Original article

Somatoform disorders and causal attributions in patients with suspected allergies: Do somatic causal attributions matter?☆

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Abstract

Objective: Somatic causal illness attributions are being considered as potential positive criteria for somatoform disorders (SFDs) in *DSM-V*. The aim of this study was to investigate whether patients diagnosed with SFDs tend towards a predominantly somatic attribution style. **Methods:** We compared the causal illness attributions of 48 SFD and 149 non-somatoform disorder patients, in a sample of patients presenting for an allergy diagnostic work-up, and those of 47 controls hospitalised for allergen-specific venom immunotherapy. The SFD diagnosis was established by means of the Structured Clinical Interview for DSM-IV. Both spontaneous and prompted causal illness attributions were recorded through interview and by means of the causal dimension of the Revised Illness Perception Questionnaire (IPQ-R), respectively. Patients' spontaneous and prompted responses were assigned to a psychosocial, somatic, or mixed attribution style. **Results:** Both in the free-response task and in their responses to the IPQ-R, SFD patients were no more likely than their nonsomatoform counterparts to focus on somatic explanations for their symptoms. They were just as likely to make psychosocial or mixed causal attributions. However, patients with SFDs were significantly more likely to find fault with medical care in the past. **Conclusion:** Our data do not support the use of somatic causal illness attributions as positive criteria for SFDs. They confirm the dynamic and multidimensional nature of causal illness attributions. Clinical implications of these findings are discussed.
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Keywords: Allergy; Attribution style; Causal illness attributions; Positive criteria; Somatoform disorders

Introduction

In view of the forthcoming *Diagnostic and Statistical Manual for Mental Disorders* (*DSM-V*) and the *International Classification of Diseases* (*ICD-11*), there is an ongoing debate about the terminology and classification of somatoform disorders (SFDs) [1–5]. There have been calls to move away from the 'negative definition' of SFDs as 'medically unexplained' towards a positive one, considering, among other things, somatic causal illness attributions as potential positive criteria [3,5–12]. Since the early 1990s, causal illness attributions have been shown to influence the development, maintenance, and management of somatoform and functional somatic syndromes [3,5,13–22]. The *ICD-10* already lists the adherence to somatic causal attributions as one of the main features of SFD patients [12]. However, empirical evidence of this assumption is relatively rare. Furthermore, variation in data collection methods and instruments, in data handling, and in the population studied certainly contributes to the heterogeneity of the findings (e.g., Refs. [23,24]): some studies support the notion of a tendency towards somatic illness attributions among SFD patients [25–28]. More recent studies and reviews [29–35] and, in particular, qualitative studies on doctor–patient interaction [36–38], however, present more of a mixed picture, with SFD patients being open to both somatic and psychosocial explanations of their symptoms.

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Attribution theory and research have identified three main (exclusive) dimensions of causal attribution, namely, psychosocial, organic, and normalising [25,39,40]. In addition, supporting the notion that illness attribution is a multidimensional process, with patients holding coexisting explanations for one and the same symptom or illness, factor analytic approaches based on the Illness Perception Questionnaire (IPQ) and its revised version (IPQ-R) have identified a number of attribution categories: psychological, risk factors, immunity, and chance factors [41–46]. Quantitative measures of illness attribution include lists of predetermined causal explanations from which patients can choose the one(s) closest to their own beliefs. This method assumes that the range of beliefs that are of interest are largely known [23]. On the contrary, qualitative studies allow patients to use concepts and categories that are relevant and meaningful to them. They have assessed attribution by simply asking patients what they attribute their symptoms to [19,32], by means of the more elaborate explanatory model interview [21,30], thematic content analysis of in-depth interviews [47], or transcripts of audiotaped consultations [36,37]. Similar to many of the quantitative studies, most of these analyses have focused on the dichotomy of psychosocial and somatic causal attributions.

The main purpose of this article was to assess the use of somatic causal attribution as a positive criterion of SFDs, with the long-term view to provide the basis for better diagnostic and therapeutic management. In particular, we aimed to test the hypothesis that SFD patients tend towards a predominantly somatic attribution style, combining and comparing both qualitative and quantitative research measures.

Method

This study is part of a larger cross-sectional study exploring potential positive criteria for SFDs [48]. In a sample of patients presenting for an allergy diagnostic work-up, we examined causal illness attributions of SFD and non-somatoform disorder (NoSFD) patients and those of their controls, hospitalised for allergen-specific immunotherapy (VIT). We compared patients' spontaneous and prompted causal attributions using both qualitative and quantitative research measures.

Participants

Three hundred consecutive patients admitted to the TUM allergy department were invited to participate in the study. Two hundred and forty-five were hospitalised for allergy testing (work-up patients). Their symptoms could not be diagnosed with sufficient certainty in an outpatient setting, or provocation testing was considered fraught with risk. Fifty-five patients already had an established diagnosis of hymenoptera (bee and wasp) venom allergy and were admitted for allergen-specific venom immunotherapy (VIT). They were included in the study to control for possible effects of the work-up situation. Patients were recruited when they were aged 18–65 and had a good command of the German language. An 11-month study period was chosen to account for seasonal variations in the type of allergies presented.

Measures

Within the first 2 days of their stay in the clinic, all eligible patients were contacted by the research team. Patients giving informed consent were then interviewed by one of two board-certified psychiatrists (both certified SCID interviewers) and asked to fill in a set of self-report questionnaires. Two days following the interview, and prior to obtaining any medical test results, questionnaires were collected by the research team.

Interview

The interviewers emphasised that they were not members of staff and that they had no previous knowledge about the interviewee, thus attempting to create an atmosphere in which a discourse about the patients' experiences and thoughts about their health and previous contact with the health care system could freely develop.

First, patients' medical history, current symptoms and illnesses, and utilisation of health care services in the last 12 months were recorded. Then, patients' *spontaneous causal attributions* were explored. The main question asked was, 'What do you think is or are the causes of your current symptom(s) and/or intolerance(s)?' Responses were recorded verbatim.

The diagnosis of a SFD was ascertained using Section 'G' (somatoform disorders) of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I, German version), the current gold standard for the diagnosis of SFDs [49,50]. The SCID SFD diagnoses are based on a systematic review of organ systems and on the number, duration, and organic explicability of, as well as the impairment caused by, patients' symptoms. In addition, criteria for multisomatoform disorder [3,51] were applied. Patients who fully met criteria for a somatisation disorder, multisomatoform disorder, pain disorder, or undifferentiated SFD were identified as SFD patients. A primary SFD diagnosis was given to patients whose current and predominant symptom(s) could not be medically explained. The secondary SFD category was used to refer to patients suffering from a SFD, but whose *presenting* symptoms were medically explicable (e.g., a patient having had an anaphylactic reaction caused by analgesics and concurrently suffering from a somatoform pain disorder).

The modified causal attribution dimension of the IPQ-R

As part of a battery of self-report measures [48], the IPQ-R causal attribution scale (German version [52]) was