

Original articles

## Causal symptom attributions in somatoform disorder and chronic pain

Wolfgang Hiller<sup>a,\*</sup>, Marian Cebulla<sup>b</sup>, Hans-Jürgen Korn<sup>b</sup>, Rolf Leibbrand<sup>a</sup>,  
Bodo Röers<sup>c</sup>, Paul Nilges<sup>d</sup>

<sup>a</sup>Department of Clinical Psychology, University of Mainz, Mainz, Germany

<sup>b</sup>Roseneck Center of Behavioral Medicine, Prien, Germany

<sup>c</sup>LWL Psychiatric Hospital, Hamm, Germany

<sup>d</sup>Red Cross Pain Clinic, Mainz, Germany

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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. © 2010 Elsevier Inc. All rights reserved.

**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

\* Corresponding author. University of Mainz, Department of Clinical Psychology, Wallstr. 3, 55122 Mainz, Germany. Tel.: +49 6131 3939100; fax: +49 6131 3939102.

cognition [8–10]. Some authors consider unexplained physical symptoms as an “idiom of distress” [11], although the exact pathways between a circumscribed psychological conflict and the development of its somatic expression still remain to be specified. Explanations are further complicated by the heterogeneous nature of the somatoform symptoms with respect to type of symptom, clinical presentation, severity, and duration. Therefore, the attribution of ambiguous symptoms to a single and simple cause is questionable and not 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 genetic and aging factors.” In contrast, scores indicating psychological factors and personal distress as possible causes were not different from those of patients without SFD. Henningsen et al. [13] reported that organic attributions were prominent only in patients with “pure” SFDs, whereas there was a balance between organic and psychological attributions when the SFD was accompanied by a comorbid depressive or anxiety disorder.

However, there are increasing doubts as to whether it is appropriate to simply dichotomize patients as attributing either organically or psychologically. In the study of Rief et al. [12], most patients reported not only one but multiple attributions. When patients suffer from several symptoms, it is not unlikely that the subjective explanations change from symptom to symptom. Furthermore, attributions do not necessarily have to be present in the form of absolute convictions, as patients may consider alternative explanations to be more or less probable or even additive. It also appears oversimplified to classify patients with SFD as global “somatizers” whose thinking is limited to a unidimensional style of biomedical attribution. For example, subgroups of patients with medically unexplained symptoms in the study of Henningsen et al. [13] reported psychosocial causes spontaneously or were even considered as “psychologizers” with predominant psychological explanations. Robbins and Kirmayer [14] introduced an additional dimension “normalizing” as opposed to pathological explanation. It was shown that frequent attenders of general practices [15] as well patients with high anxiety and hypochondriasis scores [16] responded less with normalizing attributions when asked to specify possible causes of common somatic symptoms.

When causal attributions are studied in patients with SFD, interpretation is often limited due to methodological

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 spontaneously 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 characterize the pattern of causal attributions in patients diagnosed as SFD. This group will be compared with chronic pain 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 characteristics 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 pseudoneurological symptoms? (2) Can attributions be classified into meaningful superordinate clusters? (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

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