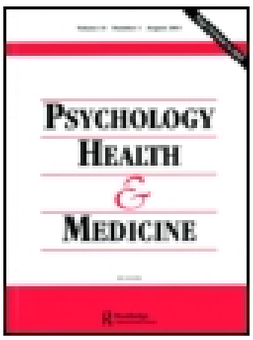

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Trust in the medical profession and patient attachment style

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ABSTRACT

Attachment style is a person's approach to interpersonal relationships, which develops from early experiences with primary caregivers and can remain stable into adulthood. Depending on a person's attachment style, the amount of trust one has in others can vary when forming relationships, and trust is important in formation of the patient–physician relationship. The purpose of this study was to see if there is an association between attachment style and trust in physicians in general. Participants were recruited from an emergency department (ED) and an online university participant pool, and completed short questionnaires assessing attachment style and trust in the medical profession. Results revealed that individuals with a fearful attachment style reported significantly lower levels of trust in the medical profession than those with a secure attachment style. ED participants also reported higher levels of trust in the medical profession in comparison to student participants. This study provides a better understanding of trust in the medical profession, and insight into future care for patients who have low trust.

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Acting in the best interests of the patient underlies many responsibilities of physicians (Canadian Medical Association Code of Ethics, 2004). Perception of a physician acting in the patient's best interest is reflected in the trust that a patient has in a physician (Hall, Dugan, Zheng, & Mishra, 2001), and trust is an essential component of the patient–physician relationship (Hall, Camacho, Dugan, & Balkrishnan, 2002; Hall et al., 2001). Attachment style – one's general approach to interpersonal relationships (Bartholomew, 1990) – can affect the level of trust one has in others when engaging in close interpersonal relationships (Collins & Read, 1990). It is thus possible that attachment style may impact a patient's level of trust in the medical profession, regardless of quality of care provided (Holwerda et al., 2013).

Attachment

Attachment style in adulthood reflects an individual's approach to interpersonal relationships (Bartholomew & Horowitz, 1991), and some research indicates that attachment style remains relatively stable throughout one's life (Hazan & Shaver, 1987). This approach, which develops from

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an individual's experience in childhood, can affect the types of interpersonal interactions he or she will have in adulthood (e.g. Bartholomew, 1990). Attachment style reflects whether individuals view themselves and others positively or negatively in relationships (Griffin & Bartholomew, 1994). Adults can be placed in one of the four categories of attachment style in response to how they feel in relationships generally, which can be further simplified into secure versus insecure attachment (Bartholomew & Horowitz, 1991). Securely attached individuals are able to be in relationships confidently, expecting positive relationship behaviors from both themselves and others (Hazan & Shaver, 1987). These individuals are able to be apart from another person without difficulty (Bartholomew & Horowitz, 1991). Secure individuals had childhood experiences that were consistent – the caregiver was there when needed, and the child's emotional needs were met (Bartholomew, 1990).

In contrast, individuals with an insecure attachment style – classified as preoccupied, dismissing or fearful – do not see others and/or themselves positively (Bartholomew, 1990). Preoccupied individuals have low self-esteem, viewing themselves negatively, and heavily relying on others, who they view positively (Bartholomew & Horowitz, 1991). Inconsistent and/or insensitive care provided by a primary caregiver forms the foundation for preoccupied attachment (Bartholomew, 1990). These individuals wanted to be close to their caregivers, but the caregivers were inconsistent in providing for this need (Bartholomew, 1990).

Both dismissing and fearful individuals have a negative view of others and can be described as experiencing avoidance if they must confront others (Bartholomew, 1990). Dismissing individuals view themselves as positive, and feel sufficient being independent without getting close to others (Bartholomew, 1990). This view of the self and of others is related to a lack of emotional support from early caregivers (Bartholomew, 1990). Fearful individuals also have a negative self-view, and want to have the support of others but fear rejection; therefore, involvement with others is often avoided (Bartholomew, 1990). Fearful attachment arises from being rejected by caregivers and being exposed to negative caregiver emotions (Bartholomew, 1990).

