

Expanding the patient-centered clinical method: doctor-patient relationship and attachment theory

Ampliando o Método Clínico Centrado na Pessoa: a Relação Médico-Paciente e a Teoria do Apego
Ampliación del Método Clínico Centrado en la Persona: la Relación Médico-Paciente y la Teoría del Apego

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Abstract

Introduction: The Attachment Theory can be useful to complement the Patient-Centered Clinical Method, especially in its fourth component, “enhancing the patient-doctor relationship.” **Objective:** To perform an integrative review of studies that associate the Attachment Theory with the doctor-patient relationship and extract its applicability in the routine of family physicians. **Methods:** Integrative review in the United States National Library of Medicine (PubMed) and Scientific Electronic Library Online (SciELO) databases using the terms “doctor-patient relationship” and “attachment theory.” **Results:** In February 2021, we retrieved 184 articles in PubMed and one in SciELO, reducing them to 11 articles. Their settings involved oncology/palliative care or general primary care, considering the vulnerabilities of each context and how they can activate the attachment system. The impact of Attachment Theory principles on several aspects of the doctor-patient relationship and even on clinical outcomes was evident. Correlating attachment styles with Emanuel and Emanuel’s (1992) doctor-patient relationship models can help us understand which model is best for each style. People with “secure” attachment benefit from deliberative relationships; those with “anxious-preoccupied” attachment need the physician to be more active to compensate for their low self-confidence, as in the paternalistic model; in the “dismissing” attachment, the patient needs to feel independent, and the informative model contributes to strengthening the relationship; and individuals who have “anxious-fearful” attachment tend to share negative feelings with the physician, who needs to understand this and reaffirm the bond despite the person’s counterproductive attitudes, and the interpretive model has a way of dealing with the situation. **Conclusion:** The Attachment Theory can potentially address many anxieties that plague the daily practice of the family physician and that the Patient-Centered Clinical Method cannot solve alone. We can infer that the Attachment Theory complements the method, providing tools to continue applying it with its four components.

Keywords: Physician-patient relation; Patient-centered care; Primary health care.

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Resumo

Introdução: A Teoria do Apego pode ser útil para complementar o Método Clínico Centrado na Pessoa, sobretudo em seu quarto componente, “Fortalecendo a relação médico-paciente”. **Objetivo:** Realizar revisão integrativa de pesquisas que associem a Teoria do Apego à relação médico-paciente e extrair sua aplicabilidade no dia a dia do médico de família e comunidade. **Métodos:** Revisão integrativa nas bases de dados *United States National Library of Medicine* (PubMed) e *Scientific Electronic Library Online* (SciELO) utilizando os termos “relação médico-paciente” e “teoria do apego”. **Resultados:** Identificamos 184 artigos na PubMed e um na SciELO em fevereiro de 2021, que foram reduzidos a 11 artigos. Estes tinham como cenário oncologia/cuidados paliativos ou atenção primária em geral e consideravam as vulnerabilidades de cada contexto e como elas podem ativar o sistema de apego. Percebe-se o impacto dos princípios da Teoria do Apego em diversos aspectos da relação médico-paciente e até em desfechos clínicos. Correlacionar os estilos de apego com os modelos de relação médico-paciente de Emanuel e Emanuel (1992) ajuda-nos a entender que modelo é melhor para cada estilo. Pessoas com apego “seguro” beneficiam-se de relações deliberativas; aquelas com apego “ansioso-preocupado” precisam que o médico seja mais ativo para compensar sua baixa confiança em si, como no modelo paternalista; no apego “desprendido”, o paciente necessita sentir-se independente, e o modelo informativo contribui para fortalecer a relação; e quem apresenta apego “ansioso-assustado” tende a trazer sentimentos negativos ao médico, sendo necessário compreender isso e reafirmar o elo apesar de atitudes contraproducentes por parte da pessoa, e o modelo interpretativo traz uma forma de lidar com a situação. **Conclusão:** A Teoria do Apego tem potencial de responder a muitas angústias que assolam a prática diária do médico de família e comunidade e que o Método Clínico Centrado na Pessoa não consegue resolver sozinho. Pode-se dizer que a Teoria do Apego complementa o Método, fornecendo ferramentas para continuar conduzindo-o em seus quatro componentes.

Palavras-chave: Relação médico-paciente; Cuidado centrado no paciente; Atenção primária.

