Original article

A Study of Patient Clinician Interaction and Abnormal Illness Behaviours among Subjects with Chronic Non Organic Pain

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Abstract

Introduction: Patient clinician interaction is an important component of Abnormal Illness Behaviours (AIB) and can have significant impact on the patients' as well health care settings. AIB has been measured more with self-report scales compared to objective rating scales. This study assessed patient clinician interaction among in chronic pain using an objective scale, Illness Behaviour Assessment Schedule (IBAS).

Method: Details of demography and illness were collected using a semis-structured schedule. IBAS was administered to 301 adult subjects with chronic non-organic pain to assess patient clinical interaction and illness behaviour patterns.

Findings: Majority of the sample consisted of women (N=208; 69%). The mean duration of pain symptoms in years was 5.78± 5.43. Majority of the subjects did not acknowledge or were not sure of receiving any explanation for their illness. Subjects recalled the causal explanation as having both psychological and somatic causes. Nearly 70% of the subjects attributed their affective disturbance to somatic problems. Gender differences were noted in communication of affect with more men having moderate to marked inhibition. (Chi square 7.78, p=0.005).

Conclusions: This study highlights that patients often do not recall the explanations provided for their symptoms and may attribute their symptoms based on their own beliefs. This may correlate to abnormal illness behaviours. It is important to patient clinician interaction regarding the pain symptoms and attribution for appropriate management.

Keywords: Abnormal Illness Behaviours, pain, patient clinician interaction

Introduction:

Pain is often the commonest symptom which makes a person seek help. Pain is defined as an "unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage"(1). The response to pain by an individual depends on his past experience and to think about the cause and seek alleviation. Persistence of pain can make the individual think more about the cause and hence start seeking answers from health professionals. When the cause is clear, the pain symptoms get a label of "disease". If not, persistent pain may be labelled as psychological. If the ways of perceiving, responding to pain are maladaptive they can lead significant impairment in functioning and increased help seeking including abnormal illness behaviours and

sick roles. Illness behaviour is defined as the "ways in which given symptoms may be differentially perceived, evaluated and acted (or not acted) upon"(2). Pilowsky proposed the definition of abnormal illness behaviour (AIB) in 1969 (3). The elements of definition of AIB include persistence of a maladaptive mode of experiencing, perceiving, evaluating, and responding to one's own health status, despite the fact that a doctor has provided a lucid and accurate appraisal of the situation and management to be followed (if any), with opportunities for discussion, negotiation, and clarification and based on adequate assessment of all relevant biological, psychological, social and cultural factors.

Research has documented that multiple factors influence illness behaviour. Sirri et al (4) clubbed them as three categories which include patient related, illness related and doctor related variables which could determine illness behaviour. Illness behaviour is a personal and variable experience that is influenced by culture, past experience of illness and other cognitive variables. AIB has been studied in chronic pain and somatization using self reprot scale Illness behaviour questionnaire (IBQ)(5–7). Since clinician's role is essential for evaluation of AIB, an objective assessment of AIB would be necessary to understand the patient clinician interaction and illness behaviors.

A standardized interview known as the Illness Behavior Assessment Schedule (IBAS) was used to assess specific clinical aspects of AIB as well as patient clinician interaction. It has been validated with individuals from a psychiatric inpatient clinic and those attending pain and rheumatology outpatient clinics. In this study, psychiatric patients acknowledged more affective difficulties with recognition of the contribution of psychological factors to their illness, pain clinic patients showed greater symptom awareness and disease preoccupation while patients in the rheumatology group provided responses consistent with a greater somatic than psychological focus, with less extreme illness attitudes than those of the pain clinic and psychiatric patients (8). IBAS has also been used in Indian settings and the studies have focused on functional somatic symptoms. Patients with somatization showed abnormal illness behavior. More than half of the patients were convinced of having a somatic pathology (9). In another study in women with multiple somatic symptoms alexithymia scores correlated with communication of affect, somatic illness causal beliefs and denial on IBAS (10). The current study focused on objective assessment of illness behaviors and patient clinician interaction among subjects with chronic pain.

