



Review

Descriptive and predictive validity of somatic attributions in patients with somatoform disorders: A systematic review of quantitative research

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ABSTRACT

Objective: Research on hypochondriasis and other somatoform disorders (SFD) has provided evidence that patients with SFD tend to attribute their symptoms to organic dysfunctions or disease. However, recent studies appear to discredit this. There is no systematic evidence on whether patients with SFD predominantly rely on somatic attributions, despite calls to include somatic attributions as a positive criterion of somatic symptom disorder (SSD) in the upcoming Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

Methods: This study is a systematic review of quantitative studies which assess the descriptive and predictive validity of somatic attribution in SFD. The literature search was restricted to studies with patients who met the DSM-IV criteria for SFD.

Results: Somatic attribution style in SFD has acceptable descriptive but insufficient predictive validity. This confirms that the overlap between somatic and psychological attributions is often substantial. Attribution style can discriminate between SFD patients with and without comorbidity.

Conclusion: A somatic attribution style does not qualify as a positive criterion in SSD. However, there is an urgent need for further research on causal illness perceptions in the full spectrum of medically unexplained symptoms in order to confirm this result. Given its high prevalence, research on psychological attribution style is warranted. Re-attribution does not provide a framework sophisticated enough to address the needs of patients in primary care.

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Introduction

Abundant evidence attests to the insufficiency of the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) [1] and the 10th edition of the International Statistical Classification of Diseases and related health problems (ICD-10) [2] to accurately and adequately define the full spectrum of somatoform disorders (SFD) and symptoms as captured by the diagnostic category of SFD [3–11]. Major modifications are due in DSM-5. The introduction of positive psychological and/or behavioural features as diagnostic criteria of the 'J 00 Somatic Symptom Disorder (SSD)' in the diagnostic category of 'somatic symptom disorders' which will replace 'SFD' in DSM-5, is suggested in order to achieve a more valid and clinically useful classification of somatoform disorders [12]. Although absent from the current proposed diagnosis of SSD (last updated April 2012; <http://www.dsm5.org/ProposedRevision/Pages/proposedrevision.aspx?rid=368>) among the criteria which have been considered for inclusion in J 00 SSD's criterion B, is the presence of somatic attributions [13].

Research conducted from the 1990s onwards demonstrated that illness attributions are major determinants of health anxiety (HA) as well as of several somatoform disorders and symptoms [14–16]. The majority of these studies found that patients with SFD are associated with mutually exclusive attribution styles and that patients typically claim physical problems and/or medical explanations when asked about the cause of their symptoms [17–21]. This led to the inclusion of the organic causal illness perception style as a feature of SFD in the ICD-10. However, recent research has cast doubt on the broadly accepted notion that SFD patients employ, for the most part, physical explanations. For instance, according to Hiller et al. [22] this is an exaggerated conviction which stems from methodological shortcomings of studies on attribution, mostly from the fact that research has almost exclusively relied on self-report questionnaires as opposed to interviews. Moreover, the traditional categorization and conceptualisation of causal attribution styles has been challenged by a number of important quantitative studies and evaluative reviews [23–25] and – most pertinently – by evidence coming from qualitative research [26–30]. Qualitative studies indicated that SFD patients do not adhere to simplistic, monocausal, stable and fairly distinct attribution styles. The aim of the review was to assess the *descriptive and predictive validity of somatic causal illness perception in somatoform disorders*, thus providing evidence as to whether somatic attribution style may qualify as one of the positive criteria (B

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criterion) of the J 00 Somatic Symptom Disorder, the term postulated by the DSM-5 SSD work group and/or somatoform disorders in the upcoming ICD-11.

Predictive validity refers to the degree to which a diagnosis or diagnostic criterion is linked to prospect outcomes such as the course of a disorder or response to therapy. For instance, with regard to somatisation disorder (SD), increased number of somatic symptoms is associated with poor clinical outcome in terms of disability and health care use [31]. Thus, number of symptoms is a factor with good predictive validity in SD.

Descriptive validity stands for the amount of specificity of a diagnosis in reference to the clinical presentation that it is meant to capture. If one diagnostic criterion is shared by other psychiatric disorders then this criterion lacks in descriptive validity. A feature of low descriptive validity in SFD is anxiety because this symptom is highly prevalent in patient populations with a number of mental disorders, notably anxiety disorders.

Methods

Search strategy

The disarray in definitions and descriptive categorisation in SFD (across the DSM-IV and ICD-10) and the substantial heterogeneity in diagnostic measures and operationalization criteria used in studies of populations subsumed under different terms such as MUS, FSS complicates things in terms of answering the research question via a meta-analysis. This study aimed to investigate attribution styles within SFD in DSM-IV using the *best available evidence*. Therefore, the literature search was restricted to studies published from 1994 onwards, the publication year of the DSM-IV, thus permitting the collection of data on the much discussed DSM-IV (DSM-IV-TR [32]) criteria of SFD.

Inclusion and exclusion criteria

Studies that reported quantitative data on illness/symptom perception in patients with SFD diagnosed as such according to a diagnostic interview, or a validated self-report questionnaire which were carried out from 1994 onwards were eligible for inclusion. Also eligible were studies employing the criteria of abridged somatisation [33], multisomatoform disorder (MSD) [34], bodily distress syndrome (BDS) [9], polysymptomatic distress disorder (PSDD) [13,35], physical symptom disorder [11], the Conceptual Issues in Somatoform and Similar Disorders (CISSD) example criteria [36] and SSD. Functional somatic syndromes or single-symptom MUS [Chronic Fatigue syndrome (CFS), Irritable bowel syndrome (IBS), Fibromyalgia (FM), chronic fatigue, tinnitus, migraine, dizziness, chronic constipation etc.] were eligible for inclusion, if the DSM criteria were applied.