Resumen

Introducción: La Teoría del Apego puede ser útil para complementar el Método Clínico Centrado en la Persona, especialmente en su cuarto componente, “Fortalecimiento de la relación médico-paciente”. **Objetivo:** Realizar una revisión integradora de la investigación que asocie la Teoría del Apego con la Relación Médico-Paciente y extraer su aplicabilidad en el día a día del Médico de Familia y Comunitario. **Métodos:** Revisión integrativa en las bases de datos PUBMED y Scielo utilizando los términos “relación médico-paciente” y “teoría del apego”. **Resultados:** Identificamos 184 artículos en PUBMED, 164 y 1 en Scielo en febrero de 2021, reduciéndose a 11 artículos. Los artículos tuvieron un escenario de Oncología/Cuidados Paliativos o Atención Primaria en general, considerando las vulnerabilidades de cada contexto y cómo pueden activar el Sistema de Apego. Se percibe el impacto de los principios de la Teoría del Apego en varios aspectos de la Relación Médico-Paciente e incluso en los resultados clínicos. La correlación de los estilos de apego con los modelos de relación médico-paciente de Emanuel y Emanuel (1992) nos ayuda a comprender cuál es el mejor modelo para cada estilo. Las personas con apego seguro se benefician de las relaciones deliberativas; aquellos con apego ansioso-preocupado necesitan que el médico sea más activo para compensar su baja confianza en sí mismos, como en el modelo paternalista; en el apego desapegado, el paciente necesita sentirse independiente, y el modelo informativo contribuye a fortalecer la relación; y quien tiene Apego Ansioso-Miedo tiende a traer sentimientos negativos al médico, es necesario entender esto y reafirmar el vínculo a pesar de actitudes contraproducentes por parte de la persona, y el modelo Interpretativo aporta una forma de afrontar la situación. **Conclusiones:** La Teoría del Apego tiene el potencial de responder a muchas ansiedades que plagan la práctica diaria del Médico de Familia y Comunitario, y que el Método Clínico Centrado en la Persona no puede resolver por sí solo. Se puede decir que la Teoría del Apego complementa el Método, brindando herramientas para continuar conduciendo el Método en sus cuartos componentes.

Palabras clave: Relaciones médico-paciente; Atención dirigida al paciente; Atención primaria de salud.

INTRODUCTION

The Patient-Centered Clinical Method (PCCM) emerged in a context aimed at expanding the notion of patient autonomy and changing the perspective of the physician’s role. By taking the focus from the doctor and the disease, we try to be closer to the person so as to provide the best possible care and thus obtain better therapeutic results. Previously described as six components, the last edition of the book by Stewart et al.¹ reduces them to four components, didactically separated. The last of them, “enhancing the patient-doctor relationship,” can be considered both a step in the process and one of its results. At this point, we need, above all, to understand the forces that influence the doctor-patient relationship (DPR) and that, thus, can act to strengthen or weaken the bond created between the two people.

In Family Medicine (FM), PCCM is an essential tool. This method cannot be used in all situations because, depending on the type of visit, the doctor should not spend much time exploring too many

details to achieve the result needed at that time. Each scenario has a more appropriate method. Still, the opportune use of PCCM is not always successful in practice.

In theoretical terms, we have transference and countertransference notions and the motivational interview to justify in part such situations. Yet, this is often not enough. From this perspective, the Attachment Theory has been established as a theoretical framework that can help FM fill the gap in understanding relational variables.

The Attachment Theory was developed mainly by the Englishman John Bowlby, a child psychiatrist and psychoanalyst, together with the American-Canadian psychologist Mary Ainsworth, in an initially separate process that converged to their meeting, as well as several collaborators.² We stress that the theoretical notion of attachment is somewhat distinct from the colloquial use of the word. In that case, attachment refers to “the enduring tie that one person has with another who fulfills needs for safety and comfort.”³

The theory is based on the idea that the first relationships that the human being establishes (with their mother or main caregiver) have a strong impact on the patterns of later relationships. The mother-baby relationship has a protective nature, with the fragile bond needing the presence of the “attachment figure” to feel safe. By feeling secure, the child can explore the environment knowing they have someone to rely on in case of danger. To ensure this safety, the baby uses what they have available to draw their caregiver’s attention (by crying, for example) and bring them closer. This pattern of behavior was later described in other mammals and birds, congruently with the hypothesis that the attachment system is part of an evolutionary component. Bowlby defined the ways in which humans learned to react systematically to these situations as “internal working models”.⁴

