Attachment theory in chronic pain clinics

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Introduction

The therapeutic relationship (TR) lies at the center of the clinical practice in chronic pain clinics - without it, it would not be possible to make diagnosis or negotiate treatments. In patients with chronic low back pain, the quality of the TR predicts clinical outcomes. However, physicians frequently find it difficult to build trusting relationships with their patients. Attachment theory us a useful framework to understand difficult TRs in medical settings.

Attachment theory, developed by Bowlby, explains lifelong patterns of interpersonal relating as a result of early experiences of parent-infant interactions in situations of perceived danger or threat, which are internalized as internal working models of others and self. In the Bartholomew and Horowitz model of adult attachment, individuals can view themselves and others either positively or negatively, resulting in a four-quadrant model with four attachment styles (Fig. 1). Secure attachment is characterized by a positive view of self and others. Individuals who view themselves and/or others negatively have insecure attachment styles – further classified as preoccupied, dismissing and fearful. Preoccupied attachment results in dependency and clinginess. Dismissing attachment results in self-reliance and independency. Fearful attachment results in both dependency and hostility towards others.

The present case report illustrates how a disrupting TR with a patient with chronic low back pain was managed in the light of attachment theory, highlighting the role of psychiatry in the multidisciplinary management of patients with chronic pain.

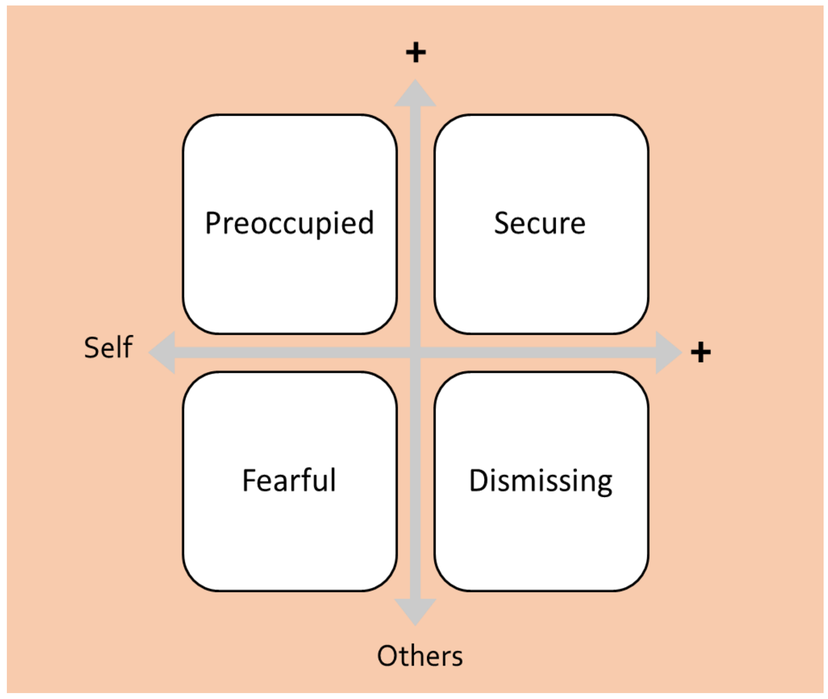

Fig. 1 – Adult attachment styles

Case report

G.D. is a 43-year-old woman who was referred to a chronic pain clinic by her neurosurgeon because of a multifocal, multifactorial, refractory and incapacitating chronic low back pain, for which she operated twice. At her first appointment with two chronic pain physicians, the patient was outright hostile, demanding, anxious and reluctant to accept suggested pharmacologic and non-pharmacologic interventions.

Given the incomprehensible behavior of the patient and the difficulty in delivering care, the case was discussed in a monthly multidisciplinary team that includes a psychiatrist and a psychologist.

Later, in psychiatric consultations, a life history of physical and emotional abuse/neglect was identified. Antidepressant medication for symptomatic treatment of anxiety and support psychotherapy improved the patient's behavior and her relationship with the team, ultimately allowing her to accept new treatments.

