Improving Patient Care: Applying Attachment Theory to Medical Practice

Cheri L. Marmarosh, Ph.D.
Associate Professor
Professional Psychology
The George Washington University
OUTLINE

- Relevance of examining individual differences and health care
- Review Attachment Theory
- Apply Attachment Theory to medicine
- Propose a research project with goal of identifying potential collaborators
Why apply psychological theory to medical care?

1) To attain benefits of psychotherapy, patients must be engaged in the therapeutic process. Patients engage in psychotherapy when, it appears, that they received a treatment that is consistent with their expectations, have positive expectations for success, and feel understood by the psychotherapist (Wampold, 2015).

2) Alliance research points to the importance of collaborative work between the psychotherapist and the patient (Hatcher & Barends, 2006). Some patients, perhaps due to poor attachment history, will have difficulty forming an alliance, but it is the psychotherapist’s contribution, not the patient’s contribution, to the alliance that makes a difference (Baldwin, Wampold, & Imel, in press).
Therapist contribution

- Empathy & Listening skill
- Openness
- Genuineness
- Engagement
- Presence
Researchers have shown that patients are more likely to adhere to treatment and be satisfied with medical care if they feel their physicians are respectful, interested, supportive, and understanding.

To improve clinical outcomes through better adherence and satisfaction, the physician might have to focus on providing a flexible treatment approach based on patients’ fears, their unique perspective of their illness, and their general underlying needs.

Being attuned to patients, however, can also require that the physician understand their patients’ patterns of interpersonal relationships.
Illness activates the Attachment system

- Being sick, dependent, vulnerable activates familiar coping mechanisms—and the automatic response to dependency---
- withdrawing-deactivating from caregiver (denial)
- overwhelmed and over-engaged with caregiver (emotionally needy, angry)
- able to both receive support and acknowledge needs while staying engaged in treatment process
Love, Fear and Health

How Our Attachments to Others Shape Health and Health Care

ROBERT MAUNDER AND JONATHAN HUNTER
ATTACHMENT THEORY

Overview
The major goal of the attachment system is to keep vulnerable infants in close proximity to promote safety and exploration—SAFETY (Felt Security via emotional attunement) in order to EXPLORE/Be Curious in relationships and environment.

When caregiver does not provide felt security, the FOCUS becomes affect regulation...

EXPLORATION decreases (focused on safety and proximity to caregiver at expense of separation) OR EXPLORATION becomes organizing (relies on distraction from distress via exploration—detaches from feelings and seeking felt security from others).
Strange Situation

- Observe child during separation from caregiver and during reunion with caregiver in infancy (12-18 months of life).
- Observe secure behaviors
- Observe avoidant behaviors
- Observe preoccupied behaviors
- Observe disorganized behaviors
Cradle to the Grave

- Sroufe et al. (2005) tracked 200 infants for 30 years to examine the impact of early attachment on development.
- Found a link between secure infant attachment and ability to regulate emotions and later less psychopathology.
- **Secure do still have difficulties later in life but appear to better able to cope.**
- **The most at-risk individuals were disorganized during infancy.** Correlations between disorganization at infancy and psychiatric problems at the age of 17 and marital hostility in adulthood.
Infant attachment and Physical Health in Adulthood

Puig, Englund, Simpson, and Collins (2013)

The current participants were the first-born children of the original participants in the Sroufe study; all were born into low-SES, high-risk environments.

Attachment classifications were assessed at ages 12 and 18 months using the Ainsworth Strange Situation Procedure.

At age 32, 163 participants completed a questionnaire asking about the presence of or treatment for current physical illnesses.