Ainsworth combined her direct observations of families with Bowlby’s ideas and the patterns of security theory, which she knew through William Blatz,² demonstrating them in the famous experiment “strange situation.” Based on this experiment, she understood that children showed a secure attachment pattern when they felt able to explore the environment in their mother’s presence but stopped the action in her absence and tried to call her back, finally resuming playing when their mother returned. Children who showed other patterns were classified as having an insecure attachment, which could be ambivalent or avoidant. Later, a fourth type was described: disorganized.⁵

As other authors expanded on Bowlby’s and Ainsworth’s propositions, the Attachment Theory was extended to adulthood. Hazan and Shaver⁶ used it as a basis to suggest that romantic relationships are an attachment process and that this situation could be considered the individual’s pattern, inherited from their childhood experiences in continuity. Thus, other adults would serve as “attachment figures” throughout life. Bartholomew and Horowitz⁷ proposed dimensions to work with adults based on Bowlby’s internal working models. Such dimensions are anxiety and avoidance, related to internal models, that is, the perspective that the person had of themselves and others, respectively. By combining these dimensions, four quadrants were formed, determining four attachment types.

The dimensions described are inversely related to their respective models. A positive model of self means low anxiety, while a negative model of other represents high avoidance. Therefore, a person who felt worthy of others’ care (low anxiety) and trusted that others could provide such care (low avoidance) had a secure attachment. The other quadrant combinations (Table 1) comprise insecure attachment styles: dismissing, preoccupied, and fearful.

Table 1. Models of adult attachment.

		Models of self (Anxiety)	
		Positive	Negative
Model of other (Avoidance)	Positive	Secure Comfortable with intimacy and autonomy	Preoccupied Preoccupied with relationships
	Negative	Dismissing Dismissing of intimacy Counter-dependent	Fearful Fearful of intimacy Socially avoidant

Source: Adapted from Bartholomew and Horowitz⁷.

Although the original theory valued the idea of stable internal working models throughout life, describing people in a “continuum of security” is currently more practical than rigidly grouping them into categories.⁸ Categories are important to understand the phenomenon as a whole, but individual differences exist according to the relevance of each dimension.⁷

In short, the Attachment Theory emerged to try to explain the ways people can connect with others according to previous experiences, and its validity in adulthood is widely accepted. Understanding such ways can be extremely useful in explaining how individuals can engage with each other in various situations, even in DPR, which can facilitate and/or expand the use of PCCM in FM practice.

METHODS

We performed this integrative review because the relationship investigated (DPR and Attachment Theory) has a great theoretical and subjective component. Also, as it analyzes a greater diversity of sources and methods, this type of review provides a broad view of complex subjects like this one.⁹

Such reviews are carried out in six stages, as Souza, Silva, and Carvalho demonstrated.⁹ The first consists of elaborating a guiding question, which, as the name indicates, will define the scope of the literature search. The guiding question adopted was: what is the influence of Attachment Theory principles on DPR from the patient’s perspective?

The second stage is acquiring the sample in the literature. We searched the following databases: United States National Library of Medicine (PubMed) and Scientific Electronic Library Online (SciELO). The keywords used were “*teoria do apego*” and “*relação médico-paciente*” in Portuguese and their variations in English (“attachment theory” and “physician-patient relationship” or “doctor-patient relationship” or “patient-provider relationship”) and Spanish (“*teoría de apego*” and “*relación médico-paciente*”). The search results in February 2021 were 184 articles in PubMed and one in SciELO.

In addition to congruence with the guiding question, the inclusion criteria were: articles in Portuguese, English, or Spanish and mentions of aspects related to or derived from DPR, such as therapeutic alliance, adherence, or other terms that imply a relational process. The exclusion criteria were: publications exclusively focused on psychology and psychotherapy since they could address the same issue in the light of another context, namely, the patient-therapist relationship; and mentions of the Attachment Theory from the doctor’s perspective instead of that of the patient.

The articles were classified according to the evidence hierarchy suggested by Stetler et al.,¹⁰ which allows categorizing descriptive and qualitative studies, as well as experience reports:

- level 1: evidence resulting from the meta-analysis of multiple controlled and randomized clinical studies;
- level 2: evidence obtained from individual experimental studies;
- level 3: evidence from quasi-experimental studies;
- level 4: evidence from descriptive (non-experimental) or qualitative studies;
- level 5: evidence from case or experience reports;
- level 6: evidence based on expert opinions.

