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Using attachment theory in medical settings: Implications for primary care physicians

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Abstract
Background: Mental health researchers, clinicians and clinical psychologists have long considered a good provider–patient relationship to be an important factor for positive treatment outcomes in a range of therapeutic settings. However, primary care physicians have been slow to consider how attachment theory may be used in the context of patient care in medical settings.
Aims: In the current article, John Bowlby's attachment theory and proposed attachment styles are proffered as a framework to better understand patient behaviors, patient communication styles with physicians and the physician–patient relationship in medical settings.
Conclusion: The authors recommend how primary care physicians and other health care providers can translate attachment theory to enhance practice behaviors and health-related communications in medical settings.

Keywords: *attachment theory*, *attachment styles*, *physician–patient relationship*, *communications*, *primary care physicians*, *medical settings*

Introduction

Attachment theory, developed by John Bowlby, posits that the parent–child attachment bond that is formed during childhood is directly associated with mental and physical health, health-related behaviors and overall functioning in adulthood. Bowlby (1977) and others (Ainsworth, 1989; Bartholomew & Shaver, 1998; Bretherton, 1995) have postulated that a secure attachment style should serve as a protective factor (from cradle to grave) during times of distress, adverse events, illness and increased anxiety, whereby one is able to actively seek out and request appropriate support from family members and significant others in one's life. Psychologists, psychiatrists and other health care providers have long recognized the utility of attachment theory as it relates to the provision of patient care, therapeutic contexts and therapeutic encounters (Ainsworth, 1989; Bifulco et al., 2003; Brennan & Shaver, 1995; Byng-Hall, 2002; Feeney, 2000; Griffin & Bartholomew, 1994; Hooper, 2007; Marotta, 2002; Norcross & Wampold, 2011).

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More recently, primary care physicians are considering its usefulness in the context of medical settings (Bifulco et al., 2008; Ciechanowski, 2010; Maunder & Hunter, 2009). Attachment theory may provide a blueprint for attachment-based practice in the context of medical settings. This blueprint or guide can help physicians better understand and respond to the ways in which patients' presenting symptomatology are described and discussed, and the manner in which patients form relationships and interact with other significant persons, including health care providers (e.g. primary care physicians, nurses, psychologists, psychiatrists) (Levy et al., 2011). It appears that a link can be made between attachment style and health presentation, communications and relations with providers, and illness behavior and functioning (Ciechanowski, 2010; Feeney, 2000). Moreover, this possible link may inform best practices relative to health outcomes, patient satisfaction, treatment adherence and the physician–patient relationship in medical settings (Arbuthnott & Sharpe, 2009; Feeney, 2000; Hunter & Maunder, 2001; McWilliams & Bailey, 2010; Miller, 2008).

In the current article, we describe how primary care physicians and other providers can use attachment theory to improve and inform their patient care and research in medical settings. We begin with background information on the importance of physician–patient relationships. Next, we discuss Bowlby's (1969, 1973, 1977, 1980) attachment theory and the four styles of attachment. Finally, we identify strategies for physicians working with each of the four attachment styles.

Physician–patient relationships

The criticality of the physician–patient relationship cannot be overstated. In some ways, without a warm and trusting physician–patient relationship, effective medical treatment cannot take place (Adler, 2002). Thus, primary care physicians who fail to recognize the influence of the physician–patient relationship relative to most if not all therapeutic and medical encounters may be providing less than optimal care (Cox et al., 2008; Miller, 2008). In contrast, understanding patient relational and interactional preferences (e.g. attachment styles) may enhance positive medical encounters and thus treatment outcomes in medical settings (Levy et al., 2011; Miller, 2008; Norcross & Wampold, 2011).

As previously mentioned, it is well established in the clinical, developmental and family psychology literature that the provider–patient relationship is correlated with treatment adherence, patient satisfaction and health outcomes (Feeney, 2000; Levy et al., 2011; McWilliams & Bailey, 2010). However, primary care physicians have been slow to consider how attachment theory – and thus patients' attachment styles – may be utilized in the context of patient care in medical settings (Miller, 2008; Salmon & Young, 2009).

