Difficult doctor–patient interactions

Applying principles of attachment-based care

KAY WILHELM MB BS, MD, FRANZCP, AM
TAD TIETZE MB BS, FRANZCP

Understanding a patient's attachment style allows prediction of likely patterns of interaction in clinical settings and helps in tailoring an overall treatment approach to suit the patient's style. This attachment-based care approach is particularly useful in the context of difficult doctor–patient interactions.

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KEY POINTS

- Difficult doctor–patient interactions are common and can be a barrier to effective care, with negative emotional consequences for both patient and doctor.
- Attachment theory can help us understand such interactions as relational styles that both patient and doctor bring to clinical settings.
- Understanding difficult interactions in terms of a social relationship helps shift attention away from a pejorative and unproductive focus on the 'difficult patient'.
- Adults with insecure attachment styles ('preoccupied', 'dismissing', 'fearful' and 'disorganised') are more likely than those with a 'secure' style to have problems in the context of illness and stress.
- Attachment style can help predict potential problems in the clinical interaction.
- Simple interventions can address specific difficulties in the doctor–patient interaction.

There is significant literature on 'difficult patients' presenting for health care, who have been given many names, including 'manipulative', 'demanding', 'complaining', 'needy', 'frequent flyers', 'heartsink' and even 'hateful'.[1] The range of 'difficulties' demonstrated by these patients generally fall into the following groups:

- have repeated visits with little apparent benefit, especially when it is difficult to conclude the interview, sometimes with excessive dependence on and flattery of the doctor
- have unreliable attendance and poor adherence to advice and treatment
- make complaints that seem to have no medical explanation or are significantly out of proportion with the physical findings
- display intense negative affect (i.e. patients who are unduly demanding, angry, defensive, frightened or aggressive).

Although doctors can experience these patients as emotionally draining, intimidating or simply hard to relate to, the degree of perceived difficulty varies from one doctor to another and can reflect differences in experience and the personal

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Professor Wilhelm is Head of the Consultation–Liaison Psychiatry Service at St Vincent's Hospital Sydney; Conjoint Professor, UNSW Psychiatry; and Professorial Fellow, Black Dog Institute, Sydney.
Dr Tietze is a Staff Specialist in the Consultation–Liaison Psychiatry Service at St Vincent's Hospital Sydney; and Conjoint Lecturer, UNSW Psychiatry, Sydney, NSW.

style of the doctor or the context and setting in which the difficult interaction occurs. Doctor-related factors include a doctor's approach that is defensive, irritable and dogmatic. Context-related factors include a doctor being tired or pressed for time, language and literacy issues during the consultation, and carers who tend to subvert or distract in the interview process.

Acknowledgement of factors related to the doctor and the context and setting of the consultation alongside patient factors is reflected in the recent trend in the literature towards considering 'difficult doctor–patient interactions' rather than 'difficult patients'.[1,2] Although this is a step forward, it still tends to focus on the negative aspects of the interaction and can lead to a sense of disempowerment for both doctor and patient. By way of contrast, in this article we suggest a more useful method is to recognise and address attachment styles within a therapeutic interaction.

This article aims to apply the principles of attachment theory (a theory of social development describing how patterns of close interpersonal relationships emerge in early life) to the understanding and management of difficult doctor–patient interactions in general practice.[3] The attachment approach differs from approaches that focus on a patient's personality style or illness behaviour in that it sees problems arising in the social relationship between clinician and patient, rather than situating all the difficulties in the patient themselves. We propose that this is a productive approach for doctor and patient and provides a nonjudgemental framework for dealing with obstacles in the doctor–patient relationship.

What is attachment theory?

Attachment theory was developed by the English psychiatrist John Bowlby, who studied the patterns of interaction between infants and their primary caregivers during and after World War II.[4] He proposed that infants have a biological drive to seek proximity to their caregivers. These infant–caregiver interactions provide infants with a perception of whether their caregivers are available, attuned to their signals for help and generally consistent in their responses. As infants mature, these interactions translate into their impressions of how trustworthy and caring other people are overall. These interactions also contribute to their own 'working model' of themselves – that is, whether they consider themselves worthy of care and support from attachment figures, their self-esteem and their confidence at dealing with caregivers and people more generally.

