



Insecure attachment style and cumulative traumatic life events in patients with somatoform pain disorder: A cross-sectional study



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ABSTRACT

Objective: Current models assume somatoform pain disorder (SPD) to be the result of a complex interaction between bio- and psychosocial factors, but the etiology is still not well understood. This study aimed to investigate the distribution of attachment style and the frequency of traumatic life events, especially childhood adversities, in patients with SPD compared to healthy controls.

Methods: We compared 65 patients with SPD (confirmed by Structured Clinical Interview, SCID-I) to 65 age- and gender-matched healthy controls. The following questionnaires were employed: Relationship Scale Questionnaire (RSQ), Essen Trauma Inventory (ETI), Childhood Trauma Questionnaire (CTQ) and Patient Health Questionnaire (PHQ-15). A logistic regression analysis was used to identify the association between SPD and psychological factors.

Results: Insecure attachment was significantly more prevalent (60%) in patients with SPD compared to healthy subjects (14%; $p < 0.001$). Overall, 70.4% of patients with SPD reported three or more traumatic events in their life, compared with healthy subjects who reported predominantly one (40%). Patients with SPD scored significantly higher in all CTQ subscales compared to the healthy controls. The factor most strongly related with SPD was the insecure attachment style (OR = 11.20, 95% CI: 1.32–94.86). Other significant predictive factors were depression (OR = 3.35, 95% CI: 1.84–6.11) and number of traumatic events (OR = 2.04, 95% CI: 1.06–3.92). Insecure attachment, depression symptoms and the number of traumatic events explained 86.2% of the variance.

Conclusions: The high predictive value of insecure attachment style and cumulative traumatic events emphasize their importance as risk factors of SPD.

1. Introduction

Patients who have somatoform pain disorder (SPD) complain of persistent, severe and distressing pain, with the 12-month prevalence rate among the German general population being 8.1% [1]. SPD is defined by the presence of pain which either persists in the absence of a physical condition, or is not fully explained by a medical condition. Psychological factors are central in the onset, severity, exacerbation and maintenance [2]. Current models assume somatoform pain as resulting from a complex interaction between bio- and psychosocial factors [3,4] but the etiology is still not well understood.

There is increasing empirical evidence that an insecure attachment style, traumatic life events, especially early childhood adversities, play an important role in the development, maintenance and progression of mental and functional disorders over the lifetime [5,6]. The same

factors have been investigated in patients with SPD [3].

2. Attachment

Attachment theory is a psychological model that describes the dynamics of interpersonal relationships and represents a fundamental aspect of personality development [7]. On the basis of the interaction with primary caregivers during infancy and childhood, children develop a stable and secure internal “working model” of the self and others, which may help them to predict and understand the responses of others and to establish future relationships [7]. Bartholomew and Horowitz [8] identified four main attachment types in adults, which are conceptualized in terms of secure (viewed as healthy and adaptive) and insecure (dismissing, preoccupied and fearful) attachment styles. A secure attachment ensures that the person will be able to manage

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distress and regulate emotions as well as promote adaptive responses to threat throughout the lifespan. An insecure attachment contributes to a dysfunctional regulation of stress and emotion [9] and represents a risk factor for chronic pain.

Numerous studies suggest that there is a high prevalence of insecure attachment among patients with chronic pain [10–14]. Ciechanowski et al. [10] showed an association between insecure attachment and number of reported somatic symptoms. Waller et al. [11] reported insecure attachment to be significantly more frequent in somatoform disorders, including SPD, than in nonclinical controls. Patients with chronic pain have reported an insecure attachment style more often than pain free controls [12] and insecure attachment was found to be highly associated with medically unexplained musculoskeletal pain [13].

In terms of the impact of attachment on pain, Meredith et al. [15] postulated that insecure attachment represents a sensitivity for developing chronic pain and those with insecure attachment are more likely to have a maladaptive response to pain. For example, individuals with an insecure attachment style show a heightened physical pain sensitivity, as well as a reduced pain threshold on experimentally induced pain [16,17].

3. Traumatic life events and childhood adversities

Prospective studies could demonstrate an association between chronic pain and lifetime traumatization [5,18]. Reviews have found substantial associations between history of sexual abuse and a lifetime diagnosis of somatoform disorders [6,19]. Brown et al. [20] found that patients with somatization disorder reported more emotional and physical abuse, and had witnessed more violence in their childhood in comparison to patients with a disorder of medical origin. In addition to this, patients with a somatization disorder were found to have suffered significantly more physical and sexual abuse in childhood than patients with a depression [21]. Moreover, psychiatric patients who had experienced traumatization reported more somatoform symptoms [22]. A meta-analysis [23] showed that traumatic events are associated with an increased prevalence of somatic syndromes. Furthermore, traumatized abuse survivors were found to report more chronic pain [24].

