Journal of Psychosomatic Research 97 (2017) 131–135

Contents lists available at ScienceDirect

Journal of Psychosomatic Research

journal homepage: www.elsevier.com/locate/jpsychores

Patient-provider relationship as mediator between adult attachment and self-management in primary care patients with multiple chronic conditions

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ARTICLE INFO

Keywords:
Attachment
Physician-patient-relationship
Primary care
Self-management
Mediation analysis

ABSTRACT

Objective: The conceptual model of attachment theory has been applied to understand the predispositions of patients in medical care and the patient-provider relationship. In patients with chronic conditions insecure attachment was connected to poorer self-management. The patient-provider relationship is associated with a range of health related outcomes and self-management skills. We determined whether the quality of the patient-provider relationship mediates the link between adult attachment and self-management among primary care patients with multiple chronic diseases.

Method: 209 patients with a minimum of three chronic diseases (including type II diabetes, hypertension and at least one other chronic condition) between the ages of 50 and 85 from eight general practices were included in the APRICARE cohort study. Adult attachment was measured via self-report (ECR-RD), self-management skills by the FERUS and the patient-provider relationship by the PRA-D. The health status and chronicity were assessed by the GP. Multiple mediation analyses were used to examine whether aspects of the patient-provider relationship (communication, information, affectivity) are a mediators of associations between adult attachment and self-management.

Results: The analysis revealed that the quality of the patient-provider relationship mediated the effect of attachment on self-management in patients with multiple chronic conditions. Particularly the quality of communication and information over the course of treatment has a significant mediating influence.

Conclusion: A personalized, attachment-related approach that promotes active patient-provider communication and gives information about the treatment to the patient may improve self-management skills in patients.

1. Introduction

Self-management has a key part as an essential element of evidence-based medical care for patients with chronic diseases in primary care [1]. But there are different definitions. Self-management is a complex, multi-component construct that includes aspects such as coping and self-efficacy. We defined it as the ability of patients to manage their problems actively and independently and to pursue their goals. Primary health care is the first point of contact for health care for most people. It is mainly provided by GPs (general practitioners). A major task in primary care is the treatment of elderly patients with multiple chronic diseases [2,3]. The GP is often the main contact for these patients. However, to implement effective patient-centered self-management programs in primary care, it is important to understand the differences in patient interaction styles. Attachment theory provides a psychosocial model to explain the individual differences in experience and behavior in relation to interpersonal closeness and distance to stress and affect regulation in situations that are subjectively perceived as threatening [4,5]. Based on the central assumptions of attachment theory, a model for the activation of the attachment system in adulthood was developed [6]. The model supports the adoption of the attachment activation by chronic diseases [7]. There are other model assumptions which describe the different influences of insecure attachment on the maintenance of diseases or chronic disease through example low self-management skills [8]. Researchers found evidence in diabetic patients, that insecure attachment was associated with poorer diabetes self-management and negative outcomes [9,10]. In our own studies, we also found a relationship between insecure attachment and low self-management in patients with diabetes and other chronic conditions. Attachment anxiety was significantly linked to impaired coping and lower self-

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http://dx.doi.org/10.1016/j.jpsychores.2017.04.007
Received 9 January 2017; Received in revised form 23 March 2017; Accepted 14 April 2017

efficacy, hope, dietary control, and physical activity. Attachment avoidance, on the other hand, was associated with lower levels of social support and health-care use [11]. The present study is based on a conceptual classification of the two attachment dimensions anxiety and avoidance [12]. Patients scoring high on the avoidance scale have learned to suppress their attachment needs and use deactivating attachment strategies. The main characteristics of deactivating strategies are denying attachment needs, trivializing risks, as well as the repression of negative emotions and cognitions [13]. Avoidant patients are also characterized by high levels of self-reliance, greater interpersonal distance [14] and minimal help seeking behavior and expression of distress [15,16]. They cope with stress by cognitive distancing from their emotions, denial and distraction [17]. Among the hyper-activating strategies, patients with higher scores of anxiety attachment show increased attention to threatening situations with their chronically activated attachment system leading to the perception of more risks (e.g. increased awareness of symptoms of illness reported to the physician) and to a hyperactive search for proximity, e.g. by the catastrophizing of symptoms [13]. Patients' attachment styles can influence their health seeking behavior and the ability to accept help from primary care physicians and other health care professionals [18]. Some studies show the importance of the family physician as a primary caregiver [19]. Physicians are powerful figures who provide emphatic support by listening and care in phases of activation of the attachment system [20]. Accordingly, we hypothesized that characteristic of the patient-provider relationship (especially the GP-patient relationship) has a mediating influence of the relationship between attachment characteristics of patients with multiple chronic diseases in primary care and their self-management.