Attachment styles are one way in which providers and researchers might classify the relationships between physicians and patients (Ciechanowski, 2010). Of significance, attachment styles are as much about the behaviors in which patients engage as they are about the relationship style that patients have with significant others (Ciechanowski, 2010). These styles, or ways of being and relating, have utility in better understanding the patients with whom physicians work. Thus, clarifying and understanding a patient's attachment style may help providers better anticipate or predict how best to relate to and treat the patient. Most would agree that ethical, competent and culturally responsive providers should try to understand how to best engage patients in their healthcare (Huntsinger & Luecken, 2004), successfully encourage their patients to come in for and schedule appointments when needed, co-create patient-centered treatment plans (Adler, 2002; Arbuthnott & Sharpe, 2009; Miller, 2008; Norcross & Wampold, 2011), and encourage patients to

adhere to the treatment evidence-based guidelines set forth by the physician (McWilliams & Bailey, 2010). Bowlby's (1977) attachment theory, if used, may provide a blueprint for attachment-based best practices or optimal care for diverse patients with various attachment styles (Cox et al., 2008).

Attachment theory

Attachment theory is a model advanced by the collaborative efforts of Bowlby (1969, 1973, 1977, 1980) and Ainsworth (1989; Ainsworth et al., 1978). Bowlby and Ainsworth et al. attempted to create and define a theory to explain the functional and healthy lifelong development that would be grounded in the quality of the parental (usually maternal) attachment relationship (Bretherton, 1995; Feeney, 2000). The theoretical underpinnings of Bowlby's (1969, 1973, 1977, 1980) work were developed in his three-part series on attachment, separation and loss. In this series, Bowlby clearly delineated the varied trajectories that the child (and the adult that he or she becomes) may experience as a result of separation, deprivation and loss. While most of Bowlby's training was psychoanalytic, Bowlby argued that the underlying premise of psychoanalysis was inadequate in explaining pathology or the impact of adverse events (e.g. life-threatening illness, mental illness, childhood trauma and so forth) on the social and emotional development of the child and the adult that he or she becomes. Therefore, attachment theory is based on the integration of ethology, cybernetics, information processing, developmental psychology and psychoanalysis (Bowlby 1969, 1973, 1980; Bretherton, 1995). Also evident in Bowlby's set of early writings is his preliminary hypothesis identifying the transmission of early attachment relationships (Bretherton, 1995) to current significant relationships (e.g. patient and physician relationship).

Attachment theory provides a useful framework for understanding the impact and transmission of parent–child attachment or relationship to the physician–patient attachment or relationship (Miller, 2008; Raque-Bogdan et al., 2011; Thompson & Ciechanowski, 2003). In his descriptions of the function of attachment behaviors, Bowlby (1988) articulated the implications of attachment behavior for development and for current and future relationship functioning. Bowlby contended that attachment behaviors serve to protect the young from danger and that the infant's relationship with the caregiver is the prototype for subsequent relationships. These early experiences with a caregiver become psychologically internalized as mental representations or internal working models (IWMs) of future relationships. Further, by the time the person reaches adolescence, early patterns or interactions with attachment figures become organized into generalized interactional styles that are driven by the person's IWM. IWMs or cognitive schemata are often carried into and maintained in adulthood (Bowlby, 1988; Brennan & Shaver, 1995; Miller, 2008).

Kobak and Hazan (1991) proposed that IWMs are not simply determined by past relationships, but also function in a reciprocal process with current relationships (e.g. the relationship a patient has with his or her physician). However, research has supported the idea that childhood IWMs set up an expectation that future relationships will be similar to early emotional relationships and will ultimately result in the same predictable response patterns (Feeney, 2000). Therefore, children who experience an insecure attachment style in childhood may repeat this style in adulthood with physicians and other health care providers. In adulthood, this style could negatively influence the physician–patient relationship (Miller, 2008; Salmon & Young, 2009), health-related behaviors (Huntsinger & Luecken, 2004) and adherence to treatment recommendations, thereby negatively influencing the patient's physical and psychological health (Feeney, 2000).

Attachment styles

Over the years, attachment styles have been represented by different terms and assessed using different methods (to be described later) among scholars, providers and researchers. Bowlby (1969) described four different styles of attachment in children. Main and Goldwyn (1994) and Griffin and Bartholomew (1994) described and operationalized corresponding attachment styles in adult relationships. The four established categories of adult attachment styles described by Griffin and Bartholomew are as follows: (a) secure attachment, (b) insecure-dismissing, (c) insecure-preoccupied or avoidant and (d) insecure-fearful (Griffin & Bartholomew, 1994). Attachment theorists and researchers understand that current adult attachment style classifications are derived from the way the person describes and currently interprets his or her childhood experiences (Brennan & Shaver, 1995). Consequently, although child attachment style does not completely determine adult attachment style, the continuity is undeniable (Feeney, 2000; Levy et al., 2011).