The interaction does not need to be perfect. 'Good enough' parental attachment figures should provide a satisfactory 'safe base' from which to explore the world, an 'emotional template' from which to fashion their own emotional regulation and ideas about how to view their 'self' and 'others'.[5]

Ainsworth and colleagues built on Bowlby's work with parents and infants by identifying three main infant attachment styles: secure (type B), insecure avoidant (type A) and insecure ambivalent/resistant (type C).[6] They concluded that these attachment styles were the result of early interactions with the mother. A further attachment style, disorganised/disoriented, was added later by Main and Solomon.[7] These attachment behaviours have been validated across a wide range of social and cultural contexts.[8]

Adult attachment styles

Attachment behaviours have been described as 'interpersonal actions that are intended to increase an individual's sense of security, particularly in times of stress or need'.[3] These behaviours are thought to be relatively stable from their development in infanthood through to adulthood, when they are called 'adult attachment styles'.[3] A meta-analysis of studies of adult attachment assessments in nonclinical populations suggest that about 40% of adults have an 'insecure' attachment style.[9] Importantly, it is considered that insecurity of attachment is not itself a pathology but represents a vulnerability in terms of effective stress and distress management.[10] Attachment insecurity can also be a contributing factor in adult depressive vulnerability.[11,12] Childhood experiences of trauma, neglect and pathological family dynamics are strong predictors of adult attachment insecurity.

There are several different categorisations of adult attachment styles. Useful videos about attachment and featuring Dr Dan Siegel, Clinical Professor of Psychiatry at the UCLA School of Medicine, USA, are available on the PsychAlive website (http://www.psychalive.org/author/dr-daniel-siegel); these videos can also be recommended to patients.

TABLE 1. SUMMARY OF WORKING MODELS OF SELF AND OTHERS ASSOCIATED WITH DIFFERENT ATTACHMENT STYLES[7,10,13]

	Low dependence on others	High dependence on others
Low avoidance of others	*Secure attachment style* 'I can...' 'I like to do it myself but will ask for support when I need it' • Typified by high trust in self and others	*Preoccupied/ambivalent/ anxious attachment style* 'I can't do it myself' 'I need someone to help me/ don't want to be on my own' • Typified by low trust in self, high trust in others
High avoidance of others	*Dismissing/avoidant attachment style* 'I can't rely on others' 'I don't need support/help, I have been let down too many times and prefer not to rely on others' • Typified by high trust in self, low trust in others	*Fearful attachment style* 'I can't ...' 'I would like help but am afraid to ask for support because I am afraid of being let down/ abandoned' • Typified by low trust in self and others

One useful conceptualisation of adult attachment is that of Bartholomew and Horowitz, which was originally developed to consider romantic relationship styles in adults but has now been more broadly applied in adults, including clinical interactions.[13] These researchers categorised four main attachment styles: secure, preoccupied, dismissing and fearful.[13] These styles are shown in Table 1 in terms of how an individual perceives their 'self' and the 'others' they relate to in their interpersonal context.[7,10,13] Various authors have given slightly different names to the styles – we have elected to use the Bartholomew and Horowitz names but mention alternative names to show how these fit together.

Attachment styles

Secure style

A secure attachment style is seen in people who experienced consistent and responsive caregiving when young, and who see themselves as worthy of care. It is typified by low emotional dependence (comfortable receiving care when appropriate) and low avoidance of emotional closeness (can trust others sufficiently to disclose their concerns).

Preoccupied (or 'ambivalent' or 'anxious') style

A preoccupied (or ambivalent or anxious) attachment style is seen in people who experienced inconsistent, often overprotective caregiving when young. It is typified by high emotional dependence on others (described as 'needy' or 'clingy' when distressed), lack of belief in their own worth and their 'right' to receive care, low avoidance of closeness, focus on negative affect and need to amplify distress and have symptoms acknowledged. They are also likely to become depressed and anxious in stressful situations.[11,12]

Dismissing/distrustful (or 'avoidant') style

A dismissing (or avoidant) attachment style is seen in people who experienced unresponsive caregiving when young, where they felt let down and learned it is best to develop strategies to become 'self-reliant'. It is typified by low emotional dependence (feeling that caregivers are unlikely to be trustworthy) and high avoidance of emotional closeness; however, people with this attachment style have a positive view of themselves as survivors, not needing others, and indeed take pride in their self-reliance and independence. An extreme variant of this style has been called 'derogating' or 'angry-dismissing', and is characterised by active hostility to caregivers and treatment.