In the third stage of integrative review, data were collected from the articles, aided by the instrument indicated in the appendix of the article by Souza, Silva, and Carvalho,⁹ validated by Ursi.¹¹ With such data, we could perform the critical and systematic analysis of the studies — the fourth stage of integrative review.

The fifth and sixth stages are, respectively, discussion of results and presentation of the integrative review, whose content is examined in the remainder of the article.

RESULTS

We selected 13 articles from the PubMed database and one from SciELO, totaling 14 articles. Among them, one was excluded when reading the abstract due to its psychoanalytical, rather than DPR, perspective. Two articles were removed after full reading. Table 2 summarizes the data from the studies selected for the review.

Part of the works had an empirical nature, often with a cross-sectional or cohort design, while the other part comprised reviews with low accumulated evidence power. This finding agrees with the notion that these themes are quite theoretical, and their juxtaposition is expected to follow the same pattern.

DISCUSSION

The correlations between DPR and the Attachment Theory are fragmented, similar to the isolated study of DPR. The characteristics of a robust DPR are: trust, empathy, communication, listening, and sharing information.¹² Therefore, we can assume that the attachment style can impact the DPR by directly interfering in aspects such as formation of the therapeutic alliance^{13,14} and trust in the doctor.¹⁵

Almost half of the articles found on the subject were related to oncology and/or palliative care, which can be explained by the person's increased vulnerability. Such scenarios are conducive to activating the attachment system, enhanced by the progressive dependence on others and the decreased self-sufficiency.¹⁶ The patient needs an attachment figure in order to feel safe even in less drastic situations, such as acute diseases, in which they are still in a position of vulnerability.¹⁷ In patients with secure attachment, this transition is smoother, as they feel worthy of care and that they can rely on others (caregivers, health staff) to provide it.¹⁶ However, when a person shows an insecure attachment style, such components are not that well balanced, making it difficult to connect with¹⁸ and sometimes even to feel empathy for the individual, depending on their reaction to circumstances. These people are precisely the ones who need health professionals to understand their relational style more deeply so as to provide care in a way that does not further harm the bond.

Table 2. Data from the studies selected.

Authors	Study type	Scenario	Level of evidence	Conclusion
Kelly et al. ²⁷	Systematic review	Oncology	4	The attachment style provides a framework for doctors to understand the patient's behaviors and needs, thus allowing adjustments in the approach to the therapeutic relationship in development with the patient.
Brenk-Franz et al. ²⁵	Analytical Cross-sectional	Primary care	4	The results support the hypothesis that the doctor-patient relationship mediates the association between attachment in adults and self-care in patients with multimorbidities.
Zaporowska-Stachowiak et al. ¹⁸	Analytical cross-sectional	Palliative care	4	Insecure attachment is related to worse doctor-patient relationship scores compared to secure attachment. A deeper understanding of the attachment role in the doctor-patient relationship in primary care can lead to better patient care and improve the clinical experience of the general practitioner.
Frederiksen et al. ¹⁷	Qualitative	Primary care	4	The Attachment Theory explains why having a regular doctor is valuable and is an argument for general practice having a special quality compared to the remainder of the health system.
Holwerda et al. ¹⁵	Cohort	Oncology	4	The Attachment Theory is useful for studying cancer patients' perspectives on their doctors, as well as helping the physician understand and deal with different patient behaviors. A deeper understanding of the attachment role in the doctor-patient relationship can lead to better patient care and improve the clinical experience of the family physician. By recognizing that the patients' disease behavior and the doctors' responses to them may be manifestations of attachment patterns, the doctor can be more empathetic with patients who may be otherwise seen as hateful, demanding, or difficult.
Thompson and Ciechanowski ¹⁴	Literature review	Primary care	4	The attachment theory has many implications for clinical care, as patterns of abnormal disease behavior may be susceptible to tailored interventions for particular attachment styles.
Jimenez ¹⁹	Narrative review	Primary care	4	An approach to patients grounded in the Attachment Theory provides insight into understanding their needs in relationships, their defense strategies, and the reciprocal influence of patients and caregivers on the relationship in development. Attachment processes can be critically important determinants of therapeutic relationships in the palliative care context, combined with cultural, religious, and social factors.
Tan et al. ¹⁶	Review/ Experience report	Palliative care	5	Identifying the attachment orientation of terminal cancer patients can be useful in clinical and research contexts.
Calvo et al. ¹³	Cohort	Oncology	4	The Attachment Theory helps explain why different patients need different approaches.
Maunder and Hunter ²⁴	Analytical cross-sectional	General	4	Patients assign basic attachment and safe harbor roles to health professionals.
Ciechanowski et al. ²⁰	Cohort	Primary care	4	Patients with dismissing attachment who perceive their communication with the health professional as poor have worse HbA1c levels than those with other attachment styles, regardless of the quality of communication between patient and professional.

