The difficult patient: an attachment perspective

Panzer A, Viljoen M
Department of Physiology, School of Medicine, University of Pretoria
Maunder RG, Hunter JJ
Department of Psychiatry, Mount Sinai Hospital, University of Toronto

Correspondence: Prof M Viljoen, Department of Physiology, School of Medicine, University of Pretoria, PO Box 2034, South Africa. Tel: +27 (12) 319-2140, Fax: +27(12) 321-1679, e-mail: *mviljoen@medic.up.ac.za*
Keywords: illness behaviour, attachment theory, difficult patient, help-seeking behaviour

Abstract

Stressors such as illness, injury and hospitalisation are likely to activate attachment behaviours. The way people react to these stressors; (i.e.; their illness behaviour); varies widely; and is strongly correlated with their attachment style. In this paper we briefly review attachment theory, with reference to difficult patient behaviours, including compulsive self-reliance, compulsive care seeking and rejection of staff coupled with exaggerated help-seeking behaviour. We conclude by suggesting simple interventions that can easily be applied to enable staff to cope, and thus be more able to help patients with difficult illness behaviours. *(SA Fam Pract 2003;45(8):11-13)*

INTRODUCTION

Every healthcare worker has come across patients who are difficult to help; and has felt frustrated and exasperated as a result. Examples of 'difficult' patients are those who do not adhere to treatment, keep on seeking medical care without having a physical problem or are derogatory towards healthcare workers without giving them a chance to even try to administer a treatment. Difficult patient behaviour forms part of the illness behaviour repertoire, i.e. the way the patient behaves when stressed by ill health. Illness behaviour is partially learned through parental reinforcement and modelling[1,2], and has been shown to be culture=dependent[3,4]. Some characteristics of so-called abnormal illness behaviour may be considered normal within certain cultures[3,4]. In certain cases, illness behaviour may also be driven by secondary gain – a fact that may underlie economic survival in socio=economically-deprived environments.

This paper approaches the "difficult patient" problem from the attachment theory perspective. A brief overview of attachment theory is given, followed by an account of the four attachment styles (viz. secure, avoidant, anxious and disorganised). Subsequently, suggestions are made on how the needs of individuals who conform to the different styles of illness behaviour can best be accommodated.

OVERVIEW OF ATTACHMENT THEORY

Attachment theory was conceptualised by John Bowlby, who watched the reactions of children who were separated from their mothers during hospitalisation[5]. "Attachment" refers to the bond of the infant to its primary caregiver (usually the mother), and later towards meaningful others. This bond is a necessity for mammalian newborns, who all are born immature and thus unable to immediately survive by themselves[6]. The attachment system has two main aims: firstly, to ensure safety against predators by maintaining proximity to the attachment figure (usually the mother) and secondly, to provide a 'secure base' from which the environment can be explored and to which the infant may return to if frightened[7]. Attachment behaviour, e.g. crying, following and clinging, is triggered when a threat appears, when the attachment figure leaves unexpectedly, or when the infant is hungry, tired or ill[8].

All babies become attached to their primary caregivers, even if these are physically or psychologically abusive[7]. However, a disorganised attachment is most likely to develop in the case of abuse. The quality of the attachment between mother and child can be measured in a standardised laboratory procedure, termed the 'Strange Situation'[8]. In this procedure, infant attachment behaviour is graded in response to separation from the mother and compared to behaviour towards a stranger[8]. Four main categories (secure, avoidant, anxious and disorganised) can be discerned when the infant is as young as 12 months of age[8,9], and these categories remain relatively stable across a person's life[10].

Adults can be divided into four similar basic categories by means of the Adult Attachment Interview, which asks interviewees to report on their past and present relationships[11]. In the scoring of the responses, the degree of coherence of the report is important (e.g.

describing the mother as 'perfect', but then elaborating with a story of neglect or punishment, which would be considered incoherent). The degree of reflective functioning, which is the ability to understand both one's own and others' psychological experience, is also graded[12]. Securely attached individuals score high in coherence and reflective functioning, while these are diminished in the insecure (anxious and avoidant), and especially in the disorganised, categories.

The reason why attachment subtypes tend to persist throughout an individual's life is thought to be that a baby comes to expect a certain pattern of caregiver reaction, based on previous experience. This expectation is termed the 'working model', a cognitive schema that predicts the likely behaviour of attachment figures at a time of stress, and then assigns appropriate behavioural action to the self[7]. This pattern of reaction to a stressor remains constant in most people from infancy to adulthood[10] and will be considered in the next section.

ATTACHMENT SUBTYPES

For the sake of simplicity, four distinct attachment styles can be described. We will now discuss each of the four subtypes, i.e. secure, insecure-avoidant, insecure-anxious and disorganised. In each case, adult attachment style is thought to result from the interaction of parental style with the infant's temperamental needs and strengths, modified to a varying degree by subsequent life experience.

