and weather influence (39.0%). On average, SFD patients chose 2.57 and pain patients 3.86 different attributions for each symptom. These numbers were substantially larger than those of initial spontaneous attributions. Correspondence analysis revealed underlying dimensions with three groups labeled “environmental,” “somatic,” and “psychological/stress.” While pure environmental attributions were rare (1.1%), somatic factors were chosen for 28.3% of the symptoms, psychological/stress for 22.1%, and the combination of both for 25.6%. Approximately 10% were attributed in a multicausal sense to all three groups. Depression was found to correlate positively with psychological/stress and negatively with somatic attributions. Conclusion: The results do not support the perspective that SFDs generally result from poor acknowledgement of emotional factors. SFD and chronic pain showed distinguishable attributional patterns.

Keywords: Somatoform disorder; Somatization; Pain; Medically unexplained symptoms; Causal symptom attributions

Introduction

Physical complaints represent one of the most fundamental experiences of human life. The detection and evaluation of symptoms is of great importance to most people, mainly because symptoms may indicate the development of a somatic disease and enable the person to search for professional help. When presented to the physician, medical examinations and tests can be performed to determine the underlying disease. In many cases, however, negative or nondistinctive findings result from even thorough medical evaluation, in which case other possible causes have to be considered. Several studies demonstrated that 25–40% of all symptoms presented in the primary care setting are of unclear origin [1]. Patients with such symptoms are often diagnosed as somatoform disorder (SFD) whenever their medically unexplained symptoms have resulted in significant distress or psychosocial impairment [2]. The SFDs belong to the most common mental disorders with estimated lifetime prevalence rates of up to 20% [3–5].

Various attempts have been made during the past years to explain the pathogenetical and etiological mechanisms that underlie SFDs. The suggestions made in the literature range from biological abnormalities [6] to physiological sensitization [7] and dysfunctions of perception and
interpretation is often limited due to methodological
common somatic symptoms. It was shown that frequent attenders of general
psychological factors and personal distress as possible
genetic and aging factors. It appears oversimplified to classify patients with SFD as
attributions to be more or less probable or even additive. It also
convictions, as patients may consider alternative explana-
symptom to symptom. Furthermore, attributions do not
attributions. When patients suffer from several symptoms, it
primary care patients diagnosed as SFD had elevated scores on two
“vulnerability to infection and environmental factors” and “organic causes including
in the study of Henningsen et al.[13] reported psychosocial
symptoms with respect to type of symptom, clinical
traditional and severe, and duration. Therefore, the attribu-
tion of ambiguous symptoms to a single and simple cause is
consistent with our current state of knowledge. Professionals are often left with the situation
that explanations they give to the patient are to some extent
merely plausible presumptions.

Despite the lack of scientific clarity, assumptions about
the nature and origin of symptoms play an important role in
patients’ perspectives. It has been hypothesized that patients
with SFD tend to consider their complaints as organic, while
neglecting or even denying the impact of psychological and
psychosocial factors. Rief et al. [12] found that primary care
patients diagnosed as SFD had elevated scores on two
questionnaire dimensions labeled “vulnerability to infection and environmental factors” and “organic causes including
as opposed to pathological expla-
neurological symptoms? (2) Can attributions be
and psychopathology? (3) Can SFD patients be characterized by a tendency to consider
their symptoms as primarily due to biomedical factors? (4) Is there a relationship between symptom attributions and psychopathology?

Materials and methods

The CAI

This semistructured interview was designed to identify
the type and pattern of subjective symptom attributions in

problems of assessment. Most published studies have used
self-report measures such as the Symptom Interpretation Questionnaire [14]. This instrument allows to choose
between physical, psychological or normalizing explanations for 13 common bodily sensations or symptoms such as
“You feel your heart pounding” or “you notice your mouth is
dry.” However, these perceptions do not have to correspond
to the existing symptoms of the patient and responses can
therefore be merely theoretical judgments. Other instruments
such as the Illness Perception Questionnaire have the
disadvantage that ratings can only be made globally for all
current symptoms, not separately for each symptom [12,17].
It appears that the usefulness of self-ratings is at best
moderate for the differential assessment of symptom
perceptions and interpretations.

We therefore decided to investigate causal symptom
attributions using an interview technique. The Causal
Attributions Interview (CAI) was developed in a way to
overcome the limitations of self-rating scales. In particular,
attributions can be assessed separately for a freely chosen
number of individual symptoms, the responder is not forced
into an all-or-nothing and the difference between sponta-
neously expressed and cue-elicited attributions is taken into
account. The CAI also assesses how the person developed his
attributions and to what degree they are stable.

The goal of this study is to introduce the CAI and
classify the pattern of causal attributions in patients
diagnosed as SFD. This group will be compared with chronic
patients treated in a specialized tertiary care hospital. There is evidence in the literature that pain can be
distinguished from SFDs with regard to clinical character-
istics and course of treatment [18,19]. Previous studies have
addressed illness attributions in patients with different pain
conditions (e.g., Refs. [20,21]). Our comparison group
consists of patients with various types of pain, including
those with clear or predominant organic causes. It must
therefore be expected that the proportion of biomedical
attributions should be greater in the pain sample.

After reporting the psychometric properties of the CAI,
we will focus on four major questions: (1) Are there specific
attributional profiles for the two clinical groups and to what
degree are attributions specific for pain, gastrointestinal and
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