Assessing illness behaviour
What condition is my condition in?

In a paper in this issue, Rief et al. [1] present a new scale for assessing illness behaviour. The Scale of the Assessment of Illness Behaviour (SAIB) comprises five dimensions: verification of diagnosis, expression of symptoms, medication reliance, illness consequences, and bodily scanning. The initial validation of the scale has been completed through comparison of patients presenting with unexplained physical symptoms with normal controls and depressed patients, as well as through doctor ratings of patient behaviour. The scale represents a considerable advance in the development of the concept of illness behaviour, as well as its measurement. The increased focus by Rief and his colleagues on illness behaviour also opens more opportunities for intervention. Behaviours such as scanning, verification of diagnosis, and so forth provide targets that may be directly addressed in an intervention programme. Patients who are caught in a recurring and often dangerous pattern of specific illness behaviour have the potential to be more adequately assessed using the SAIB and an intervention programme instituted to address their particular profile.

The original concept of abnormal illness behaviour was developed by Pilowsky to describe a maladaptive mode of perceiving and responding to one’s health despite reassurance or explanation by a doctor. In particular, the degree to which psychological characteristics may explain exaggerated or extreme responses to illness [2]. Abnormal illness behaviour has been characterised by a broad mixture of hypochondriacal tendencies, illness-related attitudes and abnormal affective responses, such as a difficulty in expressing emotions and irritability. The Illness Behaviour Questionnaire was an attempt to measure these various dimensions [3].

Unfortunately, this scale is highly correlated with measures of negative affect which creates difficulties in research or clinical settings where patients are complaining of symptoms or illness [4]. In this aspect, the new measure by Rief and his colleagues represents an important improvement.

Despite a move away from directly assessing hypochondriasis, the SAIB is still somewhat grounded in the “abnormal” behaviour setting, evident in its use with somatising and depressed patients. Therefore, researchers or clinicians may find the scale most useful for patients with functional illnesses such as chronic fatigue syndrome or chronic pain syndromes. However, potential exists in the wider health field to develop scales that assess illness behaviours independent of psychiatric caseness. The shift in nomenclature from “abnormal illness behaviour” to “illness behaviour” in the paper may signal the start of this change. For many years, abnormal illness behaviour has been closely associated with hypochondriasis and somatoform disorders. However, illness behaviours such as doctor shopping are actually very common and appear in many patients who are not hypochondriacal or do not meet formal criteria for a psychiatric diagnosis [5]. Moreover, behaviours, such as heightened scanning for symptoms and a strong belief in medication, can also reflect patients’ idiosyncratic perceptions of their illness or medication [6].

Illness behaviour can be simply conceptualized as how individuals respond to a perceived health threat or illness. This prompts us to understand the (mis)perceptions of the illness or health threat that underlie the illness behaviour. Such research can help identify how specific beliefs and perceptions of the threat, as well as environmental factors (such as the presence of others or a community’s level of concern about particular symptoms) influence illness behaviour. The large variety of illness behaviours is reflected in a growing range of scales to include such behaviours as the refusal of medical treatments, use of alternative medicines and self-treatment [7].

Looking from the perspective of the patient, illness behaviour can be also conceptualized as reassurance failure on the part of the doctor. Some evidence suggests that the group of patients that fail to be reassured in medical consultations following normal test results may be larger than once thought [8]. Moreover, patients with higher levels of health anxiety, erroneous beliefs about their symptoms or about their level of personal risk may need more effective interventions to reduce illness behaviour and disability over the longer term. For a proportion of these patients, iatrogenic factors such as over-investigation, poor advice and inappropriate medication may serve to maintain negative illness perceptions and illness behaviour [9].

Dysfunctional illness behaviour represents a major source of over investigation and over treatment in the health system. Considerable work needs to be done to develop a better theoretical understanding of the development of...
illness behaviour. For instance, we have little knowledge about why some individuals develop tendencies to doctor shop while others prefer to remain focused on scanning their body for signs or symptoms. It is hoped the paper by Rief and his colleagues will prompt researchers to take a wider view of illness behaviour and its measurement.

References