Trust

Trust is a component of interpersonal relationships (Rotter, 1971), and attachment style works with trust in forming the basis of these relationships (Haggerty, Hilsenroth, & Vala-Stewart, 2009; Mikulincer, 1998). Securely attached individuals have a high level of trust in others (e.g. Mikulincer, 1998) and can enter an interpersonal relationship with trust in the other person (Givertz, Woszidlo, Segrin, & Knutson, 2013). In contrast, insecurely attached individuals have less overall trust in others in relationships (Givertz et al., 2013). Preoccupied individuals worry that the other will not return and be supportive, and place great importance on approval from the other person in the relationship (Bartholomew & Horowitz, 1991). Fearful individuals do not try to form trusting relationships because of their negative outlook on both themselves and others (Bartholomew & Horowitz, 1991), and similarly, dismissing individuals avoid being close to others and resist forming trusting relationships (Ciechanowski & Katon, 2006).

Patient–physician relationship

The patient–physician relationship is built on trust (Hall et al., 2002). If the patient is unable to trust the medical professional, medical care may be negatively affected (Safran

et al., 1998). The patient must provide necessary personal information to the physician, and willingness to do so varies based on the amount of trust a patient feels in the relationship (Safran et al., 1998). Moreover, trust can influence the patient's decision to follow the physician's orders (e.g. Safran et al., 1998) and influence the patient's overall outcome (Martin, Williams, Haskard, & DiMatteo, 2005). A patient's level of trust is also important when considering how the patient feels upon entering the medical system, as the patient's current state of health may lead to feelings of vulnerability (Hall et al., 2001). An optimistic (trusting) outlook toward the physician can be part of overcoming such feelings (Hall et al., 2001).

Trust within the patient–physician relationship is affected by the patient's attachment style (Holwerda et al., 2013). For example, in a study of cancer patients, insecurely attached patients were less likely to fully trust their physician, less satisfied with their relationship with their physician and were more likely to be guided by their attachment style needs (Holwerda et al., 2013). These individuals may be focused on other aspects of the patient–physician relationship, rather than concentrating on their medical condition specifically (Maunder et al., 2006). Understanding more about the patient's attachment style can be helpful in exploring the patient's formation of interpersonal relationships in a medical setting (Thompson & Ciechanowski, 2003).

It has been suggested that preoccupied individuals focus on receiving attention from the physician and present high confidence in the physician, leading to frequent and sometimes unnecessary medical visits; these individuals are searching for attention and reassurance from their physicians (Thompson & Ciechanowski, 2003). This is in contrast to dismissing individuals, who have confidence in themselves but not others, and as a result can present ignorance when confronting personal medical issues (Thompson & Ciechanowski, 2003). Patients with fearful attachment styles can be reluctant to adhere to treatment suggestions because of their low trust in others (Thompson & Ciechanowski, 2003). Overall, insecurely attached patients may be seen as difficult by physicians due to the nature of the relationship that is developed based on their attachment style needs (Maunder et al., 2006). In this way, attachment can affect not only a patient's relationship with the physician, but also the overall effectiveness of the care received (Thompson & Ciechanowski, 2003).

In a setting where there is not much time spent with the patient, such as the fast-paced emergency department (ED), different attachment styles can also influence the patient–physician relationship (Maunder et al., 2006). The ED involves quickly forming relationships with patients of all attachment styles and levels of trust (Maunder et al., 2006). Increased time with patients may increase trust (Fiscella et al., 2004). However, due to the nature of the ED, the physician may not be able to spend an adequate amount of time with each patient in order to satisfy each individual's needs (Maunder et al., 2006).

To date, there has been no research that has examined how trust in the medical profession and patient attachment style relate in the ED setting. This study examined whether patients with different attachment styles varied in their levels of trust in the medical profession. Additional participants were recruited from an online student participant pool as a comparison group. We hypothesized that individuals with secure attachment would have the most trust in the medical profession while individuals with insecure attachment styles would have less trust. Specifically, dismissing and fearful individuals were hypothesized to have the lowest trust based on their general negative view of others.

Method

Participants

Ninety-three (24 male, 69 female) ED patients, recruited from the ED at the largest hospital in a small city, participated in the study. The average age of the ED participants was 52.02 (SD = 19.53). Patients were excluded from the study if they were not awake or alert, or were not permitted by their current state of health to engage in a conversation. Patients who were currently involved in medical procedures were not asked to participate. ED patients did not receive compensation for their participation. Sixty-one (14 male, 47 female) students, recruited from a university psychology department participant pool, also participated in an online survey. The average age of the online participants was 21.90 (SD = 5.30). Students received extra course credit for their participation.