2. Method

2.1. Study design and recruitment

The APRICARE study (Adult Attachment in Primary Care study, funded by the German Research Society, DFG: GE 2073/5-1) included 219 patients from eight general practices in Germany. It was designed as a multi-center, prospective, longitudinal, observational cohort study. In each practice, a list of patients was drawn up based on the electronic database of the GP. This list comprised all patients who had three predefined chronic diseases (type II diabetes, hypertension, and at least one other chronic condition out of a standardized list of chronic diseases [21]), who were between the ages of 50 and 85 and had consulted their GP at least once within the previous 3-month period. Emergency patients, patients from other family practices and those unable to give informed consent were excluded from the study. A total of 25 to 35 patients from each of the eight units were included in the study. The recruitment was carried out in accordance with the primary care research recruitment rules of “The German Multi-Care-study” [21]. Recruitment and baseline data collection took place from March 2012 until June 2012. The study was conducted in accordance with the “Declaration of Helsinki”, the guidelines of Good Clinical Practice and was approved by the Institutional Review Board of the Jena University Hospital (No. 3009-12/10).

2.2. Data collection

25 to 35 of the eligible patients from the list of multi-morbidity patients with the predefined chronic diseases were selected at random (by a list of random numbers) and invited to participate in the study by means of a telephone call or a letter from the practices. Patients willing to participate and who agreed to the terms of the study were asked to sign an informed consent form at the practice. The physician then filled out a sheet with the basic documentation and inclusion criteria; the patient received a comprehensive questionnaire for self-assessment, which had to be completed at home and returned in a sealed envelope to the practice. Patients were reimbursed for this, receiving EUR 10 for their efforts. The questionnaires the physicians had to complete included the ICD-10 diagnosis and assessment of the severity of the participants' chronic conditions. Each GP received EUR 500 per measurement point.

2.3. Measures

The patients' socioeconomic status was assessed based on the recommendations of the Association of “Epidemiologic Methods” in the German Association of Epidemiology [22].

2.3.1. State of health and documentation of multi-morbidity

In order to determine the patients' health status and multi-morbidity various scores were used. The patients completed the list of chronic diseases and assessed their state of health by means of a visual analogue scale from 0 to 100 [23] German: [24]. The physician also documented the chronic diseases based on the equivalent list of chronic diseases. Moreover, the degree of chronicity was rated using the Cumulative Illness Rating Scale for Geriatrics. The CIRS-G is a multi-morbidity index based on disease severity grouped at organ system levels [25]. A 4-level classification of severity is used to assess the 14 organ systems [26].

2.3.2. Attachment

A self-rating questionnaire was used to measure adult attachment. The Experience of Close Relationships – Revised in its German version [12,27] is a dimensional measure of adult attachment style on the two subscales - avoidance and anxiety - with a seven-point Likert scale. In general, individuals with higher scores of attachment avoidance report lower intimacy. They find intimacy uncomfortable and prefer to seek their independence. Patients scoring highly on the attachment anxiety dimension have a tendency to fear rejection and abandonment. A requirement to the instrument was to put specific focus on the relationship to the current or previous partner. The validation of the German version showed Cronbach's alpha reliability scores of 0.91 and 0.92 for the two relevant sub-scales. Due to the participants being elderly and having several ailments, the instrument had to be brief and easy to use and understand, as well as easily implemented in primary care, so we used the short form ECR-RD12 [28].

2.3.3. Self-management

A self-management questionnaire (FERUS26) for the measurement of resources and self-management skills was used [29]. The FERUS26 includes 26 items to be answered on a five-point Likert scale. The subscales self-verbalization, coping, self-efficacy and hope can be combined to the scale “self-management skills”. The internal consistency (Cronbach's alpha) for the subscales ranged between 0.86 and 0.93.

2.3.4. Patient-provider relationship

The patients' perception of the patient-provider relationship was measured by the Patient Reaction Assessment (PRA) [30,31]. The three subscales include communication, information and affectivity, which were measured on a seven-point Likert scale (higher scores indicate higher quality of the patient-provider relationship). The subscale information describes the perception of the patient to see the doctors as transmitters of information, who provide a more detailed description of the diseases and treatment. Communication subscale assesses the ability to actively participate in the communication process. The affective subscale measures a respectful interaction of the physician with the patient and if the physician shows emotional support and understanding. The internal consistency is high (between 0.87 and 0.91). A total sum score can be calculated for determining the quality of physician-patient relationship. Cronbach's alpha for the total score ranged between 0.83 and 0.91 in former studies [30,31].