Secure attachment style

Adults who can be classified as securely attached are high functioning and have psychosocial skills and coping strategies applicable across many contexts. They are aware of and able to identify the significance of attachment relationships. According to Griffin and Bartholomew (1994), securely attached individuals have a positive view of self and a positive view of others. Secure adults feel comfortable supporting and receiving support from others (e.g. receiving support from medical and mental health care providers). Consequently, those who are securely attached can respond to stressors, illness and adverse events in a flexible and adaptive manner. Moreover, they may be agreeable to, and help co-create, the treatment recommendations put forward by health care providers and physicians. Research has suggested that behaviors and outcomes often associated with securely attached individuals include resilience and good psychological and physical health. The premise is not that securely attached individuals are free from stressors, illness, and adverse events and environments, but rather that these individuals adopt and possess skills that facilitate social competence, hardiness and communicative behaviors that are used in times of crisis or distress (e.g. diagnosis of cancer).

Patients with secure attachment have usually experienced responsive and attentive caregiving as children. They have a positive view of others and a positive view of the self. They believe that they are worthy of care, and they trust others to give appropriate and necessary care. When these people feel vulnerable or threatened, they feel comfortable relying on others (Ciechanowski et al., 2002). They are usually described as adaptable, capable, trusting and understanding (Maunder & Hunter, 2001). Secure individuals can balance their need for autonomy with their need for intimacy. They know when to depend on others and when to act independently (Tan et al., 2005). They feel "comfortable and flexible in interpersonal relationships" and have "realistic appraisals of personal resources and challenges" (Maunder & Hunter, 2009, p. 125). They also have a well-developed capacity to soothe themselves using both external support and internal resources (Maunder & Hunter, 2009).

Insecure attachment styles

Conversely, people with an insecure attachment style are at risk for being ill equipped to regulate emotions, tend to have limited coping strategies and may resist treatment recommendations put forward by health care providers and physicians (Salmon & Young, 2009; Thompson & Ciechanowski, 2003). Insecurely attached adults tend to have less competent

affect-regulation strategies. Furthermore, instances of adversity, illness and trauma only increase the potential for deleterious outcomes and future risks for adult functioning (Levy et al., 2011; Miller, 2008). Several researchers contend that dysfunctional adult relationships stem from insecure IWMs derived from inconsistent and poor parental caregiving (Bowlby, 1988). Moreover, patients with an insecure attachment style can be intermittently overly argumentative, overly independent (avoidant) and/or overly dependent (anxious).

Insecure-dismissing attachment. Patients with insecure-dismissing attachment usually experienced consistently unresponsive caregiving as children. They have a negative view of others and believe that people will reject or ignore any attempts to gain support. Because of this, they are less likely to seek support and self-disclose to others. However, they have a positive view of the self, focussing mainly on their independence and self-sufficiency (Ciechanowski & Katon, 2006). Traditionally, people with this attachment style attain autonomy and a sense of self-worth at the expense of intimacy (Maunder & Hunter, 2001). They take pride in depending on themselves only; however, because of this, they do not create meaningful, intimate relationships. People with this attachment style either downplay their symptoms and the severity of their illness or do not report symptoms at all as a way to reinforce their self-sufficiency and avoid a relationship with a caregiver or health care provider (Thompson & Ciechanowski, 2003).

Insecure-preoccupied attachment. Patients with insecure-preoccupied attachment had inconsistent or rejecting caregiving as children. They have a positive view of others and a negative view of self. More often than not, they become emotionally dependent on others' acceptance and approval and are often described as "clingy". Because of this, they may become dependent on their caregivers and over-report symptoms (Ciechanowski et al., 2001). They feel they must express a constant signal of distress or illness in order for their needs to be met (Tan et al., 2005). These individuals may also exaggerate their expression of attachment needs in the hope of evoking more consistent and predictable support and care (Thompson & Ciechanowski, 2003). Others commonly describe people with an insecure-preoccupied attachment style as anxious, emotional, excessive in care-seeking, highly likely to protest separation and approval-seeking (Maunder & Hunter, 2001).

Insecure-fearful attachment. Patients with insecure-fearful attachment most likely had overly rejecting and harsh caregivers as children. Usually, they have a negative view of others and self; they desire social contact but are inhibited by fear. They believe people will ignore or reject their attempts to gain support (Ciechanowski et al., 2001). They 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 (Tan et al., 2005). Others describe these individuals as detached, disengaged, cautious, doubting and self-conscious. "They substitute compulsive self-reliance for social support and typically are described by such terms as cold and competitive" (Hunter & Maunder, 2001, p. 180). These individuals have low self-esteem and highly negative affect. People with this attachment style will most likely be inconsistent with any mode of medical treatment (Ciechanowski et al., 2001).