Source: Authors.

Activating the attachment system is similarly relevant in chronic disease contexts, which also require strong bonds,¹⁹ considering the long-standing relationship with variable vulnerability. We can assume that one of the main determinants of this need is the perception of disease, which is a personal experience,¹ possibly directly associated with the anxiety dimension of the Attachment Theory.

Ciechanowski et al.²⁰ found higher levels of glycated hemoglobin in patients with dismissing attachment (i.e., with high avoidance or low trust in the professional) compared to other styles. Later, Ciechanowski et al.²¹ identified a 33% increased mortality in diabetic patients with an independent relationship style (dismissing and fearful), while Sullivan et al.²² noted that people with acute coronary syndrome tended to wait longer to seek medical care when they had less trust in others, which can be translated as high avoidance.

Still on clinical outcomes, the therapeutic alliance is an essential factor to take into account.²³ The attachment styles of terminal cancer patients with a negative view of others (fearful and dismissing) negatively interfere in the alliance with the doctor.¹³ Paradoxically, the physician's perception of the therapeutic alliance is not influenced by the patient's attachment style. The article by Calvo et al.¹³ explains this finding as the greater distance professionals usually develop in these situations due to the high emotional stress. Nonetheless, we underline that, despite not being the focus of this review, the care provider's own attachment style — in this case, the physician — also continuously influences the relationship,^{14,16}.

By examining the trust that patients recently diagnosed with cancer had in their doctors, Holwerda et al.¹⁵ found that this aspect influenced the satisfaction with the physician, as patients with insecure attachment (low trust in others and/or in themselves), regardless of the type, trusted less and were less satisfied with their care providers. In addition, these patients reported higher levels of suffering, which showed no direct relationship with trust, contrary to what one might think.

Health professionals serve as a safe haven for many patients, no matter the attachment style.²⁴ This situation becomes even clearer when we consider that patients with insecure attachment tend to be characterized as difficult people, not only in the health context but also in relationships in general. Thus, these people have a weaker network of social and family resources, often leaning on the health team to provide this social support while dealing with clinical issues.¹⁹

We also found an inverse relationship, with DPR influencing patient attachment, which agrees with the assumption that people have more than one attachment style and that the actions of attachment figures impact these styles. When studying patients with multimorbidities, Brenk-Franz et al.²⁵ demonstrated that the anxiety dimension in adult attachment is mediated by the information received from the doctor and the communication with the patient, while the avoidance dimension is only influenced by communication. The result is consistent with the findings of Ciechanowski et al.²⁰ in diabetic patients and with others in the literature that emphasize the importance of communication for the establishment of a good DPR and influence on clinical outcomes.²⁶

