

The Caregiving System and the Doctor–Patient Relationship: Responding to One’s Needs

El sistema de cuidado en salud y la relación médico–paciente:
responder a las necesidades del otro

O sistema de cuidado e a relação médico–paciente:
respondendo às necessidades do outro

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Abstract

The attachment theory states that human beings have in parallel an attachment system, an exploratory system and a caregiving system. The caregiving system is the counterpart of both the attachment and the exploratory systems. The caregiving system consists of providing safe haven to which the individual can go back when feeling threatened, and a secure base from which he/she can explore the environment. The caregiving system can also be experienced in the doctor–patient relationship. To be a care provider means to be available when one is most needed. Attachment patterns influence the doctor’s relationships, affecting the adherence and the illness management. Taking care of his/her patients in times of need is equivalent to activate the doctor’s own caregiving system to protect and secure the patient’s health

and wellbeing. An open and available doctor means a more open, present, secure and confident patient.

Keywords: Attachment theory, caregiving system, safe haven, doctor–patient relationship.

Resumen

La teoría del apego afirma que los seres humanos tienen en paralelo un sistema de apego, un sistema exploratorio y un sistema de cuidado. El sistema de cuidado es la contrapartida de los sistemas de apego y exploratorio. El sistema de cuidado consiste en proporcionar una base segura a la que el individuo puede regresar cuando se siente amenazado y a partir de la cual puede explorar el ambiente. El sistema de cuidado también puede ser experimentado en la relación médico–paciente. Ser un profesional de la salud es estar disponible cuando se

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es más necesario. Los patrones de apego influyen en la relación del médico con el paciente, que afecta la adhesión al tratamiento y el manejo de la enfermedad. Cuidar de sus pacientes en momentos de necesidad es equivalente a activar el propio sistema de cuidado del médico para proteger y garantizar la salud y el bienestar del paciente. Un médico abierto y disponible representa un paciente más abierto, presente, seguro y confiado. *Palabras clave:* teoría del apego, sistema de cuidado, base segura, relación médico-paciente.

Resumo

A teoria do apego afirma que os seres humanos têm em paralelo um sistema de apego, um sistema de exploratório e um sistema de cuidado. O sistema de cuidado é a contrapartida dos sistemas de apego e exploratório. O sistema de cuidado consiste em proporcionar uma base segura à que o indivíduo pode regressar quando se sente ameaçado e uma base segura a partir da qual pode explorar o ambiente. O sistema de cuidado também pode ser experimentado na relação médico-paciente. Ser um profissional da saúde é estar disponível quando é mais necessário. Os padrões de apego influenciam a relação do médico com o paciente, afetando a adesão ao tratamento e o manejo da doença. Cuidar de seus pacientes em momentos de necessidade é equivalente a ativar o próprio sistema de cuidado do médico para proteger e garantir a saúde e o bem-estar do paciente. Um médico aberto e disponível representa um paciente mais aberto, presente, seguro e confiado.

Palavras-chave: teoria do apego, sistema de cuidado, base segura, relação médico-paciente.

Introduction

The attachment theory postulates that individuals have biological-rooted needs for protection and security. Given that they are not born mature enough to survive by themselves and that they are even more social creatures when feeling threatened, human beings seek proximity of a stronger

and wiser attachment figure to attain protection and security. This collective behavior-seeking is called attachment system, denominated after all the biological functions and adaptive tendencies it encounters. However, being relational, an attachment system activates a capacity for caring, which can be developed in the caregiving system, which is the attachment figure ability to respond and being sensitive to the individual's needs (Bowlby, 1990; Mikulincer & Shaver, 2007; Ramires & Schneider, 2010).

The caregiving system also is linked to the exploratory system, which is the individual's capacity to explore the environment around him/her, being delighted by it, experimenting it and being in it. An attuned caregiver can pace him/herself as to learn when coming to the rescue to an individual and when to applaud from the far all the accomplishments he/she is conquering (Cassidy, 2016).

The main idea is that the experiences of the individual and their peers will construe emotional bonds. The caregiver can become available and respond to a safe haven that defines what kind of behavior the child, and later the adult, will be able to rely on. This work aims to review some concepts about the caregiving behavioral system and its relationship with the attachment behavioral system, the exploratory system and the internal working model.

Becoming Attached: Attachment System and Exploratory System

The attachment behavioral system is a biological-rooted system, with adaptive tendencies, composed of attachment behaviors, and is activated when one is feeling threatened or in danger, it is thus linked with the fear behavioral system. That menace can be real or fantasized, being the experience of unsafety the prominent factor for that system. It is present from the cradle to the grave and is relational-based, starting with the primary caregivers, usually the parents. Once activated, the

attachment system seeks proximity and safety of an older and wiser attachment figure, usually the caregiver (Bowlby, 1990, 1997; Cassidy, 2016).

When that need is met, the attachment system deactivates, with the individual being able to activate its exploratory system. In its turn, the exploratory system increases survival’s advantages feeding information about the environment and how it functions, like how to use tools, build structures, obtain food, for example. One can explore the environment and simultaneously be able to use the attachment figure as a secure base, experiencing with curiosity and fierceness. Thereby the individual can have a sense of effectiveness and competence, with joy, exhilaration, exuberance and pride which are affective markers of the exploratory system (Cassidy, 2016; Fosha, 2000). That constitutes a secure type of attachment.