How patient attachment style can be measured

Given the possible implications of attachment style on the patient–physician relationship, communication interactions and treatment outcomes (Arbuthnott & Sharpe, 2009) some discussion of attachment style needs to address the varied techniques used to capture the

latent psychological attribute. Specifically, there are several frameworks that have been advanced to measure attachment styles. Two differential frameworks are often used, and thus are reviewed in this discussion (Jacobvitz et al., 2002). The first descended from a personality and developmental psychology perspective and relies on interviews and observational measures for attachment. The second perspective originated from social psychology and uses self-report measures to assess attachment style.

The first framework relies on observational or interview methods to capture attachment style. One widely documented observational method is the Strange Situation Test developed by Ainsworth and Wittig (1969). Observations of infant behaviors are used to classify them into the four attachment styles proposed by Bowlby (1969). Additional observational measures include the Attachment Q-set (Waters & Deane, 1985) and the Pre-school Assessment of Attachment developed by Crittenden (1992). Although these methods provide a clear behavioral representation of attachment, they are not easily accessible to most researchers and are most widely used on infants and toddlers.

The development of interview-style measurement procedures also developed from the developmental/personality framework. These interview measures can be used on both children, as with the Child Attachment Interview (Target et al., 2003), and on adults, as with the Adult Attachment Interview (George et al., 1985). These measures involve in-depth personal accounts of attachment behaviors over the long term, as opposed to observational measures that can only be inferred over the short term. These interview-style measures have been gaining popularity in clinical practice. As an example, the Attachment Style Interview (ASI) (Bifulco et al., 2008) is seen as a useful screening tool for adoption and fostering practice.

Self-report measures of attachment are also popular, however, they are developed primarily from a social psychological perspective, which relies heavily on experimental techniques. The first two methodologies reviewed above make it challenging for researchers to incorporate multiple independent or dependent variables within a controlled environment. Self-report measures allow for a quick and reliable measurement of attachment. Two examples of self-report measures are the Adult Attachment Scale developed by Collins and Read (1990) and Bartholomew and Horowitz's (1991) Relationship Questionnaire. These measures are relatively easy to administer in experimental studies, however, one limitation to this methodology is the inability to use self-report measures on children. Additionally, there is a lack of consistency among the labels put forward to describe the attachment styles. For example, Bartholomew and Horowitz use the term fearful attachment style to describe the most deleterious attachment style different from her counterparts who use alternative descriptions (e.g. disorganized, fearful-avoidant).

As we can see, both Observational/Interview and Self-report measures can be useful in different situations. Shaver & Mikulincer (2002) theorized bridging the gap between these two methodologies by arguing for simple self-report measures that are as reliable as Observational/Interview techniques. Shaver & Mikulincer provide a rationale for the use of self-report measures, as they argue these measurements have been shown to capture the same underlying latent information as the longer, more burdensome sister measurements. Bifulco et al. (2002) provides counterpoint commentary on this debate of attachment measurement procedures by highlighting the informative nature of Observational/Interview techniques. Bifulco argues that a brief item self-report questionnaire could never capture the vast amount of information collected from the Observational techniques. Additionally, these techniques more easily capture true behaviors by the subject. The purpose of this article is not to argue the validity of either method of measurement, rather, to outline that patient attachment style can aid the physician with patient-centered and patient-tailored plans that

can better facilitate the physician–patient interaction (Adler, 2002; Bifulco et al., 2003; Norcross & Wampold, 2011).

Derived from these different measures, as well as others, are different terms to describe attachment styles. The next section describes some of the different terms found in the literature.

Different terms for attachment styles based on different measures

Similar to the range of measures from which researchers, physicians and providers can select, there are a range of terms (i.e. classifications) that have been put forward to describe attachment styles. These alternative terms are likely derived from and based on the researcher's clinical training, his or her lines of empirical investigation (e.g. child–mother attachment, romantic relationships), his or her target population in the study for which the measure was developed, and his or her judgment as an attachment-based researcher or practitioner. A comprehensive review is beyond the scope of this paper but some of the terms (i.e. classifications) for attachment styles in addition to the four (secure, dismissing, preoccupied and fearful; see Bartholomew & Horowitz, 1991; Griffin & Bartholomew, 1994) described earlier in the paper include, but are not limited to, the following: (1) autonomous/secure, dismissing, preoccupied, unresolved and cannot classify (see AAI; Main et al., 1985); (2) angry-dismissive, enmeshed, fearful, withdrawn and secure (see ASI; Bifulco et al., 2002); and (3) insecure and proximity-seeking (see Vulnerable Attachment Style Questionnaire (VASQ); Bifulco et al., 2003).