Even after statistically controlling for gender, SES, current BMI, life stress, negative emotional style, and perceived social support, individuals who had been insecurely attached early in life were significantly more likely to experience illnesses in general and specifically inflammation-related illnesses than those who were securely attached during infancy.
Adult Attachment Styles & Dimensions
Styles from the infant attachment and adult attachment literature

- Secure
- Resistant/Preoccupied
- Avoidant/Dismissing
- Disorganized
<table>
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<tr>
<th>Secure:</th>
<th>Anxious:</th>
<th>Avoidant:</th>
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<tr>
<td>I find it relatively easy to get close to others and am comfortable depending on them and having them depend on me. I don’t often worry about being abandoned or about someone getting too close to me.</td>
<td>I find that others are reluctant to get as close as I would like. I often worry that my partner doesn’t really love me or won’t stay with me. I want to merge completely with another person, and this desire sometimes scares people away.</td>
<td>I am somewhat uncomfortable being close to others; I find it difficult to trust them completely, difficult to allow myself to depend on them. I am nervous when anyone gets too close, and often, love partners want me to be more intimate than I feel comfortable being.</td>
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Adult Attachment Dimensions

- **Two Adult Attachment Dimensions** *(Brennan, Clark, & Shaver, 1998)*
  - **Anxious** - characterized by more fearfulness in relationships, concerns with being abandoned, fears of rejection, desires to feel more cared for but preoccupations with disappointment (Blatt’s Anaclitic)
  - **Avoidant** - characterized by more withdrawal from vulnerability, dismissal of dependency, disengaged from emotions, focused on things outside of relationship (Blatt’s Introjective)
Interacting Dimensions

- Anxious and Avoidant Dimensions interact
Secure

- **Low** on anxiety and **Low** avoidance - **SECURE**
- Can be secure and still have a **valence** for anxiety and/or avoidance
Secure Individual
(Mikulincer & Shaver, 2007)

- Disclose well
- Forgive more easily
- Express negative feelings
- Better caregiving to others
- More empathic
- Tolerate conflict
- Can rely on others when need to
Attachment Self Report Measure—revised short version

1. It helps to turn to my doctor in times of need.  More secure
2. I usually discuss my problems and concerns with my doctor. More Secure
3. I talk things over with my doctor honestly. More Secure
4. I find it easy to depend on my doctor. More Secure
Preoccupied

- **High** on anxiety and **Low** on avoidance—Preoccupied

- Reduce anxiety by minimizing emotional distance and soliciting support often unsatisfied with response, present with significant amount of symptoms—most health costs (Ciechanowski et al., 2002)
Preoccupied Individual

- Flooded with emotions
- More self critical
- Seek out praise and caregiving from others
- Less empathic
- Difficultly forgiving
- More jealous and preoccupied with other
- Sensitive to abandonment and rejection
Measure

7. I often worry that my doctor doesn't really care for me. **HIGH ANXIETY**

8. I'm afraid that my doctor may abandon me. **HIGH ANXIETY**

9. I worry that my doctor won't care about me when I need him or her. **HIGH ANXIETY**
Carol: Preoccupied Patient

- Carol and her family have been in your practice for several years. She schedules visits for an assortment of her own medical concerns and varied symptoms despite being generally healthy.
- Carol imparts a sense of urgency as she dramatically describes her own or her children’s health concerns, even when these concerns are nonthreatening. Because she has little confidence in her own caregiving ability, she immediately seeks your assistance for minor symptoms and matters related to her children’s health.

This behavior makes you see her as anxious and needy.

She often comes to the office bearing gifts, and she frequently asks about your health and your long-term professional plans, which makes it hard for you to put limits to her frequent health care appointments. (Thompson & Ciechanowski, 2002,p. 221).