Fearful style

A fearful attachment style is seen in people who experienced inconsistent and ambivalent caregiving when young. It has elements of both the preoccupied and dismissing styles, and is typified by a fear of rejection so that although the person desires social and emotional closeness they are, because of lack of confidence in themselves, also frightened of it.

A fifth attachment style: disorganised

Additional to the four main attachment styles described above and in Table 1, there is a fifth style, described as 'disorganised'. This attachment style is correlated with profoundly chaotic, disrupted and traumatic childhood experiences and may be conceptualised as a mixture of fearful and dismissing styles.[10] The disorganised attachment style is typified by low trust, low self-esteem and a tendency to become disorganised when in stressful situations that involve emotional closeness and a need to rely on others. This style generally applies to people with borderline personality traits.

Attachment dependence versus attachment avoidance

The four main attachment styles can also be defined by levels of 'attachment dependence/anxiety' (high for preoccupied and fearful styles) and 'attachment avoidance' (high for dismissing and fearful styles).

The relevance of attachment dependence and avoidance has been considered in relation to psychosis.[14] High levels of attachment avoidance were associated with positive symptoms, negative symptoms, paranoia and interpersonal hostility, as well as poor therapeutic engagement, in patients with psychosis; high attachment dependence/anxiety was associated with overly demanding or attention-seeking behaviour.

Attachment style and doctor–patient interactions

Attachment styles have been found to provide a useful framework to view relationships in clinical settings. In a study of doctors' experiences of patients who were seen as 'personally difficult' in an emergency department setting, only 2% of patients with a secure attachment style were experienced as 'difficult', whereas among patients with insecure styles the proportion experienced as difficult was 17% for preoccupied, 19% for dismissing and 39% for fearful attachment styles.[15]

Typical patterns of doctor–patient interactions for these attachment styles are summarised in Table 2. An example of a simple self-report relationship questionnaire for determining attachment style is shown in the Figure.[13,16]

Patients with a preoccupied style

People with a preoccupied attachment style tend to have high rates of visits to doctors, associated with high emotional reactivity and low pain tolerance. They include people classified as 'somatisers', 'anxious worriers', 'heartsink patients' and some 'frequent flyers'. From an attachment perspective, they have not learned how to problem-solve independently or to be assertive, with the result that although they have trust in others they do not feel competent in their own abilities or decision-making capacity and so frequently seek reassurance. They tend to be distressed by parting (e.g. the end of an appointment) and separation. As an example, a study reporting a 12-month post-treatment follow up of patients with chronic pain showed that those with this style were more likely than those with a secure attachment style to still be having frequent visits seeking pain relief even after controlling for depression, catastrophising and pretreatment pain management.[17]

Patients with a dismissing style

People with a dismissing attachment style tend to approach health care warily and to downplay their own symptoms and need for help. They are described as 'compulsively self-reliant' and do not take in or even dismiss direct treatment advice and recommendations because of low levels of trust in the doctor and healthcare services. This can lead to poor patient–clinician communication and problems with treatment adherence. This is illustrated in a study of people with diabetes, where patients with a dismissing style have poorer outcomes in terms of glycosylated haemoglobin (HbA_{1c}) levels, foot care, and diet and treatment adherence, even after controlling for effects of depression.[18]

When the dismissing style is accompanied by high levels of anger (a derogating style) then 'demanding', 'complaining' or even 'hateful' styles of behaviour can manifest in the clinical encounter.[10,15]

Patients with a fearful style

People with a fearful attachment style have a lack of faith in their self-worth and self-efficacy combined with a lack of trust in others. This can lead to ambivalence and approach-avoidance behaviours in treatment settings; for example, they can make urgent same-day appointments with a doctor and then not turn up. They can suffer with significant symptoms but avoid medical visits for fear of being rejected. Similarly, they can tolerate inadequate treatment without speaking up so as to maintain their alliance with the doctor.

Patients with a disorganised style

People with a disorganised attachment style are generally typified by a diagnosis of borderline personality disorder or traits. They have poor interpersonal boundaries and become emotionally fragmented when stressed, and may convey a sense of helplessness and urgency to others. These patients may have serious comorbid substance abuse problems. They are not just erratic but can be emotionally overwhelmed and overwhelming. Their emotional chaos can translate into chaotic clinical encounters with sudden shifts from co-operation to rejection, as well as sudden and dramatic mood swings. They can also rapidly become angry and paranoid in response to small inconsistencies in clinical advice and treatments.