Currently, there is a lack of consensus regarding best practices associated with measuring attachment styles (Bifulco et al., 2003; Daniel, 2006; Jacobvitz et al., 2002). In some cases scholars have proposed categorical frameworks and in other cases scholars have proposed dimensional frameworks to best understand, classify (i.e. the terms that are used) and measure attachment styles. Of significance, the measure physicians and other providers select may generate and uncover different data (or attachment classifications) to inform their interactions, communication style, treatment recommendations and physician–patient relationships in medical settings.

How patient attachment style affects physician–patient relationship

Patient attachment styles can influence the relationship between the physician and patient and, consequently, the outcomes of treatment (Feeney, 2000; Miller, 2008). Interpersonal relationships largely influence how people cope with distress and adjust to life crises, including reactions to mental and physical illness (Cicero et al., 2009). According to Thompson and Ciechanowski (2003), “ill health is likely to activate the attachment system because of distress and perceived vulnerability” (p. 220). Mikulincer et al. (2003) argue that individuals will activate strategies of affect-regulation that are driven by their attachment style. As previously mentioned, individual attachment strategies consist of beliefs, expectations and patterns in relationships and assist in determining the type of relationship the patient has with the physician. Hunter and Maunder (2001) state that attachment styles affect health-seeking behavior and the capacity to be soothed by, or accept help from, primary care physicians and other health care professionals. Furthermore, Tan et al. (2005) suggest that the success of a therapeutic relationship between a patient and physician is partially influenced by the empathic response of the physicians to the specific attachment needs of the patients. The physician's approach also affects the formation and development of the relationship; it is critical for physicians to “understand the needs of the patient in relationships, their defensive

strategies and the reciprocal influence of patients and caregivers upon the relationship that develops" (Tan et al., p. 148). When physicians clearly understand their clients' attachment styles and provide appropriate empathy, compassion and support, patients tend to participate more and have more autonomy, which in turn improves treatment adherence (Ciechanowski et al., 2004). Specific attachment styles generally have consistent patient reactions and communication styles.

Kaplan et al. (1989) conducted a study to focus on specific aspects of the patient–physician relationship that affect patients' health outcomes. Four clinical trials were done in varied practice settings among chronically ill patients. The results indicated that better health (as measured by physiological, behavioral, or subjective measures) was associated with clear, positive patient–physician communication. Physicians must understand their patients' attachment styles in order to provide positive beneficial relationships and communication styles. Kaplan et al. suggest that this relationship may be an important factor in the patient's health outcome.

Secure attachment style

Patients with a secure attachment style have the most effective and beneficial relationships with their physicians. These patients feel they are worthy of care and trust others to give them adequate and appropriate health care. They are also able to ask for and accept help from physicians and other health care providers (Tan et al., 2005). The IWM of these individuals includes "an expectation that help will be sufficient, and that medical personnel can be trusted for support during the crisis" (Hunter & Maunder, 2001). According to Smith et al. (2010), patients who describe themselves as securely attached experience better quality of patient–physician relationships. This attachment style allows physicians to form positive constructive clinical relationships with their patients. Because of their willingness to confer with health care professionals and abide by the health care regimens, these individuals are thought to be less prone to chronic pain and other symptomatology (Feeney, 2000).

Insecure attachment styles

Insecure-dismissing attachment. Patients with a dismissing attachment style tend to downplay or deny any medical symptoms or illnesses. Because of this, they may avoid seeking support from others and remain disengaged in their relationships. These patients often distrust others, believing that they are incapable of sufficient support and care; therefore, these patients have a self-sufficient, undemanding attitude (Hunter & Maunder, 2001). Thus, it may be difficult for physicians to form a close therapeutic relationship with these patients due to these patients' lack of trust in others and avoidance of intimacy. Other potential complicating factors may include the fact that these patients may show hostility or may fail to comply with treatment recommendations (Feeney, 2000).

Some physicians may inadvertently minimize the importance of patients with this type of attachment style. The patient may appear undemanding and not problematic, and therefore the physician spends less time with the patient, schedules fewer visits and inquires less about the patient's illness (Thompson & Ciechanowski, 2003). This, in turn, reinforces the patient's beliefs that in order to continue to receive care, they must downplay their illness and attachment needs, thus leading to poor dedication to medical treatment.