Methods:

The study sample was chosen from the subjects attending outpatient services of the Department of Psychiatry, National Institute of Mental Health and Neurosciences, Bangalore, India. Consecutive patients who satisfied the inclusion criteria were recruited for the study. Subjects of either gender between the age of 18 to 45 years, reporting persistent pain (pain should have been present at least daily or on alternate days) for greater than 6 months for which no organic basis was found were included. Those with a history of psychosis, mental subnormality, organic brain syndrome or

medical disorders, currently or in the previous one year, were excluded.

Socio demographic and clinical details were noted systematically by a semi structured preform. Clinical diagnosis was ascribed as per ICD 10 (11). Illness behaviour was assessed using Illness Behaviour Assessment Schedule (IBAS) which is 19-item questionnaire (8). The first six items seeks to establish whether the patient recalls having received an explanation concerning his health status and where applicable, what his/her response to it was. Items 7 and 8 are concerned with the degree of conviction with which the patient affirms or derives that either a somatic or a psychological illness is present. Item 9 concerns the proportion of time during which patient is aware of symptoms. Items 10 to 12 focus upon the patient's thoughts about the illness and deals with disease phobias, disease preoccupation and patient's own thoughts about the causation of their illness, in terms of psychological and somatic factors. Items 13 to 16 are concerned with affective states. Item 17, 18 and 19 measure the extent to which patients report existence of current life problems, acknowledged life problems attributed to the presence of somatic illness and interpersonal friction respectively. The reliability and validity studies have been conducted (8) and this tool has been used in the Indian setting (10,12).

Findings:

The total number of participants for this study was 301. The mean age in years for the sample was 34.8±7.76. The mean age in years for women was 35.5±7.58 and for men 33.4±8.04. Majority of the sample were women (N=208; 69 %), married (N=224; 75%) and belonged to Hindu (N=225; 75 %) religion. Most of them were from urban background (N=171; 57 %) and belonged to lower socioeconomic status (N=182; 60%). The mean years of education were 7.9±4.74. The frequency and percentages of items on IBAS pertaining to patient clinician interaction are given in the Table 1. Only half the subjects recalled having received any explanations for their symptoms. Nearly a quarter of them recalled being told that there is "nothing wrong with them". Recall of causal explanation was denied by 64% of the subjects. Of the subjects who recalled explanation only 33% accepted it partially. Only 7% accepted the explanation completely, Table 3 depicts presence of problems in communicating affect and feelings, anxiety, depression and irritability.

Majority of the subjects did not acknowledge or were not sure of receiving any explanations for their illness. Subjects recalled the causal explanations as having both psychological and somatic causes. Nearly 70% of the subjects attributed their affective disturbance to somatic problems. Items on denial and displacement were noted in 70% and 30% in this sample respectively. Gender differences were noted in communication of affect with more men having moderate to marked inhibition (Chi square 7.78, p=0.005).

Discussion:

This study assessed the patient clinician interaction and illness behaviour by using an objective scale IBAS. In the assessment of illness behaviour by IBAS, only half of the study subjects had received an explanation for their symptoms, however the patients were not sure about the

explanations whether their illness was somatic or psychological. Many subjects had received more than one explanation for their symptoms during the course of their illness. However, the subjects attributed their illness as being somatic and were also unsure about the cause of the illness. The endorsement of the illness being psychological was not done by majority of the subjects. A significant proportion of the subjects were preoccupied about their symptoms and held a model of illness that was either somatic or mixed aetiology. Communication of feelings readily was reported by 54% of subjects. The rest had mild to marked difficulties in communication of feelings.