She has a difficult time asserting her needs and is more likely to be passive aggressive when she is disappointed or angry (not paying the bill, missing appointments).
Dismissing

- **Low** on anxiety and **High** on avoidance - **DISMISSING**
- Appear self-reliant, tend to avoid feelings, minimize dependency, deny anxiety, score similar to secure on symptoms - report more pain symptoms
Dismissing Individual

- Values independence and achievement
- Devalues dependency and vulnerability
- Tend to prefer thinking to feeling
- Uncomfortable with group cohesion
- Poor memories of childhood
- Avoid seeking help
Measure

5. I don't feel comfortable opening up to my doctor. **HIGH AVOIDANCE**
6. I prefer not to tell my doctor how I feel deep down. **HIGH AVOIDANCE**
Kim: The Dismissing Patient

- Kim, a 30-year-old married obese woman with type 2 diabetes mellitus, has been your patient for nearly 1 year.
- Although she appears outwardly friendly and pleasant, she is rather aloof, and you feel that you do not really know her. Clinical communication with her has a superficial quality, and the medical treatment and therapeutic alliance seem insignificant to her and tenuous to you.
- She often reschedules visits hours to minutes before her appointment time and occasionally forgetting them altogether.
- To inquiries about her diabetes, she responds, “everything is great . . . no problems.” She appears indifferent when asked about her serious symptoms and health behaviors.
- Although she maintains that taking scheduled medications is “not a big deal”, she acknowledges that she has not been taking them regularly, nor has she been monitoring her glucose more than once or twice weekly.
- She insists she will make the necessary lifestyle changes on her own, but you cannot help but feel doubtful and frustrated. (Thompson & Cienanchowsk, 2002, p. 221)
Fearful

- **High** on anxiety and **High** on avoidance - FEARFUL
- Alternate between anxiety and avoidance, similar to disorganized attachment, linked to trauma-utilize preventive healthcare least (Ciechanowski et al., 2002)
Fearful Individual

- Engage in both avoidance and hyperactivation
- Concerned with safety
- May dissociate to cope with pain/distress
- Fearful of abandonment and rejection
- Pull away from others
- Often history of trauma
- Can engage in self-destructive behaviors - cutting, suicidal ideation, drinking/drugs, sexual acting out
Bill: The Fearful Patient

- You see Bill, who is a colleague’s patient, while covering weekend call for your clinic.
- He is 45 years old, divorced, and because of multiple medical problems, retired. Your colleague telephones you stating, “I am totally burned out. He constantly demands and demands, but he never takes my help,” adding that the clinic staff is also feeling overwhelmed by his frequent telephone calls and angry demands.
- When you first encounter Bill, your initial impression is of an intelligent, friendly man who you believe would be a pleasure to treat. He relates a lengthy list of unresolved medical concerns in an urgent and angry fashion, however. **As you inform him that you have time in this visit to discuss the two most important problems, he interrupts and says loudly, “I knew that you wouldn’t be able to help me. . . . You’re useless!”** before slamming the door on his way out.
- **Mistrustful of caregivers and avoid preventive care.** More inclined to use alcohol and drugs to cope. More likely to have comorbid mental health issues (depression, personality disorders).
Attachment & Patient
Empirical Findings
Attachment relates to:

(a) quality of intimate relationships (Mikulincer & Shaver, 2007; Feeney & Noller, 1996);
(b) depression (Mikuliner & Shaver, 2007 for a review; Bifulco, Moran, Ball, & Bernazzani, 2002)
(c) postnatal depression (Meredith & Noller, 2003);
(d) self-esteem (Feeney & Noller, 1990);
(e) anger and hostility (Troisi & D'Argenio, 2004);
(f) coping skills (Feeney & Kirkpatrick, 1996; Schmidt, et al., 2002);
(g) communication and marital satisfaction (Feeney, Noller, & Callan, 1994);
(h) career choice and satisfaction (Roney, Meredith, & Strong, 2004);
(i) history of suicidal ideation (Armsden, et al., 1990)
(j) psychosis (Berry, Barrowclough, & Wearden, 2007),
(k) borderline personality disorder (Fonagy, 2005; Agrawal, et al., 2004), and
(l) health behaviors (Ciechanowski, Katon, Russo, & Dwight-Johnson, 2002; Feeney, 1995; Feeney & Ryan, 1994; Hunter & Maunder, 2001; Maunder & Hunter, 2001; Maunder, Lancee, Nolan, Hunter, & Tannenbaum, 2006; Schmidt, Nachtigall et al., 2002; Taylor, Mann, White, & Goldberg, 2000).
Attachment and Health Behaviors