Insecure-preoccupied attachment. Having an insecure-preoccupied attachment style heavily affects the patient–physician relationship. Patients with this type of attachment may

exaggerate their health care needs in hope of evoking more consistent, predictable support from the health care provider. These people learned from their early caregiving experiences that a constant distress signal is necessary to have their needs addressed by a caregiver, which usually results in seeking care immediately and frequently (Thompson & Ciechanowski, 2003). This is applied to the patient–physician relationship through the patients' dependency and excessive care-seeking. According to Thompson and Ciechanowski, these individuals have little self-confidence in their own decisions and abilities and therefore seek care often and immediately whenever a problem may occur. Physicians may feel that these patients are overwhelming and taxing; it is critical that physicians are aware of this and do not allow their emotions to affect their provision of optimal and appropriate treatment recommendations. This type of attachment style may make it difficult for physicians to form appropriate and adequate relationships with their patient.

Insecure-fearful attachment. Patients with insecure-fearful attachment experienced harsh, rejecting early caregiving experiences, which resulted in the belief that they are unworthy of care and that others are unable to adequately provide care. With a history of being mistreated when coping with distress, these people view all caregiving as potentially threatening and hostile (Thompson & Ciechanowski, 2003). Because of their profound anxiety about personal safety and deep mistrust of others, they are not willing to form relationships with physicians (Hunter & Maunder, 2001). This may lead the physician to experience feelings of incompetence, frustration, or intrusion, which, if left unexamined, can lead to a poor quality of care.

Ciechanowski et al. (2002) conducted a study to determine if patients with preoccupied and fearful attachment styles would more frequently report physical symptoms than patients with other attachment styles. Using a large sample of female primary care health maintenance organization patients, the authors analyzed information from diagnostic interviews as well as health utilization and costs data. Patients with preoccupied and fearful attachment styles were associated with a significantly greater number of physical symptoms compared to other patients.

Finally, and of significance, patients' attachments styles and the associated cognitions, behaviors, and intra- and interpersonal styles may engender strong reactions, including transference in patients and countertransference in physicians (Miller, 2008). The physician–patient encounter – many would contend – occurs in an attachment-relevant context (see Thompson & Ciechanowski, 2003). More specifically, because the physician–patient relationship and encounters often happen during times of stress (e.g. diagnosis of cancer) the patient's attachment system (i.e. IWMs) can be activated and applied to current relationships (Smith et al., 2010). Thus, the patient may attempt to interact with the physician in ways consistent with the interpersonal styles evinced with their caregiver in childhood (Bowlby, 1988). Thus, for patients with an insecure attachment style they may expect the physician to be emotionally *unavailable* and *unresponsive* to their health-related needs in similar ways in which the parent or caregiver was *unavailable* and *unresponsive* to their emotional needs (Levy et al., 2011). In the case of patients who present with a secure attachment style, the converse may be true: the patient may expect the physician to be emotionally *available* and *responsive* to their health-related needs in similar ways in which the parent or caregiver was. Thus, physicians must be prepared to recognize transference, to work with patients and the emotional aspects of physician–patient encounters and to understand how the attachment style can impinge upon treatment (Levy et al., 2011; Thompson & Ciechanowski, 2003).

Miller (2008) contends that countertransference experiences are commonly reported among providers and to be expected; therefore, they must be monitored by physicians. Moreover, some of the same challenges related to forming trust and a therapeutic relationship and

environment when working with patients who present with personality disorders, may be evidenced with patients who present with insecure attachment styles (Miller, 2008). These challenges may be observed in the presentation of patients' behaviors in the following ways: (1) reports of increased symptoms, (2) failure to keep appointments, (3) requests for more appointments than usual and (4) failure to follow treatment recommendations, and so forth. Miller suggests that if physicians are not watchful or prepared for countertransference or negative reactions to their patients' behaviors, physicians may repeat the very behaviors and interactions that the patient experienced in his or her childhood and thereby negatively impact the physician–patient relationship. In sum, physicians must monitor and be prepared to address transference and countertransference transactions when working with patients in the context of the medical attachment system (Miller, 2008).

How physicians can work with diverse patient attachment styles

Overall, it is critical for the physician and health care team to be aware of the patient's attachment style and to be able to appropriately address his or her needs. For example, Waldinger et al. (2006) indicated that "screening for attachment style may provide information that could allow health care providers to tailor treatment more effectively" (p. 129). As previously discussed, a number of self-report measures are available that could be easily administered to patients, including the Relationship Questionnaire (Bartholomew & Horowitz, 1991), Experiences in Close Relationships Questionnaire (Brennan et al., 1998) and the Relationship Styles Questionnaire (Griffin & Bartholomew, 1994). An alternative to the self-report measures could be an interview-based measure, the VASQ, developed by Bifulco and colleagues (see Bifulco et al., 2003). It is essential that physicians attempt to understand their patients' previous experiences, as they potentially influence the clinical relationship and communications between the physician and patient currently (Salmon & Young, 2009).

