Indian Journal of Psychiatry, April 1988, **30**(2), pp 205-208

ILLNESS BEHAVIOUR ASSESSMENT OF PSYCHIATRIC PATIENTS WITH SOMATIC PRESENTATION

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Introduction

Mechanic (1960) defined illness behaviour as the ways in which given symptoms may be perceived, evaluated and acted (or not acted) upon by different kinds of persons whether by reason of early experience of illness, differential training in response to symptoms or whatever. In 1966 he added that illness behaviour may be seen as part of the coping repertoire as an attempt to make an unstable challenging situation more manageable for the person who is encountering difficulty. He also said that illness behaviour could be seen in terms of its advantages for the patient in seeking and obtaining attention, sympathy and material gain.

Pilowsky (1967) put forward the concept of "Abnormal illness behaviour". He defined it as the persistence of an inappropriate or maladaptive mode of perceiving, evaluating and acting in relation to one's own state of health despite the fact that a doctor (or other appropriate social agent) has offered a reasonably lucid explanation of the nature of the illness and the appropriate course of management to be followed based on a thorough examination and assessment of all parameters of functioning (including the use of special investigations wherever necessary) and taking into account the individuals age, education and socio-cultural background. Abnormal illness behaviour is measured using the (1) Illness Behaviour Questionnaire (IBQ) which is a 62 item self-report instrument that provides information relevant to the delineation of a patient's attitudes, ideas, affects and attributions in relation to illness. From the IBQ are derived 7 scores on factor analytically derived illness behaviour scales, as well as scores on 2 second order factor and discriminant function; (2) Illness Behaviour Assessment Schedule (IBAS), which has been developed to overcome some of the limitations associated with self-report instruments and to provide a basis for more precise definition and study of the various patterns of illness behaviour encountered clinically.

The IBAS is a 19 item questionnaire. The first 6 seek to establish whether the patient recalls having received an explanation concerning his health status and where applicable what his 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 8 concerns the proportion of time during which the patient is aware of symptoms. Items 10

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to 12 focus upon the patients thoughts about the illness and deal with the disease phobias, disease pre-occupation and patients' own thoughts about the causation of their illness, in terms of psychological and somatic factor. Items 13-16 are concerned with affect and the patients thoughts concerning the origin of their affective state.

Item 17 provides a measure of the extent to which the patient reports the existence of current life problems other than and essentially independent of the presenting illness, while item 18 rates the extent to which acknowledged life problems are attributed by the patient to the presence of a somatic illness. Item 19 assesses inter personal friction and irritability and is probably best regarded as part of the affective subgroup of items. The reliability studies done on IBAS by Pilowsky in 1983 showed that there were low rates of agreement on some items. The overall impression remained that inter-observer agreement was satisfactorily high (% mean agreement range 67.2-95.6, Pilowsky et al. 1983-84).

Illness behaviour has been previously studied in an Indian setting (Varma et al. 1986) at Chandigarh using the IBQ in 200 pain patients. 4 factors were derived corresponding to the original version: (1) General hypochondriosis (2) Denial (3) Affective inhibition and (4) Affective Disturbance. No other studies on Illness Behaviour in India have been reported till now.

The aim of this study was to assess illness behaviour in patients attending the psychiatric O.P.D. and reporting multiple somatic symptoms.

Material and Methods

The study was conducted in the psychiatry O.P.D. of NIMHANS, Bangalore. 31 patients fulfilling the following criteria were selected (i) Those who had predominant somatic presentation and, (ii) No evidence of organic or physical pathology ruled out by history, detailed physical examination and investigation wherever necessary. Sociodemographic data was collected on a data sheet. Psychiatric history was taken and examination done uniformly. Psychiatric diagnosis was ascribed according to ICD - 9. I.B.A.S. was administered after establishing a good rapport with the patient.

Table
Percentage frequency distribution of Illness Behaviour Assessment Schedule items according to diagnosis

Item	Category	Anxiety/ Depressive Neurosis n = 18	Other disorders n = 13	Total patient n = 31
1. Recall of Explanations	A. Recalled	39	31	35
	B. Uncertain	17	0	10
	C. Not recalled	44	69	55
2. Interviewers assessment of explanation given	A. Given	61	62	61
	B. Uncertain	11	15	13
	C. Not given	28	23	26
3. Person who gave explanation	A. Interviewer	11	15	13
	B. Others	56	62	58
	C. Not known	33	23	29
4. Type of explanation recalled	A. Nothing wrong	22	15	19
	B. Minor illness	22	23	23
	C. Major illness	0	8	3
	D. Many explanations	11	15	13
	N/A	44	38	42
5. Type of causal explanation recalled	A. Somatic	6	8	6
	B. Mixed	22	15	19
	C. Psychological	17	38	26
	D. Many explanations	11	15	13
	N/A	44	38	42
6. Response to explanation recalled	A. accepts	11	15	13
	B. ±	11	0	6
	C. Rejects	28	46	36
	D. N/A	50	39	45
7. Disease conviction (soamtic)	A. +	61	54	58
	B. ?	33	8	23
	C. −	6	38	19
8. Disease conviction (psychological)	A. +	6	38	19
	B. ?	6	0	3
	C. −	88	62	78
9. Symptom awareness	A. 0%	0	8	3
	B. 1-50%	33	31	32
	C. 51-99%	39	38	39
	D. 100%	28	33	26
10. Disease Phobia (% time)	A. 0	72	53	64
	B. 1-50%	17	8	13
	C. 51-99%	11	15	13
	D. 100%	0	23	10