Secure

If an infant has a mother who is sensitive to its needs and responds appropriately, it will develop a working model of the self as worthy of care, and of the other as being able to give care as needed[7]. Adults who were not securely attached as infants may become 'earned secure' in adulthood by working through their problems and changing their working models[13]. Secure adults have a high degree of coherence and reflective functioning. Approximately 60% of the general population are secure[14] and usually do not pose problems as patients, as they are easy to help even if their medical situation is dire.

Avoidant

If a mother constantly rejects her baby's needs and is emotionally aloof, the baby will learn that others are incapable of providing care as needed, and the child will become compulsively self-reliant[8]. Such infants learn to suppress attachment behaviours, as they only further distance a rejecting mother[15]. Avoidant adults are typified by their dismissive attitudes towards love and care and are described as cold or aloof. Their internal working model leads them to believe that others are not to be trusted and will inevitably let them down[16]. Accordingly, the more stress they experience, the more they distance themselves from those who could help them. They can be difficult patients in the sense that they are dismissive of health care, often not adhering to treatment, coming to hospital too late, or refusing appropriate therapies. Avoidant persons make up about 25% of the general population[14].

Anxious

A mother who is unpredictable, sometimes providing sensitive and responsive care and at other times rejecting her baby, will have an anxious baby who is never sure what to expect[8]. The baby then develops a working model of the other as capable of providing care, but only when pressured into doing so by a continuous attachment signal, such as extreme dependent behaviour. Anxiously attached individuals have little belief in their own capacity to cope with stress, and they are thus driven to depend on others. Their need for proximity is so great, however, that they find the other's help insufficient, leaving them with nearly constant anxiety and an unquenchable thirst for comforting. Anxiously attached adults are perceived as needy, clingy and seeking of approval. They often present themselves for medical care unnecessarily with vague complaints, and are not reassured easily if at all. They are "compulsive care seekers"[16]. Approximately 10% of the population are categorised as insecure-anxious[14].

Disorganised

Frightened, dissociated or fear-inducing behaviour by the mother, which obviously includes all forms of physical or psychological abuse, leads to a 'fright without solution' in the infant, who is programmed to turn to the primary caregiver when frightened, but cannot do so because this caregiver is also the source of the threat[9]. Infants accordingly develop working models of the self as unworthy of love, and of the other as unable of providing care when needed. Disorganised adults typically are incoherent when discussing attachment issues and have a low degree of reflective functioning. These patients can be extremely difficult in the sense that they have no trust whatsoever in health-care providers or, for that matter, in anybody else. They are often perceived as being desperate, with fluctuating levels of help seeking and mistrust[16]. The way these patients cope with their profound anxiety, coupled with a deep mistrust of others, is to constantly pressure others for more care. These persons combine exaggerated help-seeking behaviour with simultaneous rejection of those who try to help. They often have an attitude of "this will never work". They are very demanding, without ever being satisfied with their care, as they believe that it is only by putting persistent pressure on others that anything will be done[16]. The disorganised category of insecure attachment has a high prevalence in all types of psychopathology[17].

MANAGEMENT OF THE DIFFERENT STYLES OF ILLNESS BEHAVIOUR

Illness and injury are physical threats, and thus stressors that will activate the attachment system[7]. Hospitalisation involves separation from meaningful others, exposure to a new environment, and the need to trust strangers, which are all attachment stressors in their own right[16]. The way people react to these stressors (i.e. their illness behaviour) varies widely and is related to their attachment style[18]. Having summarised the different attachment subtypes (see above), we will now focus on ways to accommodate these patients without

compromising their health care or the psychological well-being of the care giver.

Avoidant

Avoidant patients, who are compulsively self-reliant, can be helped by acknowledging that they are in charge of their own health. This would entail fully discussing all treatment options with them and giving them as much control as possible. One should allow these patients to set the interpersonal distance, address them by title and surname and sit down when they are lying in order not to loom over them. It may even be advisable to discharge these patients from hospital early if it is not dangerous to do so[16]. An authoritarian attitude towards these patients is sure to backfire and must be avoided at all costs.

Anxious

Insecure anxious patients tend to be compulsive care seekers. It is important to set limits, with empathic listening within these limits. For example, it may be helpful to schedule regular weekly outpatient appointments, or regular 10 minute nurse visits every two hours for an inpatient. The purpose is to provide the needed reassurance before the patient asks for it, thereby letting the patient understand that support will occur regardless of whether the patient complains of physical symptoms or not. Any avoidance will aggravate the distress the patient is experiencing, as it activates attachment behaviour, which in this case is clinging. The only way to diminish the distress signal of the patient is to respond pre-emptively with contact[16].

