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Global versus Specific Symptom Attributions: Predicting the Recognition and Treatment of Psychological Distress in Primary Care

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Abstract

Objective: Researchers have shown that primary care patients utilize global attribution styles to interpret ambiguous physical symptoms, diminishing the ability of practitioners to recognize psychological disorders. The present study examined the extent to which patients' *specific* beliefs about their presenting symptoms versus their *global* symptom attribution styles predict physician recognition of psychological distress and mental health treatment recommendations. **Methods:** Participants included primary care patients attending a five-physician medical practice. Patients completed surveys regarding their level of psychological distress, symptom attribution style, and perceptions of their presenting problems and medical consultations. Physicians completed brief assessments of each patient encounter. **Results:** Patient gender, age, severity of psychological distress, and beliefs about their presenting symptoms were reliable predictors of physician recognition and treatment recommendations. Global symptom attribution styles did not relate to these outcomes above and beyond the specific beliefs of patients. **Conclusion:** Patients' specific beliefs about their presenting symptoms play an important role in predicting physician recognition and treatment of psychological distress.

Keywords: Primary care; Recognition; Diagnosis; Psychological distress; Depression; Anxiety; Somatization; Symptom attribution

Introduction

Primary care has become the gateway for mental health services, with practitioners attempting to determine proper diagnosis, treatment, and referral for patients who report physical as well as psychological concerns. Approximately 20–40% of patients attending general medical practices experience clinically significant symptoms of anxiety, depression, or some other psychological disorder [1–5]. However, an extensive amount of research over the last several decades has shown that primary care practitioners misdiagnose or fail to recognize underlying psychological problems in nearly half of their patients [6–8]. Various provider and patient variables, ranging from physician knowledge and attitudes to the clinical presentation of symptoms, are associated with the accurate recognition and diagnosis of psychological disorders in primary care settings [9–13].

A well-documented barrier to the detection of psychological distress is patient somatization, or the tendency to interpret and present symptoms somatically during medical consultations [14–17]. In addition to somatic presentations, investigators have recently begun to explore the extent to which particular symptom attribution styles predict physician recognition of psychological problems and patient healthcare utilization patterns [18–20]. Although correlational in design, the research suggests that the manner in which primary care patients interpret the etiology of their medical symptoms may play a key role in determining physician treatment practices.

Patient symptom attribution style

To measure the symptom attributions of patients, Robbins and Kirmayer [21] designed the Symptom Interpretation

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Questionnaire (SIQ), which identifies three dimensions of causal explanations for common physical complaints: physical illness (somatic), emotional distress (psychological), and environmental events (normalizing). The authors found that these global symptom attribution styles are consistent over time, representing stable health beliefs.

Using the SIQ, Kessler et al. [19] examined the extent to which physicians detect psychological distress in patients employing somatic, psychological, or normalizing attribution styles. The researchers found that physicians recognize anxiety and depression less often when patients employ a normalizing explanatory style (i.e., attributing symptoms to benign environmental events) than when patients offer psychological interpretations for symptoms. Notably, approximately one half of patients utilize the normalizing attribution style, possibly accounting for the difficulty in diagnosing psychological distress in primary care settings [19]. In a similar primary care study, Bower et al. [18] attempted to replicate these results but found that the symptom attribution styles of patients did not consistently predict an accurate recognition of psychiatric morbidity by general practitioners. The authors therefore suggested that researchers should examine the ways that patients' *specific* attributions concerning the main presenting problems influence physician recognition [18].

Purpose of present study

While some investigators have shown that global symptom attribution styles predict proper detection of psychological disorders among primary care patients, further research is needed to explore the relationships among these styles, patients' specific symptom beliefs, as well as physician recognition of psychological distress and mental health treatment decisions. Therefore, the goals of the present study were as follows: (1) to examine the extent to which patients' global symptom attribution styles relate to their specific beliefs about their presenting symptoms and (2) to explore the extent to which both the global and specific symptom attributions of patients predict physician recognition and treatment of psychological distress.

Method

Participants

Participants were consecutive patients seeking consultations at an urban primary care office staffed by five physicians located in Western Massachusetts, USA. Approximately the same number of patients from each physician's practice was recruited during morning and afternoon business hours. Three hundred patients were approached to enroll in the study, although only 197 agreed to participate. The sample included 137 women (69.5%) and 60 men (30.5%), who ranged in age from 18 to 68 years ($M = 36.76$, S.D. = 12.33). The patients reported, on average, completing some years of college and earning a combined household income of approximately US$35,000 annually. Representing diverse ethnic backgrounds, the patients identified themselves as African-American (13.8%), European-American (69.4%), Hispanic-American (14.8%), or some other ethnic heritage (2.0%). In addition, five primary care physicians (four males, one female) participated in the study by completing brief assessments of their respective patients. The physicians, who ranged in age from 33 to 46 years, were all board-certified in internal medicine and provided services to approximately 8000 patients.

Measures

Participants completed four questionnaires regarding their demographic information, psychological distress, symptom attribution style, and medical management of their presenting symptoms. The demographic questionnaire included questions about sex, age, ethnic background, annual income, and education.

Symptom Checklist-90-R (SCL-90-R)

The SCL-90-R is a self-report instrument that assesses general psychological distress. Using a five-point scale (from *not at all* to *extremely*), respondents indicate the extent to which they had been distressed by 90 distinct symptoms during the preceding week. The instrument is comprised of nine subscales that are averaged into three global indices, the most commonly used of which is the Global Severity Index (GSI). The reliability and validity of the SCL-90-R have been well established [22–24].

Symptom Interpretation Questionnaire (SIQ)

This self-report instrument surveys attributions of 13 common somatic symptoms whose etiology is ambiguous in nature. For each somatic symptom, respondents rate on a four-point scale (from *not at all* to *a great deal*) the extent to which three separate attributions might explain the cause of the symptom. For example, the first item of the questionnaire asks respondents to indicate, if they were to experience a prolonged headache, the extent to which they would think the symptom was due to feeling emotionally upset, having something wrong with their brain, or hearing a loud noise. These three attributions correspond, respectively, to the following scales: emotional distress (psychological), physical illness (somatic), or external environmental events (normalizing). The SIQ possesses adequate validity and reliability, with Cronbach's alphas of .86 for the psychological scale, .71 for the somatic scale, and .81 for the normalizing scale [21].

Clinical Encounter Questionnaire-patient (CEQ)

Developed for the present study, this survey consists of six items that measure patients' specific beliefs regarding their presenting symptoms and perceptions of the medical encounter with primary care physicians. The only item