- (a) symptom reporting and accessing health care (Ciechanowski, Walker, Katon, & Russo, 2002; Feeney & Ryan, 1994);
- (b) unexplained physical symptoms (Taylor et al., 2000);
- (c) quality of the patient–provider relationship and treatment adherence (Ciechanowski, Katon, & Hirsch, 1999; Ciechanowski, Katon, Russo, & Walker, 2001);
- (d) satisfaction with weight and nutrition, level of exercise, and ability to implement lifestyle change (Feeney, 1995);
- (e) etiology of ulcerative colitis (Maunder, et al., 2000);
- (f) likelihood of developing breast cancer in women (Tacon, 2003)
- (g) pain perception (Meredith, Ownsworth, & Strong, 2008)
Model of Health Outcome

- Patient Attachment Style
- Depression
- Health Behavior
- Trust in Medical Provider
- Health Outcome
Including the Provider

- Patient Attachment Style
- Depression
- Trust in Medical Provider
- Health Behavior
- Health Outcome
- Provider Attachment
Doctor Patient Interactions
Physician Attachment

- Medical trainees’ higher avoidance was negatively related to their emotional intelligence, which also affected doctor-patient communication (Cherry, Fletcher, & O’Sullivan, 2013).
- Results from multilevel analyses showed that doctors’ avoidant and anxious attachment orientations were independently associated with lower satisfaction for patients higher on serious illness (Konstantinos et al., in press).
- Doctors’ insecure attachment can have adverse effects for doctor-patient interaction (Konstantinos et al., in press).
Proposal

1. study patient attachment and how it relates to the attachment to the physician (unique attachment to the medical professional).

2. study patient attachment to the physician and how it relates to perceptions of empathy and satisfaction with treatment, trust in the doctor, perceptions of pain and symptoms, ER visits, medication adherence, and follow-up care.

2. study doctor/provider attachment and how it relates to perceptions of patient difficulty, accuracy of rating patient attachment and patient satisfaction with visit.

2. Interaction between both doctor and patient attachment.
Possible Measures

Assessing Attachment
- The Experience in Close Relationship Measure (ECR-S: Bennan, Clark, & Shaver, 1998) used to assess the attachment styles of both the physicians and the patients and edited to assess Attachment to the Physician.

Assessing Physician Communication
- The Patient Reactions Assessment (PRA; Galassi, Schanberg, & Ware, 1992) will assess the quality of communication with the provider. This instrument and its subscales have demonstrated high internal consistency and concurrent validity in its ability to differentiate known groups of providers with respect to quality of patient-provider relationships.

Assessing Patient Satisfaction with Treatment
- Patients will complete the MOS nine-item satisfaction survey (Rubin et al., 1993), which assesses overall satisfaction and eight domains of visit-specific satisfaction.

Assessing Clinician Perceived Patient Difficulty
- The Difficult Doctor-Patient Relationship Questionnaire (DDPRQ) (Hahn, Kroenke, Spitzer, Brody, Williams & Linzer, 1996) will be used to assess clinician-perceived difficulty of the encounter. The DDPRQ has been previously shown to be a reliable instrument with an internal consistency of 0.88±0.96, with a score >30 indicating a `difficult' encounter (Hahn, Thompson, Stern, Budner & Wills, 1994).

Assessing Patient Symptoms
- Immediately before seeing the physician, all patients completed a questionnaire on symptom severity (0±10 scale) and duration (days); previous visits for the symptom (yes/no); worry about serious illness (yes/no); stress in the previous week (yes/no). Patients will complete the SF-6, a six-item scale that measures functional status in six domains: general health, role function, physical function, social function, emotional health, and physical pain (Ware, Nelson, Sherbourne & Stewart, 1992).