Disorganised

Disorganised patients can be very frustrating to care for and health-care workers should monitor their own emotional reactions to them, taking care not to reject these patients. Doctors should know that they will never get any praise from a patient with a disorganised attachment style and should not expect it. It is important to understand that these patients cannot afford to be grateful, as this would let the caregiver 'off the hook'. It may help to explain to other staff members that the patient is someone who is desperate for contact, but cannot bring him/herself to trust anyone. The aim is to see the patient as a challenge instead of being detestable. It is important to adhere to one's 'usual good standard of care', thus minimising the upsetting effect of the unremitting condemnation by the patient. Team meetings are vital to allow staff to discuss the inevitable irritation they feel, thus reducing any attitude of rejection that they may have towards the patient[16].

CONCLUSION

The attachment viewpoint is helpful, as it suggests simple interventions that can easily be applied clinically, even when the patient's particular type of illness behaviour is difficult to handle. Patients' behaviour can undoubtedly also be influenced by their diseases, and the effect of cytokines on the brain, as seen in sickness behaviour, is one such example[19]. From a South African perspective, it is important to remember that illness behaviour is also culture-related and that it is a function of both personal characteristics and the context or situation. More local research on illness behaviour in a cultural context is therefore urgently called for. The framework for the study of coping, illness behaviour and outcome as suggested by Shaw[20] (which includes the transactional stress model of Folkman and Lazarus as well as Leventhal's illness representation model), in association with the attachment perspective, may serve as a good starting point.❐

References

1. Levy RL, Whitehead WE, Von Korff MR, Feld AD. Intergenerational transmission of gastrointestinal illness behaviour. *Am J Gastroenterol* 2000;95(2):451-6.
2. Elfant E, Gall E, Perlmuter LC. Learned illness behaviour and adjustment to arthritis. *Arthritis Care Res* 1999;12(6):411-6.
3. Hsu SI. Somatisation among Asian refugees and immigrants as a culturally-shaped illness behavior. *Ann Acad Med Singapore* 1999;28(6):841-5.
4. Guo Y, Kuroki T, Yamashiro S, Sato T, Takeichi M, Koizumi S. Abnormal illness behavior and psychiatric disorders: a study in an outpatient clinic in Japan. *Psychiatry & Clin Neurosci* 2000;54(4):447-453.
5. Bowlby J. The nature of the child's tie to his mother. *Int J Psychoanal* 1958;39:350-73.
6. Kraemer GW. A psychobiological theory of attachment. *Behav Brain Sci* 1992;15:493-51.
7. Bowlby J. Attachment and Loss, Vol 1: Attachment. New York: Basic Books; 1969.
8. Ainsworth MDS, Bell SM, Stayton DJ. Individual differences in Strange-Situation behaviour of one-year-olds. In: HR Schaffer, editor. The origins of human social relationships. New York: Academic Press; 1971. p. 17-52.
9. Main M, Soloman J. Discovery of a new, insecure disorganised/disoriented pattern. In: TB Brazelton, M Yogman, editors. Affective development in infancy. Norwood, NJ: Ablex; 1986. p. 95-124.
10. Klohnen EC, John OP. Working models of attachment: A theory-based prototype approach. In: JA Simpson, WS Rholes, editors. Attachment Theory and Close Relationships. New York: Guilford; 1998. p. 115-40.
11. Hazan C, Shaver PR. Romantic love conceptualised as an attachment process. *J Personality Social Psychol* 1987;52:511-24.
12. Fonagy P, Steele H, Morgan GS, Higgett AC. The capacity for understanding mental states: the reflective self in parent and child and its significance for security of attachment. *Infant Mental Health J* 1991;12:201-18.
13. Pearson J, Cohn DA, Cowan PA, Cowan CP. Earned- and continuous security in adult attachment: relation to depressive symptomatology and parenting style. *Dev Psychopathol* 1994;6:359-73.
14. Mickelson KD, Kessler RC, Shaver PR. Adult Attachment in a Nationally Representative Sample. *J Pers Soc Psychol* 1997;73:1092-106.
15. Isabella RA. Origins of attachment: maternal interactive behavior across the first year. *Child Dev* 1993;64:605-21.
16. Hunter JJ, Maunder RG. Using attachment theory to understand illness behavior. *Gen Hosp Psych* 2001;23(4):177-82.
17. Dozier M, Stovall KC, Albus KE. Attachment and Psychopathology in Adulthood. In: J Cassidy, PR Shaver, editors. Handbook of Attachment: Theory, Research and Clinical Applications. New York: The Guilford Press; 1999. p. 497-519.
18. Kotler T, Buzwell S, Romeo Y, Bowland J. Avoidant attachment as a risk factor for health. *B J Med Psychol* 1994;67:237-5.
19. Viljoen M, Panzer A. Sickness behaviour: causes and effects. *South Afr Fam Prac* (in press).
20. Shaw C. A framework for the study of coping, illness behaviour and outcomes. *J Adv Nurs* 1999;29(5):1246-55.