Item	Category	Anxiety/ Depressive Neurosis n = 18	Other disorders n = 13	Total patient n = 31
11. Disease pre-occupation	A. 0	61	62	61
	B. 1-50%	22	15	19
	C. 51-99%	17	8	13
	D. 100%	0	15	7
12. Illness-Causal beliefs	A. Psychological	0	31	13
	B. Mixed	17	31	23
	C. Somatic	83	38	64
13. Communication of affects	A. Easy	56	53	55
	B.	11	15	13
	C.	22	32	26
	D. Difficult	11	0	6
14. Anxiety	A. Absent	11	46	26
	B. Mild	33	32	32
	C. Moderate	33	23	29
	D. Severe	22	0	13
15. Depression	A. Absent	11	32	19
	B. Mild	44	32	39
	C. Moderate	33	38	36
	D. Severe	11	0	6
16. Attribution of affective disturbance	A. Psychological	17	23	19
	B. Mixed	28	15	23
	C. Somatic	55	31	45
17. Denial of current life problems	A. Absent	39	54	45
	B. ±	28	8	19
	C. Complete	33	38	36
18. Displacement	A. Absent	39	38	39
	B. ±	17	8	13
	C. Complete	0	23	9
	N/A	8	30	39
19. Irritability	A. Absent	61	53	58
	B. Mild	28	8	19
	C. Moderate	11	31	19
	D. Severe	0	8	3

Results

The sample included 31 subjects, their characteristics were: 58% were above 30 years age, 58% were female and 68% were from urban background. 78% were Hindu; and 74% were married. The most frequent ICD-9 diagnosis were Anxiety Neurosis (23%) and Depressive Neurosis (35%). Thirteen cases had other somatising disorders like psychalgia, conversion react on, hypochondriasis and mixed neurosis. I.B.A.S. results (Table) showed that 55% of the cases recalled receiving explanation. 10% were not sure. In the interviewer's (S.N.B.) assessment 61% received an explanation. About 58% of the patients were convinced that they had a somatic pathology and about 78% were certain as to absence of any psychological disorder. 65% had symptom awareness more than 50% of the time. About 64% thought that the cause for their symptoms were purely somatic. 55% of the patients could communicate affect readily and 39% had mild to moderate inhibition. 61% had mild to moderate anxiety. 75% had mild to moderate depression. 45% attributed affective disturbances to somatic causes. Only 36% denied any life problems and 9% attributed current life problems to somatic problems. Irritability was reported by 42%. The diagnosis-wise frequency distribution is shown in the table. The differences in the illness behaviour items in different diagnostic groups were statistically not significant.

Discussion

It was seen that more than half of the patients assessed recalled having received an explanation, though in the interviewers assessment perhaps more had received an explanation (61%). This could be due to denial on the part of the patient to accept that there were no organic causes for his complaints. More than half (58%) were convinced of having only somatic pathology, despite the fact that they were referred to our Psychiatry O.P.D. In addition 78% were certain about the absence of any psychological disorder, probably reflecting the somatic presentation due to lack of psychological sophistication. Even though the patients were convinced of a somatic pathology a large majority were neither preoccupied nor believed that they had any specific disease. In this sample it was found that about half could easily communicate their affect and still their presentation was with somatic complaints, at the same time about 35% had mild to moderate inhibition, probably suggesting the presence of alexithymia. Anxiety and

depression were present in the majority of the patients and significantly 45% attributed the affective disturbance to somatic causes. Denial of life problems was encountered less frequently.

In conclusion, it is seen that a number of subjects with mainly affective disturbances (as reflected in the ICD - 9 diagnosis) and somatic complaints demonstrate abnormal illness behaviour patterns inspite of receiving explanations regarding their problems. Even in the absence of inhibition to communicate affect their presentation is again predominantly somatic.

On comparing our results with those reported by Pilowsky et al. (1983-84), the findings are similar to their psychiatric patients. There were differences in the type of explanation given, as in many of our patients, perhaps adequate explanation was not given. In those who were given explanation majority rejected it. Causal beliefs were different from those reported by Pilowsky et al. (1983-84), where only 23% reported somatic causes in contrast to 63% of our patients believing in somatic etiology. Denial was more frequently noted by Pilowsky et al. (1983-84) in their psychiatric patients. The comparisons demonstrate that illness behaviour might have minor variations depending on their cultural background. The results also show that many psychiatric patients, especially those with somatization show abnormal illness behaviour. Significant associations between age, religion, and background and abnormal illness behaviour were found in the present group of patients, which have been described elsewhere (Chaturvedi and Bhandari 1988, in press).

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