The main aspects that were raised by these findings were the role of the subject and the health professional in illness behaviour. Ambiguous responses from health professionals might contribute to abnormal illness behaviours (13). Patients who are anxious and overly concerned about their health might interpret the information provided by health professionals in a way that is based on the belief that they have about their symptoms. However, one of the observations during the study was that subjects acknowledge the stressors but were not linking it to their symptoms and rather were not willing to link their symptoms to stressors. It was also difficult to assess whether the stress was present beforehand or came about after the symptoms began. When there are multiple explanations including explanations by Complementary and Alternative medicine (CAM) professionals, it is difficult to comprehend the cause. The response of "being unsure" was most often used, hence, this indicates challenges on patient clinician interaction.

Conclusion:

This study highlights that patients often do not recall the explanations provided for their symptoms and may attribute their symptoms based on their own beliefs. This may correlate to abnormal illness behaviours. It is important to patient clinician interaction regarding the pain symptoms and attribution for appropriate management.

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Tables:

Table 1: Frequency of IBAS items pertaining patient clinician interaction

Recall of explanations received concerning illness	**Frequency (percentage) N (%)**
Patient says he has never received an explanation	93 (31)
Patient is not sure whether he has received any explanation	56 (19)
Patient recalls having received an explanation	152 (50)
Interviewer's assessment of whether explanation was given	
Given	151 (50)
Uncertain	56 (19)
Not given	94 (31)
Person who is believed or known to have explanation	
Interviewer	7 (2)
Other	286 (95)
Not applicable	8 (3)
Type of explanation recalled by the patient	
Recalls being told there is nothing wrong at all	73 (24)
Recalls being told that he has a minor illness	61 (20)
Recalls being told he has a major illness	0 (0)
Recalls more than one (different) explanation of his illness	57 (20)
Not applicable (no causal explanation recalled)	110 (36)
Type of causal explanation recalled by patient	
Patient recalls being told the illness is entirely due to somatic causes	7 (2)
Patient recalls being told the illness is due to a combination of somatic and psychological causes	42 (14)
Patient recalls being told the problems are entirely due to psychological (nonphysical) causes	61 (20)
Not applicable (no causal explanation recalled)	191 (64)

Patient's response to explanation recalled	
Accepts it completely	20 (7)
Accepts it partially	98 (33)
Rejects explanation completely	38 (12)
Not applicable (no explanation recalled)	145 (48)

Table 2: Disease Conviction, Disease Phobia, Symptoms awareness and Preoccuation with Disease

Disease conviction (affirmation) – somatic	**Frequency (percent)**
Patient expresses certainty as to presence of a somatic disease or pathology	98 (33)
Patient expresses some uncertainty as to presence of somatic disease or pathology	187 (62)
Patient expresses certainty as to absence of any specific somatic disease	16 (5)
Disease conviction (affirmation) – psychological	**Frequency(percent)**
Patient expresses certainty as to presence of a psychological disorder	9 (3)
Patient expresses some uncertainty as to presence of psychological disorder	128 (42)
Patient expresses certainty as to absence of psychological disorder	164 (55)
Symptom awareness	**Frequency(percent)**
Absent	0 (0)
Patient is aware of symptoms 50% of the time or less	28 (9)
Awareness of symptoms present more than 50% of the time but not constantly	108 (36)
Patient is constantly aware of symptoms	165 (55)
Disease phobia	**Frequency(percent)**
Absent	107 (35)
Present 50% or less of time	136 (45)

Present 50% or more of the time but not constantly	58 (20)
Preoccupation with disease	**Frequency (percent)**
Absent	72 (24)
Present 50% or less of the time	58 (19)
Present 50% or more of the time (but not constantly)	74 (25)
Present constantly	97 (32)

Table 3: Affective disturbance and Affective Inhibition

Variable	**Frequency(percent)**
Communication of affects and feelings Moderate and Marked Inhibition	102 (34)
Anxiety Moderate and Marked	170 (57)
Depression Moderate and Marked	89 (27)
Irritability Moderate and Marked	90 (30)