Procedure

ED patients were approached by the researcher, and asked if they would be willing to participate in a short survey. If they consented, they were given the option of completing a paper-based survey or a verbally administered interview conducted by the researcher. Participants were asked not to provide any identifying information, and answers to questionnaires remained anonymous. Student participants accessed an online research system, read a brief description of the research and provided voluntary informed consent. Online surveys were not accessed by the researchers until all participants had participated to maintain participant anonymity. Participation took 15 min or less for all participants. Three demographic questions regarding age, ethnicity, and gender were documented, in addition to questionnaires assessing attachment style and trust in the medical profession.

Measures

Relationship questionnaire (Bartholomew & Horowitz, 1991)

Attachment style was assessed based on the categorical model of attachment style as proposed by Bartholomew (1990). Placing individuals into categories based on their general relationship style has been considered desirable in a clinical setting because it is easily interpreted (Maunder et al., 2006). Attachment style was assessed with the Relationship Questionnaire (Bartholomew & Horowitz, 1991). This questionnaire consists of four paragraphs that each corresponds to a different attachment style. Participants were asked to think of their general relationship style as they rated each paragraph on a seven-point scale (1 = *Disagree Strongly*, 4 = *Neutral/Mixed* and 7 = *Agree Strongly*). Each paragraph is a series of statements regarding interactions with others (e.g. *It is easy for me to become close to others*, *I am comfortable depending on them and having them depend on me* and *I don't worry about being alone or having others not accept me*). In the end, participants chose which paragraph most closely represented their general relationship style. Psychometric properties (reliability, face and discriminant validities) are considered to be adequate to good (Ravitz, Maunder, Hunter, Sthankiya, & Lancee, 2010).

Trust in the medical profession scale (Hall et al., 2002)

This questionnaire assessed general trust in the medical profession. Participants rated each of the 11 questions with regard to their attitudes toward physicians in general. Examples of questions include 'Doctors in [general] care about their patients' health just as much or more as their patients do' and 'You completely trust doctors' decisions about which medical treatments are best.' Questions were rated on a five-point scale (1 = *Strongly Agree*, 2 = *Agree*, 3 = *Neutral*, 4 = *Disagree* and 5 = *Strongly Disagree*). This scale has good internal consistency and response variability (Hall et al., 2002).

Results

Descriptive statistics

Data were screened for missing values. The fifth question of the Relationship Questionnaire was analyzed to assess attachment style. Participants with missing data on this question were not included in the analyses, leaving 146 participants. Fifty-eight (39.73%) participants were identified as having a secure attachment style, 22 (15.07%) as fearful, 17 (11.64%) as preoccupied and 49 (33.56%) as dismissing.

All questions in the Trust in the Medical Profession Scale were included in the analyses. Negatively worded questions were reverse scored. Responses of the 152 participants who completed all 11 items in the scale were analyzed. The mean trust rating for all participants was $M = 3.34$ (SD = .80).

Inferential statistics

A one-way ANOVA revealed a statistically significant difference between attachment style groups for means on the Trust in the Medical Profession Scale, $F(3,142) = 3.40$, $p < 0.05$. Tukey post hoc tests revealed a significant difference between the secure ($M = 3.51$) and the fearful ($M = 2.93$) attachment style categories, $p < .05$, and no other significant differences between groups.

An independent samples *t*-test compared the reported trust in the medical profession of student participants and ED participants. ED participants ($M = 3.49$, SD = .79) reported a significantly higher level of trust than student participants ($M = 3.10$, SD = .79), $t(150) = 3.03$, $p < 0.01$. A trust difference between genders approached significance, $t(150) = 1.82$, $p = 0.07$, suggesting that males may have a higher level of trust in the medical profession than females.