The role of the doctor's attachment style

It is important to consider the doctor's reactions to patients' different attachment styles, and how the doctor's own attachment style can contribute to the kinds of relationship that develop. Doctors have varying levels of tolerance of the range of negative emotions (such as anxiety, irritability and anger) and also have their own differences in attachment dependence and avoidance. These differences affect levels of care, sensitivity to topics raised, how they set boundaries with patients and how they deal with emotional crises in their patients.

Avoidant strategies and 'compulsive caregiving' lie at opposite ends of a caregiving spectrum. Avoidant caregiving can relate to clinicians who have had inconsistent caring themselves, while compulsive caregiving is thought to be more common in clinicians who have been deprived of care as children and seek to provide it for others in their professional lives.[19] These differences in doctor style are reflected in what sort of patients are experienced as 'difficult'.[20]

We suggest it is useful for doctors to consider their own contributions to doctor–patient interactions and that they seek the support and advice of colleagues when difficult interactions arise with patients.

Attachment-based care (ABC) approach

Understanding a patient's attachment style allows the doctor to predict likely patterns of interaction in the clinical setting. It also provides the basis for tailoring the overall treatment approach to suit the patient's style. This is more of an issue when there are difficult interactions but can be used to predict and plan for possible problems. We have termed this 'attachment-based care' (ABC).

TABLE 2. RELEVANCE OF ATTACHMENT STYLES TO DOCTOR–PATIENT RELATIONSHIPS

Attachment style	Patient's attitude to care seeking and the 'sick role'	Impact on doctor–patient relationship	Pitfalls for the doctor	Predicted patient outcomes
Secure style	Trusting, collaborative, positive towards seeking help, comfortable with 'sick role' as appropriate	Patient is collaborative, confident, values help and advice Doctor feels sympathetic to patient's needs, valued, confident that advice will be followed May challenge some doctors by being assertive	Problems are uncommon. However, because these patients tolerate uncertainty and ambiguity the doctor may not attend enough to providing clear and consistent advice and recommendations, or miss problems in service delivery that need to be addressed	These patients work most comfortably with doctor and the clinical team(s), maximising the chance of good outcomes
Insecure styles				
Preoccupied style	Low trust in own worth and decision-making, preoccupied with relationships and pleasing others, show high emotional reactivity, seek reassurance from others, presents as 'anxious', 'needy'	Doctor feels a need to reassure patient, but this can lead to exasperation if repeatedly asked for reassurance on same matters	Patient expresses anxiety, may ask doctor to make decisions – 'I can't… you know best, you decide', which leads to overriding patient in interests of time	Patient is needy but co-operates after reassurance They may show resistance ('yes, but…'), increased anxiety ('you don't understand…'), leading to helplessness, loss of confidence, patient may give up, leave
Dismissing/ distrustful style	Wary, distant, does not trust clinician, misses appointments	Patient appears to display a lack of involvement, lack of engagement, unreliability, or can be avoidant because of a tendency to show themselves in a good light, minimise problems and need for treatment	Doctor may become frustrated, override patient when they repeatedly state: 'I can't…', 'I forgot…' or 'I don't need to do anything… it's not that bad really'	Increased withdrawal from care, bottling of problems and emotional issues, possibility of crises when strategy of self-reliance breaks down
Derogating (angry-dismissing) style	Denigrates help offered, nothing good enough If extreme, distant, disdainful, nonengaging due to hostility about being dependent	Doctor feels 'put down', unappreciated for clinical input, angry If extreme, doctor can lose patience and confidence, find ways to avoid patient, may see patient as 'hateful'	Doctor can get angry and confront, challenge patient who says 'What's the use… you can't help me anyway…' Doctor and team may decide to walk away	Anger/resistance, low frustration tolerance, tends to storm out, make complaints, threats, including self-harm May sabotage treatment, drive clinicians away by hostile attitude
Fearful style	Low trust in self and others, afraid of intimacy, expect rejection, but high emotional reactivity Present as wary, testing out doctor and relationship, ambivalent style	Doctor feels confused by alternation of approach and avoidance, patient's unpredictability	Doctor may get upset with patient's inconsistency and pulling away when help is given	Increased anxiety, depression, threats of self-harm, may withdraw, miss appointments or leave
Disorganised style	Typified by low trust and tendency to become disorganised when in stressful situations	Patient may be frightened by doctor and treatment, may also re-experience other earlier traumas Doctor may become fearful for patient, panic about ability to contain patient's overwhelming emotions	Doctor may feel a failure, keep trying harder, doing more, go beyond professional boundaries The seemingly overwhelming nature of patient's problems can split or fragment clinical teams	Patient and doctor may reinforce feelings of being overwhelmed, loss of personal control, leading to poor outcomes, chaotic care provision, and medical and mental health crises

RELATIONSHIP STYLE QUESTIONNAIRE

BELOW ARE DESCRIPTIONS OF RELATIONSHIP STYLES THAT PEOPLE OFTEN REPORT.