It is also important for the health care team to be empathic and provide support during the patient's time of medical need. The team must also help the patient obtain similar support from more accessible resources, including family, the community and – for some patients – religion (Adler, 2002). According to Ciechanowski et al. (2001), although individuals with an insecure attachment style may have difficulty forming collaborative therapeutic relationships, the responsiveness of physicians may significantly influence the ultimate success of the relationship.

Arbuthnott and Sharpe (2009) conducted a meta-analysis of published literature concerning the magnitude of the relations between patient–physician collaboration and patient adherence to treatment. Statistically significant results indicated that better patient–physician collaboration is associated with better patient adherence. The authors describe practice implications for physicians, stating that "the inclusion of the patient's perspective during the consultation is essential to obtaining cooperation once the patient has left the physician's office" (p. 60). Physicians can apply this strategy to all patients, despite their attachment styles.

Furthermore, Ciechanowski and Katon (2006) conducted a study focussing on patients' attachment styles and the influence of the interpersonal experience of health care. They selected 27 patients with type 2 diabetes attending the University of Washington Diabetes Care Center in Seattle. They used a self-report measure to determine attachment style. With varying degrees of comfort and trust in relationships, these individuals were chosen to examine issues of trust and collaboration in the health care setting. Patients with fearful and dismissing attachment styles described an inability to collaborate for a long period of time and a low level of trust for providers. These patients stated that certain aspects of the health care system were inhibiting, such as "a perceived 'wall' between providers and patients" (p. 3067). They

also reported that their trust and ability to engage would improve if physicians had more patient-centered attitudes and behaviors. This research demonstrates not only how an individual's attachment style can affect his or her trust and ability to cooperate, but also the importance of positive patient care from physicians and the entire health care system. This finding buttresses the long-held assumption about the importance of the provider–patient relationship.

Secure attachment style

Patients with secure attachment usually are willing to form positive working relationships with their physicians. According to Hunter and Maunder (2001), the IWM of these individuals includes "an expectation that help will be sufficient, and that medical personnel can be trusted for support during the crisis" (p. 179). Physicians should be able to form practical and beneficial relationships with these patients. According to Adler (2002), it is important for the physician and patient to become collaborative partners and work together against the medical and psychological problems with which the patient presents. This partnership – or patient-centered care – will usually have a positive effect on the patient's cooperation and treatment adherence. Furthermore, it is essential for the physicians to be knowledgeable and able to clearly communicate with their patients. Ciechanowski and Katon (2006) suggest that the physicians' awareness and knowledge are important elements of the patients' ability to trust their physicians.

Insecure attachment styles

Insecure-dismissing attachment. Patients with this attachment style can be challenging to work with because of their avoidant behaviors and untrusting beliefs. To successfully work with these individuals, physicians must show a respect for their need for independence through specific empathic responses that are considerate of the patient's need for space and a sense of personal control. Additionally, it is essential for the physician to relay the message that continual involvement and care are necessary for optimal care (Thompson & Ciechanowski, 2003). It is critical for these patients to not only feel a sense of independence, but also understand the importance of continuing treatment and the relationship with their physician. Thompson and Ciechanowski emphasize the importance of the physician's being aware of the possibility of worsening medical illnesses or complaints given their patients' tendency to under-report symptoms. Thompson and Ciechanowski list several strategies for physicians to use when working with patients who have insecure-dismissing attachment, including "using automate appointment-tracking systems, increasing communication through telephone calls and using proactive contracts, such as mailed appointment reminders, to ensure ongoing engagement with these patients" (p. 223).

Insecure-preoccupied attachment. Because of their consistent signs of distress and insatiable desire for other's approval, insecure-preoccupied patients may be somewhat challenging to work with. Hunter and Maunder (2001) give three recommendations for physicians when working with these patients. First, clear limits must be set, and the physician must deliver positive, empathic attention within these boundaries. Second, the physician should preemptively address the distress of the patient in an effort to externally regulate and decrease the anguish of the patient. Lastly, psychotherapeutic and pharmacological interventions may be a necessary and effective form of external regulation. According to Thompson and Ciechanowski (2003), "the aim is to assure that care will be provided before the patient requests it, thereby reinforcing that the patient will receive support regardless of symptom complaints" (p. 223). Physicians can encourage patients to develop a greater sense of their

own initiative, self-trust and competent self-care by accepting the patients' need for dependency and remaining a constant source of support and security.