Discussion

This study was the first to assess the association between trust and attachment in an ED population. We predicted that individuals with a fearful attachment style would have a low level of trust in the medical profession, and results supported this hypothesis; fearful individuals were less trusting of the medical profession than securely attached individuals. The relatively low level of trust reported by those with a fearful attachment style supports the idea that these individuals may experience interpersonal relationship difficulties with

physicians due to the patient's attachment style needs. Ultimately, these relationship difficulties might further decrease the level of trust (Thompson & Ciechanowski, 2003).

Individuals with a dismissing attachment style were predicted to have low trust in the medical profession, like the fearful individuals, because of their negative view of others and avoidance behaviors. Results did not support this hypothesis, as there were no significant trust differences between the dismissing attachment style and any other attachment style categories. One explanation for this may lie in the view of the self. Fearful individuals have a negative self-view and they fear rejection from others (Bartholomew & Shaver, 1998), and this fear of rejection likely leads to negative expectations and low trust of others in relationships, including decreased trust in the medical profession. However, the dismissing individual does not feel the need to try to build a close relationship with others (Bartholomew & Horowitz, 1991), and thus may be neither particularly positive nor particularly negative in expectations about the patient–physician relationship. The dismissing individual also has a tendency to protect himself or herself from feeling vulnerable (Bartholomew, 1990). These individuals may not present a difference in level of trust because obtaining a trusting relationship is not something that they desire or that causes them concern. Future research could directly examine this hypothesis.

Previous research has indicated that the majority of participants are classified in the secure attachment style category (Mickelson, Kessler, & Shaver, 1997). The current sample differed from these previous findings, as there were more insecure than secure individuals. Within the insecure groups, the number of dismissing individuals was the highest, and approached the number of secure individuals. Previously observed attachment style ratios may not be an accurate comparison for this study, as there has been no research in this specific geographical location regarding attachment styles. This ratio may be unique for this particular population.

Results indicated that the ED patient participants presented a higher level of trust in the medical profession in comparison to student participants. One possibility is that patients felt a degree of vulnerability while facing a current medical condition, which increased their trust (Hall et al., 2001). It can be argued that trust is unnecessary if conditions of vulnerability or dependence do not exist, and as such, ED patients may have more motivation to trust the medical profession than students who are not immediately in need of help. While this may be beneficial to the provision of care, it also suggests that doctors may need to take patient vulnerability into account when presenting treatment options. Patients who are vulnerable or dependent may be more likely to go with a doctor's recommendation, even when the doctor describes more than one viable choice for treatment.

The current results also indicated a potential (approaching significance) gender difference in trust in the medical profession, with males having somewhat higher levels of trust. Perhaps males enter the medical setting with a higher level of trust, irrespective of attachment style. One potential explanation for this result comes from Derose, Hays, McCaffrey and Bakerg's (2001) research which indicates that female ED patients are more likely to trust female physicians, whereas male patients' trust is independent of the physician's gender. Since ED patients may not yet know the gender of the care provider they will see, men may be more likely to feel trusting in this situation. Future research should further explore this finding.

Limitations

One limitation of this study is the unequal representation of females and males in the sample, with 75% of the sample identifying as female. Additionally, ethnicity results were not included in the data analysis, as ethnicity was commonly misinterpreted or was not reported among patient participants. Multiple patient participants listed their ethnicity as Canadian, and we cannot assume the intended ethnicity from these responses. As it stands, the data from this study cannot be assumed to generalize to diverse populations.

Another limitation of this study is that this sample may not be a true representation of the ED population because not all patients could be asked to participate, including patients who were too ill to participate. There is also the possibility that the current condition of patient participants, at the time of the survey, influenced responses; some patients agreed to participate, despite not feeling well, and this may have altered their responses.

Conclusion

The current research indicates that attachment style may be important in understanding trust in the medical profession among ED patients. Since trust relates to sharing relevant personal information and adhering to physician recommendations, assessing attachment style could lead to better allocation of physician time, especially in the fast-paced ED. Spending extra time with individuals with a fearful attachment style may improve outcomes, though further research is needed to test this possibility. In addition, ED patients appear to be more trusting of the medical profession than students. This has implications for understanding trust in vulnerable populations. As the first study of attachment and trust among ED patients, this research can serve as a starting point for future investigation in this area.

Disclosure statement

No potential conflict of interest was reported by the authors.

References

Bartholomew, K. (1990). Avoidance of intimacy: An attachment perspective. *Journal of Social and Personal Relationships, 7*, 147–178.