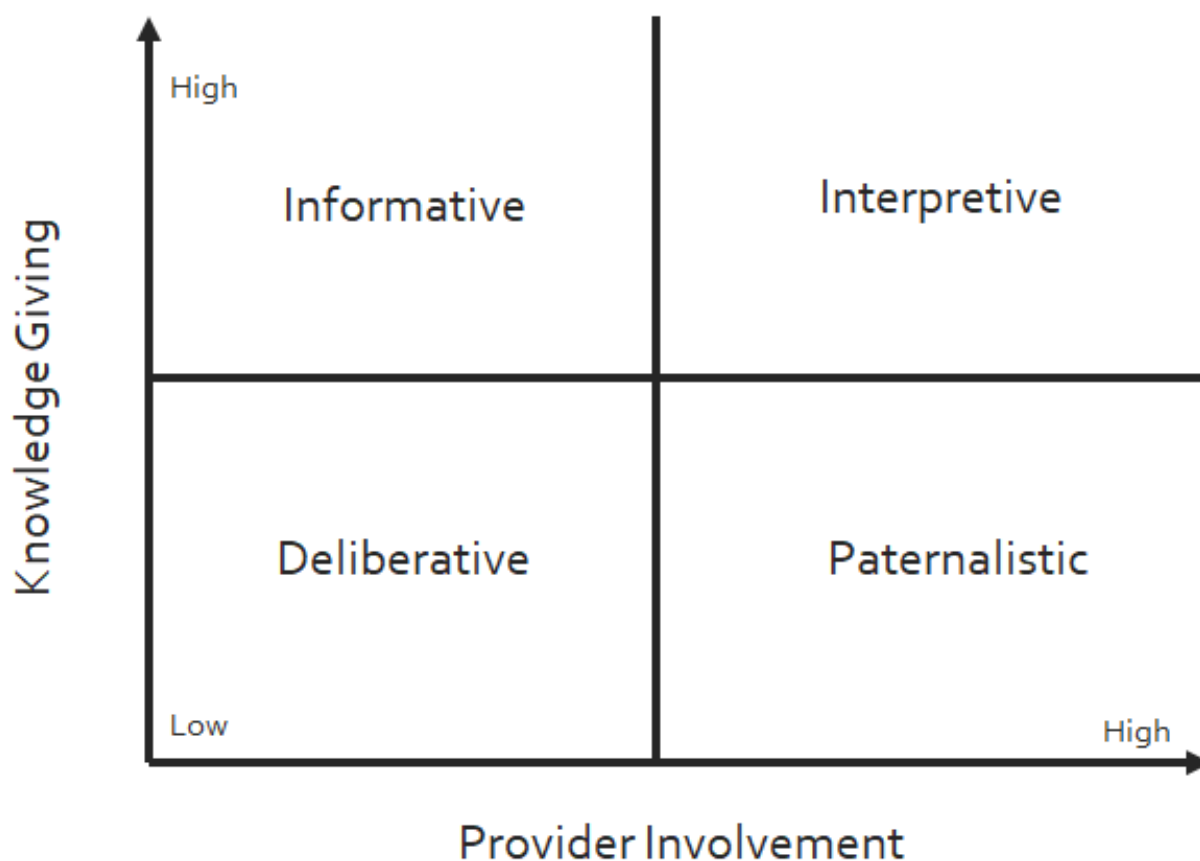
Some aspects do not depend on the parallel between DPR and Attachment Theory. For instance, wanting contact with the health professional does not directly correlate with their availability.²³ We can infer that this perception is more an expression of insecure attachment, in the case of an exacerbated anxiety dimension, than a reaction to the current deprivation of contact. This situation explains why patients who consistently experience difficulties in relationships with their professionals continue to seek them.

Practical repercussions

Among the articles, some go beyond the simple description of the correlation between Attachment Theory and DPR aspects, attempting to indicate ways to work based on it.

In their review, Kelly et al.²⁷ highlighted the types of DPR according to Emanuel and Emanuel,²⁸ correlating them with the Attachment Theory dimensions in adults. These authors described four types of DPR: paternalistic, informative, interpretive, and deliberative. In the first type — paternalistic —, the patient lives up to their name, passively receiving the doctor's directions and decisions. The provider decides what to share with the person and which approach to adopt, according to their perspective of the case and what they consider best for that individual, not worrying about the patient's wishes and values.²⁸ In the informative model, the doctor's role is only to impart technical information that the patient needs to make a decision on their own, based on their wishes and values. The third type — interpretive — is very similar to the informative one, as the physician provides all the information the patient needs to decide on the approach. However, they differ because the interpretive type is also concerned with helping patients understand their own values. This model allows the notion that the person is not always aware of their values and that they can change; so, the individual needs a guide to understand these values. Based on this, the doctor helps indicate which action is most consistent with the patient's wishes and values.²⁸ The last model is the deliberative one, in which, in addition to informing the person and helping them understand their priorities, there is an exchange, allowing the other individual in this dialogue — the doctor — also to discuss what they think is important, with the ultimate goal being the health of the person in front of them.