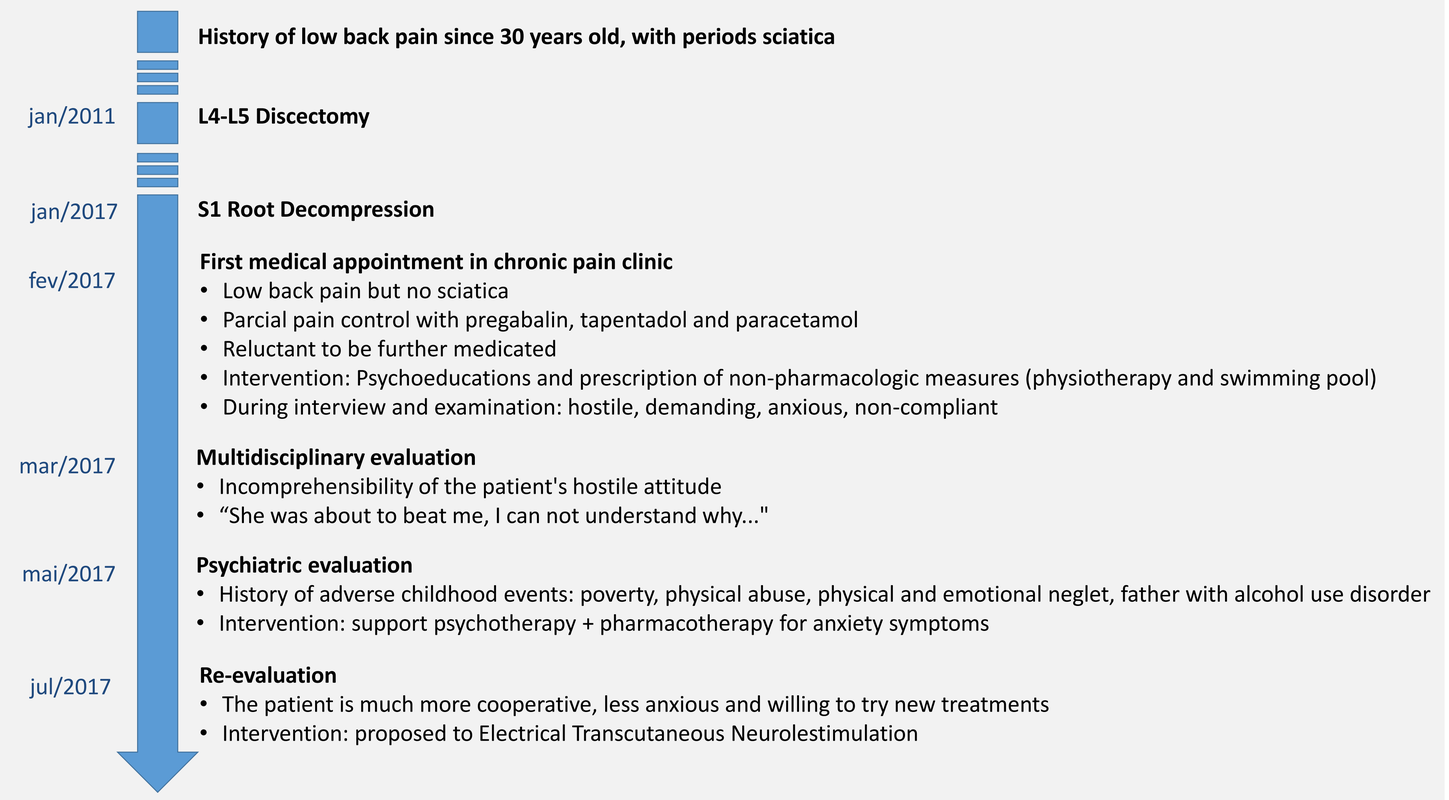

Fig. 2 – Case report chronogram

Discussion

This patient behaved in a paradoxical way - while asking for help, she was hostile and devaluing towards her physicians, as if she needed help but could not receive it. Attachment theory can be used to understand the patient's behavior in the context of the TR (Fig. 3). The pattern of interpersonal behavior demonstrated by the patient in this situation of vulnerability is typical of patients with fearful-avoidant attachment style, who frequently have antecedents of serioua childhood adverse events. This interpersonal behavior in helping relationships is the result of perceiving others simultaneously as a source of help and danger. Fearfully attached individuals think that they are unworthy of care and that others are not trustworthy for giving appropriate care. All caregiving is viewed as potentially threatening or hostile. People with this attachment style will most likely be inconsistent with any mode of medical treatment. While other insecure attachment styles may be managed by physicians with simple strategies, some authors stress the need of psychiatric liaison in the management of patients with fearful attachment styles.

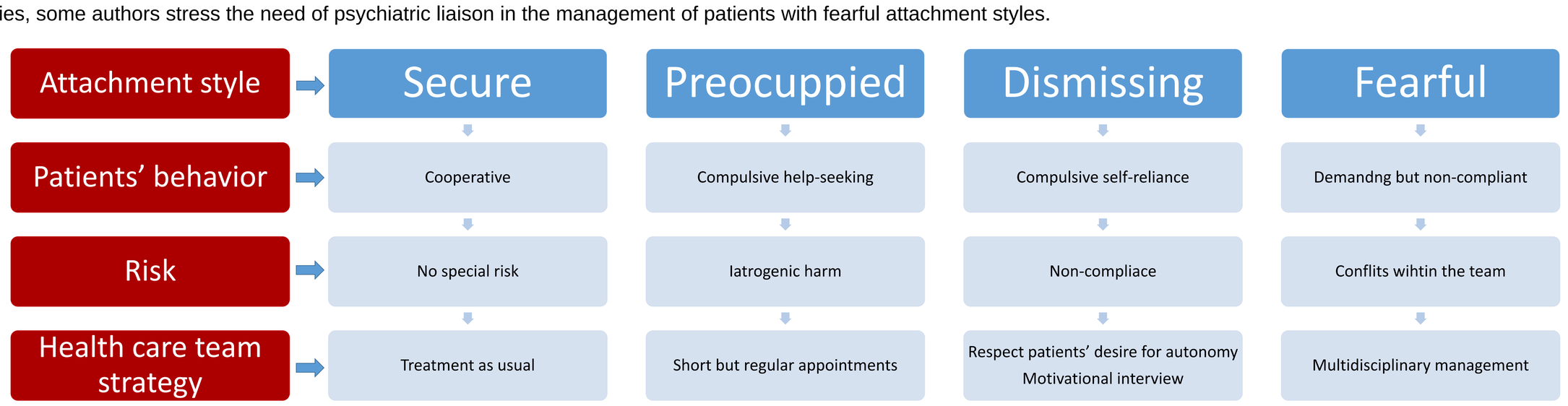

Fig. 3 – Attachment styles in clinical practice

Learning points

Attachment theory is a useful framework to understand and manage difficult TRs. Besides diagnosing and treating psychiatric comorbidities, the role of psychiatrists in multidisciplinary chronic pain clinics could be to cooperate with other physicians in understanding and dealing with difficult patients.

❖ The authors declare no conflicts of interest

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