Attachment-informed Care in a Primary Care Setting

Linda Grabbe, PhD, FNP-BC

ABSTRACT

No child grows up without an attachment pattern based on early relationships with caregiver figures. About 40% of the United States population experiences insecure attachment in childhood. When this pattern endures, it can be expressed as anxiety, depression, somatization, or illness. This article offers a framework for understanding secure and insecure attachment and suggests new strategies for helping primary care patients. The BATHE model, a therapeutic intervention for any patient with emotional and interpersonal difficulties, is described. With an attachment-informed perspective, advanced practice nurses may positively impact the quality of the patient-provider relationship, while promoting the patient's health and well-being.

Keywords: adult mental health, attachment, somatization

An infant smiles, coos, and gurgles, and, in response, the mother laughs with delight and holds her baby close. Babies also cry and fuss when stressed by physical or emotional discomfort, and the caregiver ideally responds in a predictable, sensitive, and comforting manner. The child integrates behaviors that elicit an appropriate response from the caregiver, but behaviors that are not rewarded, that is, that do not elicit comforting or rescue, are extinguished.[1] This is attachment behavior, a fundamental need of all humans, and the attachment pattern that is established in the early years is likely to develop into a lifetime pattern that works as a template to shape views of one's self, others, and the world.[2] Maternal attachment behaviors generally determine the nature of the pattern of behaviors established in infancy and childhood. If the attachment pattern is strong and positive, the child develops a sense of trust, an important initial developmental milestone for the trajectory through life. In secure attachments, children come to understand the world as a safe and secure place, and see themselves as worthy and deserving of protection and love; the child learns how to self-soothe and regulate anxiety and fear.[2,3]

With insecure attachment, caregiver behaviors may be characterized by unpredictability, negativity, rejection, and fear. If children learn that their signals of distress will be disregarded or met with anger, they learn to act as though they have no needs. Alternatively, if an intense demonstration of distress is required to elicit a response, they learn that being calm and reasonable is useless; instead, acting overwhelmed may get them what they need. Emotion regulation is not learned if the child does not learn how to self-soothe from a nurturing caregiver. These enduring early attachment behaviors help to explain much adult behavior and health patterns.

The purpose of this article is to describe the links between early attachment patterns and later adult behavior patterns and health problems. To grasp the concepts of attachment, it is important to know that early life attachment may be "secure" or "insecure," and understand the 3 subtypes of insecure attachment. Insecure attachment in itself does not constitute pathology, rather it puts the individual at risk for psychological and physical pathology in adolescence and adulthood, including somatic ailments.[4,5] Medically unexplained symptoms may be expressions of psychic distress related to an insecure attachment style,[6,7] and insight into attachment may go far to enhance the outcomes of health care encounters in primary care settings.

BACKGROUND

Attachment is a critical feature of human development, and is a powerful drive even when the attachment behaviors are maladaptive and unhealthy. The object of one's attachment changes over the course of life, although early attachment is usually the blueprint for future relationships. Parents, who are the key attachment figures in childhood, give way in adolescence and adulthood to romantic partners, one's own children, and other significant adult figures.[2] Attachment theory has had a significant impact in the field of mental health, where it provides an overarching conceptual framework to explain human behavior.[7]

John Bowlby's landmark theory of attachment was stimulated by the observation that children who did not receive maternal nurturing failed to thrive, had high rates of infection, and died early; children deprived of a nurturing relationship had lower intelligence, poor language development, and difficulty forming relationships.[8] Bowlby differentiated between secure and insecure attachment: secure attachment was associated with good long-term mental and physical health; insecure attachment was associated with later emotion dysregulation and personality disorders.[9,10] In healthy attachment, the sense of deserving nurturance becomes integrated in the individual's self-concept, conscience, and emotional understanding, and self-regulation of emotions is developed.[11] Secure attachment in childhood is likely to lead to a positive self-image, the capacity to manage distress, and healthy interpersonal relationships.[7] Insecure attachment is likely to lead to problems in interpersonal relationships; personality disorders and dissociative disorders are best understood as outcomes of "profound attachment failure."[7,12] As much as 5% of the population may have borderline personality disorder, which is characterized by emotion dysregulation, impulsiveness, a sense of worthlessness, and intense and unstable relationships.[13] Patients with borderline personality disorder present challenges in both primary care and mental health settings, due to unhealthy behaviors, noncompliance, and a lack of understanding on the part of health care providers.[14-16]

ATTACHMENT STYLES

Bowlby's attachment theory was developed further by Mary Ainsworth when she placed 1-year-old infants intentionally in a brief, but somewhat distressing, "strange situation" to identify infant-caregiver dyad behavior patterns.[17] Secure infants sought and were easily comforted by their mothers when stressed; these mothers were sensitive and consistent with their babies. Ainsworth identified 2 insecure attachment styles in babies: (a) "avoidant" babies had distant and rejecting mothers; the babies did not show distress and tended to ignore their mothers; and (b) "ambivalent or anxious" babies who escalated their cries of distress and were difficult to soothe, seeking the mother, but resisting being comforted; these mothers were unpredictable (alternately comforting or ignoring their child). Twenty years later, Main and Soloman reviewed Ainsworth's difficult-to-categorize "strange situation" videotapes and recognized that 90% of those babies fell into a third insecure attachment pattern: (c) "disorganized" babies, who displayed fragmentary, contradictory, and bizarre responses to mothers who were abusive, helpless, or dissociated.[18] The child's response was "approach-avoidant," that is, simultaneously clinging and distancing. The mother, a source of trauma, distress, and fear, was unresponsive to any behavior or strategy the child engaged in to meet his or her needs. The disorganized attachment pattern of abused children has been associated with childhood behavior disorders, dissociative disorders, posttraumatic stress disorder, and borderline personality disorder.[19]

According to Wheeler, many survivors of complex trauma (multisource, prolonged, or repeated abuses) do not fit criteria for posttraumatic stress disorder (PTSD), but have problems of shame, aggression, self-loathing, dissociation, distrust, somatization, and interpersonal and affect regulation.[20] According to the Centers for Disease Control's Adverse Childhood Experiences study, 16% of adults in the United States have sustained at least 2 types of abuse or neglect as children.[21] Some of these individuals develop PTSD, but many who do not fit criteria for PTSD still carry a significant psychological burden. Insecure attachment is not a pathology or a diagnosis in itself, although reactive attachment