The amount of traumatic life events therefore seems to have a high impact on the development of chronic pain [18,25]. In the clinical field, the conditional relationship between traumatization and SPD seems to be manifest and obvious, but there is still insufficient empirical evidence for this. To our knowledge, there is no study that investigates the prevalence of numerous traumatic events in general, as well as different facets of childhood adversities and attachment style, in the same study. Therefore, the purpose of the present study was to follow up previous findings and to gain further insight into the relation between somatoform pain, traumatic life events, maladaptive childhood experiences and insecure attachment, using a well-evaluated patient group in comparison to an age- and gender-matched healthy control group.

We hypothesized that an insecure attachment style would be more frequent in patients with SPD compared to healthy controls.

Secondly, we predicted that patients with SPD would report more traumatic life events and childhood adversities than healthy controls.

Thirdly, we presumed that insecure attachment and traumatic life events, especially childhood adversities, are psychological risk factors that have a predictive impact on development of SPD.

4. Methods

4.1. Study design and sample

Patients with pain disorders, who have failed previous outpatient medical treatments and psychotherapy in the primary care are admitted to the day clinic of Psychosomatic Medicine and Psychotherapy and/or to the Multidisciplinary Pain Center (MPC) of the Institute of

Anesthesiology. Referrals can be made by physicians, mostly general practitioners, psychiatrists or clinical psychologists. Both centers conduct a comprehensive diagnostic evaluation including medical conditions and mental disorders. The main focus of the MPC is drug treatment; in the psychosomatic day clinic psychotherapeutic methods are used. In the above mentioned units from August 2014 to May 2015 we asked 100 patients with SPD to participate in the study. Of these, 65 patients agreed to participate and were available for analysis (response rate 65%). A further 35 declined participation because of several reasons (no time or interest, logistical reasons, burdening questions). Responders and non-responders did not differ in gender or age. Selection criteria consisted of the diagnosis of “pain disorder associated with psychological factors” according to Code 307.80 of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) [2], which is also consistent with the International Classification of Diseases criteria [26]. A trained psychologist performed the diagnosis using the Structured Clinical Interview for DSM-IV (Axis I). There were 65 healthy controls who were recruited according to the “snowball” method, as well as through advertisements in the university library, and were matched for sex and gender. General exclusion criteria for both groups were: age younger than 18 or older than 65 years, current alcohol or substance abuse, any major organic or psychotic disorder, as well as insufficient German language skills or any disabilities that impair understanding the study and the questionnaires. All participants gave written informed consent. The study was approved by the local ethic committee of the Friedrich-Alexander University Erlangen-Nürnberg (FAU) (approval number: 46_14B).

To confirm the patient's diagnostic status concerning somatoform and mood disorders, we used the German version of the Structured Clinical Interview (SCID-I), for Axis-I disorders [27]. For the control group, the short-version of the Structured Clinical Interview for DSM-IV was used for screening to exclude any participants with mental disorders. None of the subjects met the criteria for a current or lifetime somatization or mental disorder. After study inclusion, each participant was invited to take part in the SCID-I and ETI interview, conducted by a trained psychologist. After the interview, participants completed the questionnaires by themselves in a separate room.

5. Psychometric instruments

5.1. Structured Clinical Interview (SCID-I)

SCID-I [27] is a semi-structured interview for detection of current and lifetime Axis-I diagnoses according to the DSM-IV criteria [2]. We applied the German version of Section G (somatoform disorders) for validation of SPD. On the basis of frequent comorbidity with depression, we also used Section D for mood disorders.

5.2. Patient Health Questionnaire (PHQ-15)

The PHQ-15, a module of the Patient Health Questionnaire [28], is a 15 item self-report questionnaire, measuring the severity of somatic symptoms. The items include the most relevant DSM-IV somatic symptoms. The total score ranges from 0 to 30 and represents the severity level of somatization whereby a score of ≥ 5 is considered mild, ≥ 10 medium, and ≥ 15 severe. PHQ-15 is considered to be a reliable and valid instrument for measuring somatic symptom severity [29].

5.3. Patient Health Questionnaire (PHQ-9)

Severity of depression symptoms were assessed using the nine item depression subscale PHQ-9 of the Patient Health Questionnaire [28]. Each of the items corresponds to one of the DSM-IV symptoms for major depressive disorder. Subjects were asked for the last two weeks. PHQ-9 score ranges from 0 to 27, with scores of ≥ 5 mild, ≥ 10 moderate, ≥ 15 severe depression severity. Psychometric properties of the PHQ-9 are

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