Specifically, the inclusion criteria for data synthesis were:

- Studies which contained primary data related to causal illness perceptions in patient populations with SFD and related concepts
- Studies that used the quantitative research strategy
- Studies that used valid measures (interviews or questionnaires) to establish diagnosis of SFD, specific disorders within SFD (DSM-IV) and related concepts (such as abridged somatisation)
- Published in peer-reviewed journals from 1994 onwards.

Excluded were:

- Studies which used the DSM-III criteria for SFD (or disorders within SFD)
- Studies not published in English
- Studies which involved children or adolescents
- Case studies
- Studies which exclusively employed a qualitative research strategy.

Results

Literature search

A total of 3215 publications were retrieved from the search of two electronic databases (1029 from PsycINFO and 2186 from MEDLINE). The string of search terms for the databases is shown in Appendix A. The titles and abstracts of the studies retrieved were read and publications not related to the topic of the review were excluded. The full texts of the remaining 221 publications (124 from PsycINFO and 97 from MEDLINE) were read separately by the authors to decide on suitability for inclusion. Overall, 17 studies were directly relevant to the scope of this review and fulfilled all inclusion criteria. One study [37] was included although it mentioned DSM-III criteria because the participants met the Escobar criteria for somatisation. For a second study [38] the full text could not be retrieved and the lead author was contacted to provide it. A third study was included since SFD were 94.5% of the sample (MUS) [39]. The keyword searches used and a PRISMA flow chart are found in Appendix A.

Study characteristics are shown in Table 1. Table 2 summarises the results and provides statistics of the studies included. In the majority of the studies illness attribution was measured with either a version of the SIQ [40] (five studies) and the causes section of the IPQ [41] (five studies). The diagnostic interview used most frequently for SFD and disorders within the SFD category was the Structured Clinical Interview for DSM IV disorders (SCID) [42] (seven studies). The most frequently used self-report measures were the Screening for Somatoform Disorders (SOMS) [43–45] (six studies) and the Patient Health Questionnaire (PHQ-15) [46] (three studies). Twelve studies provided information relevant to the descriptive validity of the SFD. Predictive validity is discussed in seven studies. In the two sections of the results which follow the studies are presented in decreasing value for each subtype (descriptive and predictive). The main measure of descriptive validity was the extent to which somatic attributions differentiate SFD from control groups (clinical and healthy controls) in terms of incidence and/or symptom severity. Indexes of predictive validity were set to be, incidence, somatic symptom severity, number of symptoms and general health measures (results relevant to the relationship with depression and anxiety are also reported here).

Discussion of studies

Descriptive validity

Rief et al. [23], reported that patients with SFD had increased somatic (organic) attributions ($P < .05$) compared to the non-SFD group. Henningsen et al. reported that somatic attributions were endorsed by 80.4% within the pure SFD group compared to 10% within the pure depression and/or anxiety disorders group (without SFD) and 43.9% within the SFD with comorbid depression and/or anxiety disorders group [38]. Psychosocial attributions were mostly given by patients with depression and/or anxiety (90%, within the group) followed by SFD plus depression/anxiety (56.1%) and pure SFD (19.6%). Furthermore, Hilbert et al. reported that when anxiety and duration of symptoms were controlled for, only somatic attributions remained significant in the regression model—increasing its significance (Tables 1 and 2) [39]. Wollburg et al. reported that patients fulfilling criteria for either SFD (DSM-IV) or SSD (DSM-5) showed increased somatic attributions compared to patients with anxiety/depression and no significant difference in psychological attributions [47]. In this study, somatic attribution was the factor with the second strongest (negative) predictive value of patients' perception of physical health for both somatoform groups (giving moderate correlations, DSM-IV: $r = -.455$; DSM-5: $r = -.445$). Psychological attributions were associated with improved physical functioning at admission.

Compared to patients suffering from conditions with established organic pathology which may or may not present with MUS-like phenomenology, one would expect SFD patients to show a less pronounced somatic attribution style. Out of five studies [22,25,48–50] which did not include healthy but clinical controls with organic pathology (no mental disorder present) one [25] found that somatic attributions were more pronounced in the clinical control group in comparison with the MUS groups (SFD and non SFD) while two found that somatic attributions were equally important to psychological in both groups [22,48]. Moreover, Binzer et al. report that two out of three indexes relevant to descriptive validity 'disease conviction' and 'disease affirmation' were higher in the conversion vs. the organic disease group (Table 2) [50]. Stone et al. report that attributions to stress patients within the functional weakness group yielded a weak correlation with anxiety and depression ($r = 0.24$) [48]. A similar pattern was found in an earlier study by the same research group: patients with recent onset pseudoseizures thought that psychological causes were less important for their condition than patients with epilepsy (Table 2) [49].

Bailer et al. [51] reported that somatic attributions in SFD were markedly more frequent compared to the controls, but this was also true for psychological attributions in SFD patients compared to the other two groups (Table 2). Tuzer et al. reported no differences in attribution styles (pain vs. control group) [52]. Patients' psychological attributions correlated with depression and anxiety; somatic attributions correlated with anxiety ($r = 0.521$) (Table 2). In the randomised controlled trial (RCT) by Nanke and Rief, both multiple somatoform syndrome groups at baseline reported increased psychological attributions compared to the rest of the coded answers (organic, genetic and environmental causes) [53].

Regarding the relationship between anxiety and SFD Steinbrecher and Hiller [54] in their longitudinal study found that patients with SFD at baseline reported higher

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