Debate & Analysis

Bowlby, Balint, and the doctor–patient relationship:

towards a theory of human relationships in medical practice

Despite continuing technological advance, there is a widespread view that something is missing in current medical culture. This arises in part at least from the lack of a theoretical framework that describes the complexity of patient-centred clinical practice. Attachment theory, working in tandem with the ideas of Michael Balint, provides just such an account.

ATTACHMENT THEORY AND HOW IT EXHIBITS

Developed originally by John Bowlby and Mary Ainsworth, Attachment theory is an evidence-based psychobiological theory of human development and relationships.[1] Although originally focused on parent–child relationships, it soon became clear that throughout the life-cycle, when feeling ill, stressed, or threatened, people seek out an 'older, stronger, wiser' attachment figure, or 'secure base', for comfort and security. Only when attachment needs are assuaged can people return to more relaxed exploratory behaviour. It seems legitimate therefore to apply the principles of Attachment to the doctor–patient relationship, given that, when consulting their doctors, patients are typically in a state of anxiety, thereby restricting their capacity to communicate fully or to absorb information.

Individual differences in attachment patterns laid down in childhood impact on the ways in which people react to those they perceive as current care-givers, for example, their GP. Anxiety assuaged, the securely attached revert rapidly to a relaxed exploratory mode in the presence of a sufficiently secure base, and are able to participate in doctor–patient democracy. For the insecurely attached (a sizable minority, around 40%),[1] however, the doctor–patient relationship is likely to be problematic.[2]

Three main patterns of insecure attachment are recognised: hyper-activating ('preoccupied'), de-activating ('avoidant/dismissing'), and disorganised.

Those who are hyper-activating assume care-givers to be untrustworthy and unpredictable, and may therefore exaggerate their emotional responses in an attempt to arouse attention and maintain contact. Medical services may perceive them as dependent and demanding. People with de-activating attachment are more likely to dampen down and deny their feelings, fearful of alienating care-givers. They may present symptoms late, with potentially serious consequences. Some patients with somatisation disorders fall into this category, in which persistent bodily ills provide a language for unexpressed emotion.

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The most disturbed pattern is that of disorganised attachment, an established vulnerability factor for later psychopathology, delinquency, poor educational achievement, and complex somatisation disorders. The developmental history of such people is that they tend to have had parents/care-givers who were either frightened or frightening, leading to them expecting similar responses from medical services. A key feature of disorganised attachment is interpersonal turbulence, with sudden eruptions of affect, (rage, confrontation, storming out, litigation, and so on) oscillation between an intrusive and disengaged relationship, and confused narrative styles (for example, regarding their symptoms), often leading such people to be labelled as 'difficult' — dreaded, denigrated, and frequently mismanaged by medical services. Attachment theory also theorises the psychological impact of loss and separation — the sudden disappearance of a secure base and the consequent reactions of denial, anger, and despair. This is highly relevant at such times when managing patients experiencing chronic illness, infertility, traumatic injury, terminal care, and children in hospital — all of which self-evidently entail loss. The inherent transience of medical training means that patients regularly experience losses of significant attachment figures, further undermining trust and augmenting anxiety.

BALINT'S 'CAPITAL'

Michael Balint, the eponymous inventor of 'Balint Groups', saw how, through group discussion, a deeper, more humane picture of the patient emerges. Balint groups lessen professional isolation, enhance morale, increase sensitivity to patients, and decrease the incidence of burnout.[3] Balint used the metaphor of a 'mutual investment company' for the gradual acquisition of knowledge and shared experience as doctor and patient negotiate the illnesses and crises the patient brings. This 'capital' can be drawn on when needed, including knowledge of patients' 'illness signature', often presaging relapse of chronic illness, and can lead to early preventive or mitigating interventions.

A key feature of Attachment relationships is their specificity. Current patterns of general practice and rapidly changing patient populations tend to erode the uniqueness of the doctor–patient relationship, so this shared capital tends to get lost. This can be mitigated if the GP practice itself takes on some of the characteristics of a 'secure base' for its patients.[4] But the capacity to provide security for others depends on feeling

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secure and 'held' oneself. If professionals feel secure within their setting, the practice itself may be more likely to be able to function as a secure base for its patients.

Functioning social systems rely on trust. UK medical scandals such as the Shipman and Bristol Royal Infirmary inquiries as well as the Mid Staffordshire NHS Foundation Trust Public Inquiry led to a breakdown of public trust in doctors, resulting in the current system of revalidation and managerial control. This trust can be considered at two levels. 'Primary trust' precedes protocols, reflecting a biologically driven search for a secure base by a distressed individual, relying implicitly on the empathic kindness of fellow humans. On the basis of this, 'secondary' explicit contractual relationships can develop, including evidence-based, ethical, respectful care, but these all too easily turn to dust in the absence of primary trust.

Fundamental to an attachment perspective is the idea that empathy is both essential and fallible[5] — we are always getting things 'wrong' and seeking ways to put them to rights. Through open and un-persecutory discussion, Balint groups can help mitigate a contemporary managerial culture that assumes all errors to be avoidable, and inherently blameworthy.

The constant cry from patients is for doctors who *listen*. To respond adequately, medical staff likewise need to feel that they are being heard at an emotional level. If the 'mind in medicine' perspective we advocate is to re-establish itself there is a need to integrate the insights of John Bowlby and Michael Balint into mainstream medical thinking and practice.

Whether attachment and emotional attunement can be revived alongside technological advance, or instrumentalism, bureaucratisation, and fragmentation will win the day, remains to be seen.

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REFERENCES

1. Holmes J. *John Bowlby and attachment theory.* 2nd edn. Hove: Routledge, 2014.
2. Maunder R, Hunter J. *Love, fear, and health: how our attachments to others shape health and health care.* Toronto: University of Toronto Press, 2015.
3. Kjeldmand D, Holmström I. Balint groups as a means to increase job satisfaction and prevent burnout among general practitioners. *Ann Fam Med* 2008; **6(2):** 138–145.
4. Elder A. The GP surgery as a secure base? Patterns of attachment in primary care. *Psychodynamic Pract* 2009; **15(1):** 57–70.
5. Allen JG, Fonagy P, eds. *Handbook of mentalization-based treatment.* Chichester: Wiley, 2006.

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