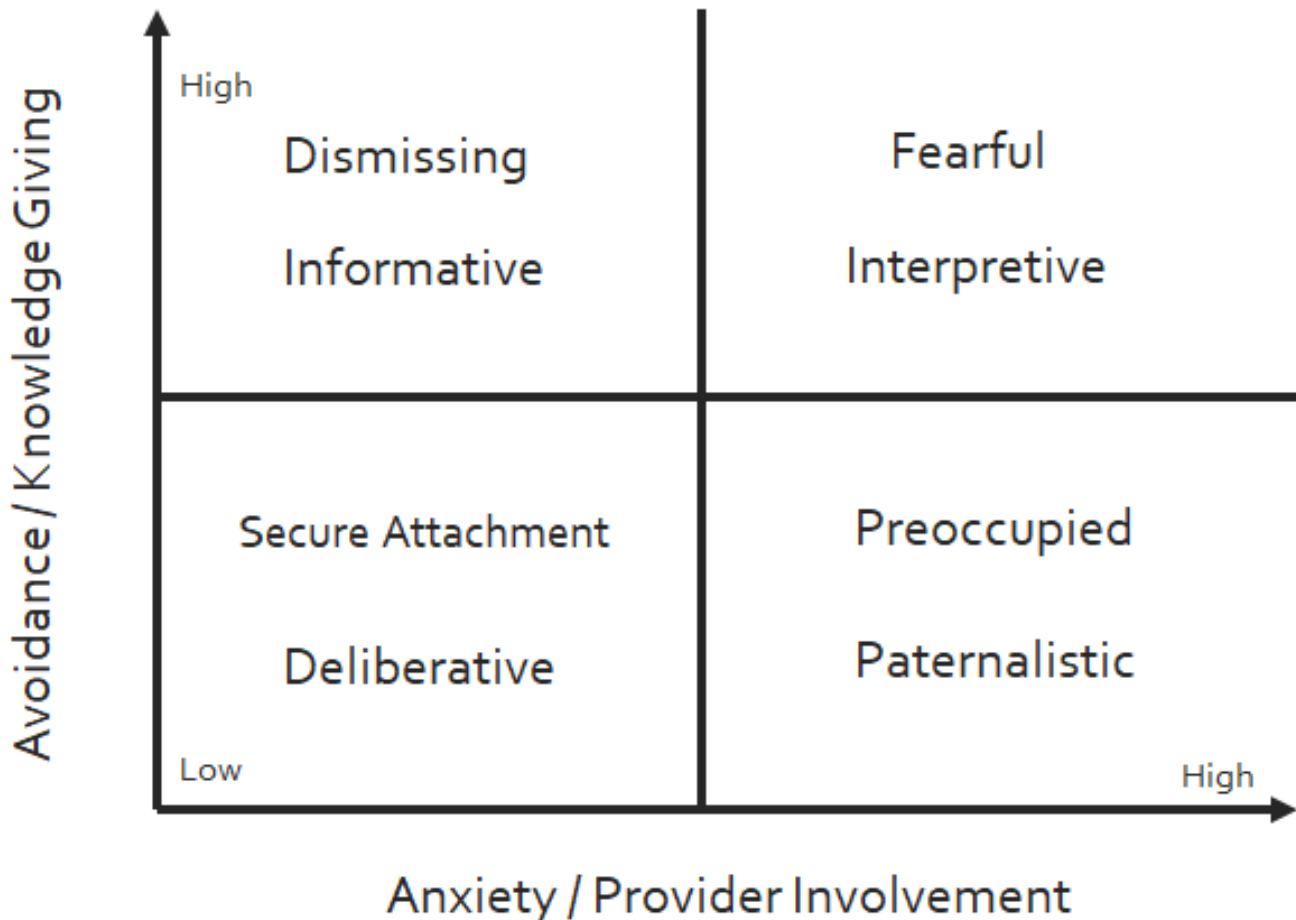
The work of Kelly et al.²⁷ defined these DPR models according to the dimensions information giving (IG) and provider involvement (PI), as follows: high IG and PI — interpretive type; high IG and low PI — informative type; low IG and PI — deliberative type; low IG and high PI — paternalistic type, as shown in Figure 1.



Source: Adapted from Kelly et al.²⁷

Figure 1. Types of doctor-patient relationship

This division could be superimposed on the graph formed between the avoidance and anxiety dimensions, with avoidance directly equating to information giving (need to control the situation) and anxiety relating to provider involvement (need for reassurance that they will receive care), determining the type of relationship that should be pursued for each type of attachment (Figure 2).



