Physicians' difficulty with emergency department patients is related to patients' attachment style

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Abstract

Doctors experience 10–20 percent of patient interactions as being personally difficult, but the sources of difficulty are incompletely understood. In particular, physician-perceived difficulty has not been studied from the perspective of an established model of interpersonal relationships. Our objective was to determine whether a relationship exists between patients' attachment style and the degree of difficulty experienced by their attending physician in an Emergency Department in Pretoria, South Africa. Patients of an Emergency Department ($n = 165$) completed the Experiences in Close Relationships—Revised Questionnaire to measure attachment anxiety and attachment avoidance. Their physicians ($n = 26$), blind to the attachment measure, rated perceived difficulty using the Difficult Doctor–Patient Relationship Questionnaire. Four categories of attachment style were identified by cluster analysis of attachment scores. Patients were divided into difficult and non-difficult groups using a cut-off score. Two percent of patients with a secure attachment style were experienced as difficult, whereas the prevalence of difficulty in the insecure styles was 'preoccupied' 17 percent, 'dismissing' 19 percent and 'fearful' 39 percent ($\chi^2 = 16.383$, df = 3, $p = 0.0009$), supporting the hypothesis that the physician's perception of patient difficulty is related to the patient's attachment style. The degree to which physicians serve attachment functions for patients in crisis merits further investigation.
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Introduction

Doctors experience 10–20 percent of patients as being frustrating or difficult (Hahn, 2001; Hahn

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et al., 1996; Hahn, Thompson, Wills, Stern, & Budner, 1994; Jackson & Kroenke, 1999). Difficulty, as perceived by the physician, is associated with several patient factors including psychiatric disorder, multiple physical symptoms, unmet expectations, dissatisfaction, difficult personality traits, and high healthcare utilization (Hahn, 2001; Hahn et al., 1996; Hahn et al., 1994; Jackson & Kroenke, 1999; Sharpe et al., 1994). Classic clinical descriptions and management guidelines based on

difficult personality styles (Groves, 1978), provide useful guidelines for the clinician but can be problematic because of derogatory labels, such as "hateful patients," and because they lack a theoretical framework to understand the nature of the difficulty (Hunter & Maunder, 2001).

According to Groves (1978), the defining feature of difficult doctor–patient encounters is the unpleasant feeling that arises in the physician as she or he interacts with the patient, which emphasizes the interpersonal nature of the problem. Although interpersonal factors may be relevant, perceived patient difficulty has not been investigated from the perspective of an established interpersonal theory, such as attachment theory. Attachment theory is not a theory of all interpersonal relationships but of a selected class of particularly close relationships which involve (among other aspects) trust, verbal and non-verbal communication, soothing contact and protective care in the face of real and perceived threats to survival and security (Bowlby, 1969). Individual differences in expectations of healthcare providers, patterns of help-seeking, and styles of expression of distress that are based on attachment style may be a useful way to understand why physicians find some patients difficult (Hunter & Maunder, 2001).

Attachment theory is, in the first place, a developmental theory describing the factors that regulate proximity between an infant and his or her primary caretaker (Bowlby, 1969). The attachment system, as described by Bowlby, is a two-person system. Within this system children develop stable patterns of signaling danger or distress, seeking proximity to caregiver, exploring independently and modulating affect, such that characteristic patterns of infant attachment to a caregiver can be reliably determined as early as 12–18 months (Ainsworth, Blehar, Waters, & Wall, 1978). Ainsworth observed infants in a standardized sequence of interactions with their mothers involving episodes of separation and reunion in the presence of a stranger in a novel environment. Infant attachment style is classified as secure if the infant uses the mother as a secure base for exploration, actively greets her when she returns and is comforted by her when upset. There are three patterns of insecure attachment: avoidant, in which the child displays little desire for comfort from the mother and seeks distance rather than proximity; ambivalent, in which the distress is amplified, contact with the mother is less comforting and exploration is minimal; and disorganized/disoriented, in which sequences of affect and behaviour are contradictory or lack an observable goal.

Aspects of the attachment system, such as signaling distress, seeking proximity to a caregiver, and using interpersonal contact to modulate affect appear to be relevant to the interpersonal negotiations involved in seeking, receiving and accepting care at times of illness. However, the application of attachment theory to relationships between adult patients and healthcare providers depends on (i) the assumption that attachment relationships can be meaningfully described in adults (see for example Hazan and Zeifman, (1999)) and (ii) that a relationship between an adult and a healthcare provider could count as an attachment relationship.

Theoretically, adult attachments are not primarily with parents but with a wider circle of attachment figures. Romantic partners are prototypic attachment figures in adulthood, but West and Sheldon-Kellor (1994) describe adult attachment relationships less exclusively as "dyadic relationships in which proximity to a special and preferred other is sought or maintained to achieve a sense of security" (p. 19). This definition is useful because it makes clear that adults may have several attachment figures, broadly, all of those individuals from whom one might potentially seek and derive a sense of security, or subjective comfort through proximity. Trinke and Bartholomew (1997) found that young adults have multiple attachment figures who need not be sexual partners. Furthermore, different individuals may serve different attachment functions as a result of the security and comfort derived. These investigators cite five aspects of relationships which Bowlby suggested distinguish attachment relationships from other interpersonal relationships: attachment relationships provide a "safe haven" in times of distress; serve as a secure base from which to venture out independently; and consist of a strong emotional tie. Furthermore, in attachment relationships one seeks proximity to the other and mourns their death. When young adults were asked to identify others to whom they relate in these ways it was found that family members were more likely to serve a secure base function whereas the safe haven function was equally likely to be served by family members and partners (Trinke & Bartholomew, 1997). An extension of the finding that attachment functions are filled by a hierarchy of several significant others is that whether or not a relationship serves an attachment function may depend on context.