Cicero et al. (2009) conducted a study focussing on the role of attachment styles and perceived social support in predicting adjustment to cancer. A sample of 96 cancer patients participated in four questionnaires, including a demographic questionnaire, the Relationship Scale Questionnaire, the Multidimensional Scale of Perceived Social Support and the Mental Adjustment to Cancer questionnaire. The results suggest that perceived social support, especially from friends, may provoke the patient to take a more active stance in fighting his or her illness. The authors state that social support and quality relationships can "elicit instrumental and informational aid that facilitates adjustment to the illness" (p. 1050). Physicians can use this information when working with patients who have insecure-preoccupied attachment and encourage these patients to take advantage of all social support being offered. Not only can this strengthen the therapeutic alliance, it can also increase the patients' self-confidence and motivation in the fighting their illnesses.

Insecure-fearful attachment. Working with patients who have this attachment style can be somewhat complicated, and it is common for physicians and other health care professionals to become frustrated and hopeless when working with this population. Therefore, it is critical that all health care professionals realize the impact of the patient's attachment style on his or her ability to constructively participate in the healing process. People with insecure-fearful attachment often have conflicting coping mechanisms. To deal with their profound anxiety, they exert a constant pressure upon the caregivers; however, they become rejecting and use passive expressions of anger for being forced into the dependent role (Hunter & Maunder, 2001). Because of this confusing and inconsistent relationship, it is appropriate to approach the patient using team care in order to provide the patient with optimal treatment. It is also essential to prepare physicians and their health care team for working with these patients and have interventions when necessary. This will ensure that the team understands the patient's personality and relational and interactional style and in turn prevents disorganization and blaming within the treatment team (Thompson & Ciechanowski, 2003). Another common way to work with these patients is to communicate clearly: set clear limits on the acceptable expressions of anger, clarify what patients should expect from physicians and treatment team, and explain that there will be no inappropriate closeness (Hunter & Maunder, 2001).

The accumulated clinical and empirical research base about many patients who present with a specific attachment style is informative. Primary care physicians should consider how attachment theory may be used in the context of patient care in medical settings. Specifically, Levy et al. (2011) and other scholars suggest physicians and other providers can consider tailoring their work with patients with select attachment styles in the following ways.

- Physicians should consider assessing for their patients attachment style to inform their work (Bifulco, 2002; Levy et al., 2011).
- Physicians should be aware that their patients attachment style can possibly foretell how *some* patients may respond to select physician communication styles (e.g. collaborative, expert and so forth) and treatment recommendations (Levy et al., 2011).
- Physicians should consider tailoring their evidence-based treatment approaches based on patients' attachment styles (Adler, 2002).
- Physicians as well as other providers should recognize that the patients' attachment style may be modified as a result of the attachment relationship formed with physicians or providers (Daniel, 2006). Miller (2008) suggests that a corrective emotional experience

can be evidenced as a result of a trusting and consistent relationship patients create with their physician.
- Physicians should monitor and be prepared for issues of transference and countertransference related to the treatment process, including the likely interaction between the physicians' and the patients' attachment styles. (Daniel, 2006; Levy et al., 2011; Miller, 2008; Thompson & Ciechanowski, 2003).
- Physicians who elect to screen for attachment styles and infuse an attachment-based framework into their practice, must be mindful of the ethical implications of doing so. Some ethical considerations include: (1) to what extent the additional screening may be burdensome for the patient, (2) how and when to disclose to patients how the information derived from the assessment might be used in the treatment process and (3) to be aware of the need to refer if previous attachment injuries impinge upon patients' physical and psychological functioning beyond the physician's level of competency.

In summary, patients who present with a secure attachment style will likely believe that physicians or providers are trustworthy and will *provide* the best treatment and services as well as believe they are worthy of and deserve to *receive* the best treatment and services from their providers (Sullivan et al., 2009). Conversely, patients who present with an insecure attachment style will likely believe they are not worthy of and will not receive the best treatment and needed services from their physicians and providers (Sullivan et al., 2009).

Conclusion

Bowlby's (1969, 1973, 1977, 1980) attachment theory and attachment styles offer primary care physicians a theory-driven framework on which to base their patient–physician communication styles and treatment recommendations. Bowlby's model also offers physicians a means to better understand how their patients' past and current relational and interactional styles may influence their relational and interactional styles with the primary care physician and thus positive and negative treatment outcomes (Adler, 2002; Feeney, 2000; Miller, 2008). When providing optimal care for patients (e.g. patient-centered, evidence-based care), physicians must be aware of their patients' attachment styles and understand how it will affect the physician–patient relationship, which will in turn influence treatment adherence (Arbuthnott and Sharpe, 2009). According to Maunder et al. (2006), "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" (p. 553). Understanding the patients' attachment styles will allow primary care physicians to focus on successful communication which allows physicians to effectively collaborate with patients to ensure the best possible patient-centered treatment.

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