Source: Adapted from Kelly et al.²⁷

Figure 2. Aligned model of patient attachment style and type of doctor-patient relationship.

In this regard, Kelly et al.²⁷ try to design how knowledge and recognition of the Attachment Theory in adults can contribute to elaborating patient-centered care. Although focused on the oncology context, their review can be considered valid for all medical fields, especially FM. Furthermore, the suggested model agrees with recommendations from other articles in this review.^{15,20,25}

Most people show secure attachment and thus are able to share their values and talk with the doctor to reach a decision together, as in the deliberative DPR. This type of visit is “ideal” for applying the PCCM as it was conceived with good results, including enhancing the DPR without great difficulty.

Patients with anxious-preoccupied attachment have low perceived self-worth (high anxiety) and high trust in others (low avoidance), so they need the doctor extremely close. In this type of patient, the physician’s reaffirmed commitment to care for them would bring more relief and, in theory, decrease the excessive frequency with which these individuals seek care.^{19,27} Having appointments scheduled with established time limits, without waiting for symptoms to visit the physician, can also be helpful.¹⁴ This is

the kind of patient who, even when submitted to the “right” techniques, will hardly have much autonomy in their self-care or even in the care of others, given their relational characteristics.¹⁹ Therefore, they need a somewhat paternalistic attitude from the professional.

In patients with high avoidance and low anxiety — dismissing attachment style —, translated into low trust in others and high trust in themselves to the point of “compulsive self-reliance”,²⁹ giving more information can bring the person closer, as it offers them a greater sense of control in the situation and shows respect for their autonomy, compatible with informative DPR.^{14,16,27} However, we must be aware that the diseases might worsen as a result of their tendency to undervalue or not share symptoms. Thompson and Ciechanowski¹⁴ also reiterate that the highly requested family physician can get complacent with the little demand from this type of patient, to the point of feeling relieved; however, strengthening the bond is essential, even if impersonally, such as with visit reminders, phone calls, and others, for the dismissing person not to incur the vicious cycle that is to think they will only receive care if they keep a certain distance.

The last type — anxious-fearful — might be the most complex.¹⁹ They present high avoidance and anxiety, which gives them a sometimes antagonistic behavior of asking for care but not allowing themselves to receive care because of the fear of getting hurt. Such behavior can create negative feelings in the doctor. If they let themselves be affected by this countertransference, avoiding or treating the patient coldly, they will feed the fearful individual’s idea that those who should provide care for them are not reliable to do so.

In these cases, we must remember that attitudes that may seem counterproductive in physician-patient interactions can have the inherent goal of obtaining or maintaining the feeling of security based on the strategies learned to adapt to threatening circumstances.¹⁹ By acting in a way contrary to the expected, that is, the doctor reaffirming the bond despite everything and accepting the patient how they are, this idea of threat is broken, and DPR is enhanced.¹⁴ In addition, the patient’s precaution for not getting hurt can make them less certain of their own values, so the interpretive model is more suitable for these situations. Another way to establish a good DPR is not to scare the patient by getting more involved than would be comfortable for them at first and helping them understand their values.

Given this fear that a person they should trust may be at the same time threatening, an interesting approach would be sharing the care among other doctors and health professionals in a coordinated way and having the clinic rather than a person be their reference.¹⁴ At some point, the person might potentially come to trust a specific professional, who should become the patient’s anchor to the health system.

FINAL CONSIDERATIONS

For FM, the Attachment Theory can potentially address many anxieties that plague the daily care practice of the family physician and that the PCCM cannot solve alone. We can infer that this theory complements the PCCM, providing tools to continue applying this method with its four components, depending on the individual factors of each patient.

However, although the suggestions for its application are appealing, the level of evidence of the findings is weak. In order to be grounded in good science, the topic needs to be further researched in the future, aiming at the greatest scientific rigor that such a subjective theme allows. At first, identifying the perception of family physicians on the applicability of the theory to their different contexts could be interesting so that we can think of studies involving patients and professionals to help us test these suggestions in practice.

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CONFLICT OF INTERESTS

Nothing to declare.

AUTHORS' CONTRIBUTIONS

IGP: Conceptualization, Data curation, Formal analysis, Writing – original draft. SCG: Conceptualization, Writing – review & editing. EPAG: Conceptualization, Writing – review & editing. GMAC: Supervision, Writing – review & editing.

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