Bartholomew, K., & Horowitz, L. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61*, 226–244.

Bartholomew, K., & Shaver, P. (1998). Methods of assessing adult attachment. In J. Simpson & W. Rholes (Eds.), *Attachment theory and close relationships* (pp. 25–45). New York, NY: Guilford Press.

Canadian Medical Association Code of Ethics. (2004). *CMA code of ethics*. Ottawa: Author.

Ciechanowski, P., & Katon, W. (2006). The interpersonal experience of health care through the eyes of patients with diabetes. *Social Science & Medicine, 63*, 3067–3079.

Collins, N., & Read, S. (1990). Adult attachment, working models, and relationship quality in dating couples. *Journal of Personality and Social Psychology, 58*, 644–663.

Derose, K., Hays, R., McCaffrey, D., & Bakerg, D. (2001). Does physician gender affect satisfaction of men and women visiting the emergency department? *Journal of General Internal Medicine, 16*, 218–226.

Fiscella, K., Meldrum, S., Franks, P., Shields, C., Duberstein, P., McDaniel, S., & Epstein, R. (2004). Patient trust: Is it related to patient-centered behavior of primary care physicians? *Medical Care, 42*, 1049–1055.

Givertz, M., Woszidlo, A., Segrin, C., & Knutson, K. (2013). Direct and indirect effects of attachment orientation on relationship quality and loneliness in married couples. *Journal of Social and Personal Relationships, 30*, 1096–1120.

Griffin, D., & Bartholomew, K. (1994). Models of the self and other: Fundamental dimensions underlying measures of adult attachment. *Journal of Personality and Social Psychology, 67*, 430–445.

Haggerty, G., Hilsenroth, M., & Vala-Stewart, R. (2009). Attachment and interpersonal distress: Examining the relationship between attachment styles and interpersonal problems in a clinical population. *Clinical Psychology & Psychotherapy, 16*(1), 1–9.

Hall, M., Camacho, F., Dugan, E., & Balkrishnan, R. (2002). Trust in the medical profession: Conceptual and measurement issues. *Health Services Research, 37*, 1419–1439.

Hall, M., Dugan, E., Zheng, B., & Mishra, A. (2001). Trust in physicians and medical institutions: What is it, can it be measured, and does it matter? *The Milbank Quarterly, 79*, 613–639.

Hazan, C., & Shaver, P. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology, 52*, 511–524.

Holwerda, N., Sanderman, R., Pool, G., Hinnen, C., Langendijk, J., Bemelman, W., … Sprangers, M. (2013). Do patients trust their physician? The role of attachment style in the patient-physician relationship within one year after a cancer diagnosis. *Acta Oncologica, 52*, 110–117.

Martin, L., Williams, S., Haskard, K., & DiMatteo, M. (2005). The challenge of patient adherence. *Therapeutics and Clinical Risk Management, 1*, 189–199.

Maunder, R., Panzer, A., Viljoen, M., Owen, J., Human, S., & Hunter, J. (2006). Physicians' difficulty with emergency department patients is related to patients' attachment style. *Social Science & Medicine, 63*, 552–562.

Mickelson, K., Kessler, R., & Shaver, P. (1997). Adult attachment in a nationally representative sample. *Journal of Personality and Social Psychology, 73*, 1092–1106.

Mikulincer, M. (1998). Attachment working models and the sense of trust: An exploration of interaction goals and affect regulation. *Journal of Personality and Social Psychology, 74*, 1209–1224.

Ravitz, P., Maunder, R., Hunter, J., Sthankiya, B., & Lancee, W. (2010). Adult attachment measures: A 25-year review. *Journal of Psychosomatic Research, 69*, 419–432.

Rotter, J. (1971). Generalized expectancies for interpersonal trust. *American Psychologist, 26*, 443–452.

Safran, D., Taira, D., Rogers, W., Kosinski, M., Ware, J., & Tarlov, A. (1998). Linking primary care performance to outcomes of care. *Journal of Family Practice, 47*, 213–220.

Thompson, D., & Ciechanowski, P. (2003). Attaching a new understanding to the patient-physician relationship in family practice. *The Journal of the American Board of Family Medicine, 16*, 219–226.