AFTER EACH STATEMENT, PLEASE RATE THE EXTENT TO WHICH YOU THINK THE DESCRIPTION CORRESPONDS TO YOUR GENERAL RELATIONSHIP STYLE.

	Not at all like me						Very much like me
Style A It is easy for me to become emotionally close to others. I am comfortable depending on them and having them depend on me. I don't worry about being alone or having others accept me.	☐	☐	☐	☐	☐	☐	☐
Style B I am uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I worry that I will be hurt if I allow myself to become too close to others.	☐	☐	☐	☐	☐	☐	☐
Style C I want to be emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them.	☐	☐	☐	☐	☐	☐	☐
Style D I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me.	☐	☐	☐	☐	☐	☐	☐
Style E I think it's a mistake to trust other people. Everyone's looking out for themselves, so the sooner you learn not to expect anything from anybody else the better.	☐	☐	☐	☐	☐	☐	☐

If you had to <u>choose only ONE</u> of the above relationship styles to describe yourself, which one would it be?

Please **CIRCLE below** the letter corresponding to the style that best describes you or is nearest to the way you generally are in your close relationships.

STYLE A **STYLE B** **STYLE C** **STYLE D** **STYLE E**

Bartholomew K., Horowitz L. Attachment styles among young adults: A test of a four-category model. Journal of Personality and Social Psychology, 1991, Journal of Personality and Social Psychology, 61, 226-244; Holmes B., Ruth-Lyons K. The Relationship Questionnaire – Clinical Version RQ-CV (5 factor Model). Infant Mental Health Journal, 2006, 310-325.

Figure. An example of a relationship questionnaire.[13,16] Styles A to D in this questionnaire correspond to the following styles described in the text: A = 'Secure attachment'; B = 'Fearful attachment'; C = 'Preoccupied attachment'; and D = 'Dismissing/distrustful attachment'. Style E is 'Profoundly distrustful attachment'.

General and specific methods that can be used by patients and doctors to optimise clinical interactions are summarised in Table 3. Research in diabetes care has shown that even when patients have an insecure attachment style that makes it hard for them to enter and maintain collaborative clinical relationships, the approach taken by clinicians may significantly improve the quality of the therapeutic alliance and adherence to treatment.[18]

TABLE 3. ATTACHMENT-BASED CARE SUGGESTIONS FOR PATIENTS WITH INSECURE ATTACHMENT STYLES – THE ABC APPROACH

Attachment style	Tasks for patient	Tasks for doctor
General principles for all insecure styles	• Consider who you can work best with, what has worked best in the past, how to voice concerns, how to inform the doctor earlier in the interaction • Learn increased tolerance of anxiety, emotional regulation and uncertainty (use of relaxation, mindfulness, problem solving) • Consider finding out information about attachment styles (e.g. the book *Mindsight* by Dr Dan Siegel – http://www.drdansiegel.com – and YouTube clips)	• Discuss the problem with the patient • Clarify expectations, patient's view • Consider the patient's attachment style; discuss with the patient as part of explaining you are individualising care • Find out about the patient's social support network • Ask about the patient's previous coping strategies, both good and bad • Make a clear plan in collaboration with the patient, encourage their input • Listen to yourself, be clear of your limits • Enlist others in management: talk to colleagues, case conference, consider whether another clinician might be able to work better with this patient • Share information and come to a unified plan with other involved clinicians on management • Monitor the patient's mood and anxiety levels
Preoccupied style	• Make lists of issues between appointments • Learn to deal with acute anxiety flare-ups • Learn to manage separation from clinicians • Consider need for psychotherapy re self-esteem, worry, anxiety symptoms (cognitive behavioural therapy can be helpful)	• Discourage pattern of patient needing to amplify symptoms to justify help-seeking by giving regular, brief appointments regardless of symptom level • Allow set period of time to address the patient's list of worries, but also ensure time is set aside for necessary assessment and treatment • Provide support but avoid constant reassurance
Dismissing/ distrustful style	• Be upfront about whether you are happy with doctor's approach and advice • Ask the doctor to give you information so you can problem-solve • Consider keeping a journal, using internet-based resources to navigate medical care	• Remember that the patient lacks trust in others • Emphasise self-empowerment strategies to work with (rather than against) 'compulsive self-reliance' • Provide information about treatment options but give patient room to come up with their own solutions, with agreement on monitoring of progress
Fearful style	• Learn emotional regulation techniques – regular exercise and mindfulness are very useful • Expect and plan for possible crises	• Be consistent and enable patient to plan for clinician absences • Have strategies for dealing with patient ambivalence and avoidance
Disorganised style	• Be aware of specific techniques to assist with tasks detailed under general principles – e.g. dialectical behaviour therapy • Collaborate with a management plan, when required	• Be very consistent to provide a sense that things are under control • Clarify the patient's expectations and be upfront about what you can and cannot provide; set limits if necessary • Communicate regularly with other clinicians involved to prevent splitting • Construct a management plan for clinical care, with a crisis management plan to deal with the patient decompensating under stress (including acute mental health service back-up)

Patients with secure attachment styles

Patients with secure attachment styles comprise about 60% of patients seen. They tend to have adaptive coping mechanisms and benefit less from specific interventions aimed at improving attachment style than do insecure patients.

Patients with insecure attachment styles

Patients with insecure styles benefit from interventions aimed at improving their particular attachment style. General principles for this are outlined in Table 3, and should be considered when difficult interactions develop between these patients and their doctors.

High attachment dependence/anxiety

Patients with preoccupied styles tend to have 'high attachment dependence/anxiety' and low trust in themselves. They rely on others to make decisions and provide a sense of security. Therefore the goals in clinical interactions with these patients are to:

- encourage patient autonomy
- build patient self-confidence
- encourage patients to increase their tolerance of anxiety and uncertainty.

Scheduling regular appointments for the patient with the doctor, rather than having the patient feel the need to amplify symptoms to receive care, can help in achieving these goals. Providing explanations for anxiety and mechanisms for underlying symptoms (preferably in written or diagrammatic form) and delivering regular, consistent care before anxiety levels build up can also be useful. These patients are more likely than others to develop clinically relevant anxiety and depressive disorders, and therefore mood monitoring is useful.

High attachment avoidance

Patients with dismissing styles tend to have 'high attachment avoidance' and low trust in others. Therefore the goals in clinical interactions with these patients are to:

- provide a predictable caregiving framework (bearing in mind these patients' lack of basic trust)
- provide information and support in a manner that is clear but not emotionally challenging.

These patients may not tolerate a 'counselling' approach but may do well with an internet-based program or an educational session. They may feel the need to 'test' the doctor's reliability and generally do better if their self-reliance is acknowledged and they are given choices that acknowledge their need to be autonomous, such as by being educated on how to manage their medical condition and then coming up with solutions themselves on the basis of that information.

Although these patients may appear less emotional, there is often an underlying sense of anger that becomes apparent when they are stressed, particularly in those with an angry-dismissing style. This is likely to lead to them trying to push away their doctor and other care providers.

Combined high attachment dependence/anxiety and high attachment avoidance

Because people with a fearful attachment style have low trust both in themselves and in others ('high attachment dependence/anxiety' and 'high attachment avoidance', respectively), they often show inconsistent attendance or ambivalence in decision-making – that is, a pattern of approach-avoidance. These patients can become angry and overtly distressed when in crisis and can decompensate into a more disorganised attachment style. The crisis can be a reworking of some earlier incident and the gravity of the perceived stress may not be obvious to care providers.

Conclusion

Attachment processes are important determinants of therapeutic relationships, along with cultural, religious and social factors. Using the attachment-based care (ABC) approach to doctor–patient interactions provides a framework to understand the needs of patients in relationships, their defensive strategies and the reciprocal influences of patients and clinicians upon the relationships that develop. This perspective may provide a 'lens' to view and appreciate nuances in doctor–patient relationships and individualise response rather than getting caught up in unproductive interactions. MT

References

A list of references is included in the website version (www.medicinetoday.com.au) of this article.

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