As aforementioned, the attachment system is activated by the relationship with the caregiver. The infant can safely explore the environment, and, more importantly, he/she starts to privilege some strategies considered to be more adaptive. It is the beginning of the construction of his/her internal working model.

The internal working models are mental representations of the relationship and the surroundings that are internalized in what Bowlby (1990) called scripts or blueprints that help the individuals to predict and to act in the environment. The working models can represent the self, meaning the experience about oneself, or others, the relational experience of others. If the internal working model of self and others is positive, then one tends to have a secure attachment, with low anxiety and low avoidance. However, sometimes the dyad’s needs are not met, obliging the individual to recur to secondary strategies, where one resorts to defense mechanisms, especially defensive exclusion, to adapt to the relational environment and maintain the proximity to the caregiver. If the model of the self is positive, and the model of others is negative, the tendency is to have an avoidant-dismissive at-

tachment, with low anxiety and high avoidance. If the model of the self is negative and the model of other is positive, there is a preoccupied attachment, with high anxiety and low avoidance. Finally, if both models of the self and of others are negative, then it is likely that the individual has an avoidant-fearful attachment type, with high anxiety and high avoidance (Mikulincer & Shaver, 2007; Pietromonaco & Barrett, 2000).

The internal working models are the ways in which the child, or the care recipient, forms patterns of relationships to attain the parent’s or partner’s attention, or care, activating the caregiving system. For every dyad, whenever an attachment system is activated, a caregiving system is also activated, being that a secure or an insecure relationship (Cassidy, 2016; Pietromonaco & Barrett, 2000).

The Caregiving System: Being a Secure Base and a Safe Haven

The attachment theory postulates that individuals have a capacity for caring for a (at times, temporarily) dependent other that needs support and protection. Although at first it was denominated attachment-caregiving social bond, nowadays it is termed as caregiving behavior, and it is used to describe the behaviors that the caregiver perceives as threatening or distressing and when he/she approaches the individual with the primary objective of retrieving him/her from danger. From an evolutionary perspective, it is organized to increase the chances of the child’s survival. Many times, the dyad works together to keep the optimal proximity (Cassidy, 2016; Mikulincer & Shaver, 2007).

Caregiving provides support and complement to attachment and exploration behaviors. That said, the caregiving system is essential for the infant survival, and that is why babies, according to ethologists, have such endearing features (Cassidy, 2016; Feeney & Woodhouse, 2016):

it is likely that the close link between the child's attachment and fear systems is paralleled by a close link between the parent's caregiving and fear systems, such that when a parent's fear's system is activated, so too is his or her caregiving system (Cassidy, 2016, p. 11).

The caregiving behavior is terminated only when the attachment system is deactivated. Moreover, the intensity of emotions for the activation is proportional to its deactivation (George & Solomon, 2008).

The caregiving system's role is not restricted to keeping proximity to the individual, but also to steering support and protection when needed. It provides a safe haven by which the attached partner can get the necessary support and comfort; and a secure base from which one can explore the relationship and the environment. A safe haven offers support to the individual, including comfort, reassurance, and assistance, when feeling distressed. The secure base encourages the individual to explore the environment, acknowledging and respecting his/her needs and shaping his/her behavior (Bowlby, 1997; Feeney & Woodhouse, 2016).

As stated by the same authors, the caregiver's role is to have an empathic and intuitive comprehension of the child's attachment behavior, as well as being sensitive and responsive to restore and maintain felt security. The attachment figures also must acknowledge and organize the child's affects, like frustration and desire for love, and to respect the formation of other attachment relationships, with the child's peers, for example. Good enough caregiving involves being attuned to the attached partner and regulating his/her behavior accordingly.

Since the Strange Situation experiment, developed by Mary Ainsworth, maternal sensitivity has been defined as the ability to perceive and interpret the child's signals, responding at the same to attachment and exploration activations. It also includes attunement and accurate interpretation of

the other's signals (distress and need, for example), responding accordingly. Parental sensitivity is vital because it helps children to regulate themselves when they are still learning how to build the capacity of self-regulation (Ainsworth, 1979; Feeney & Woodhouse, 2016; Mikulincer & Shaver, 2007).

This way, the caregiver frees the child from monitoring him/herself so he/she can turn his/her attention to exploring. Monitoring the child is a critical role for the attachment figure, given that often parent and child do not agree upon the distance of the relationship and the environment menaces. In many situations, the attachment figure's caregiving system is activated, but the child's attachment system is not, because the parent has more information and perception about the environment, a situation that sometimes can lead to conflict. That said, it is essential for the caregiver to be aware of the child's needs and how to respond to that. It is not always possible to attend to all the infant's demands, whether for work reasons or because other family members (such as other children or romantic partners) also need the caregiver's attention (Cassidy, 2016; George & Solomon, 2008).

Caregiving is activated, usually, when someone has to cope with stress, danger or discomfort, and seeks or needs help; or when a person needs someone to be validated, celebrated, motivated or encouraged for any opportunities or accomplishments. If an individual fails to see the signs, is intrusive, infers incorrectly or neglects some signs, he/she is not adopting a caregiving role (Mikulincer & Shaver, 2007).

The caregiver's role means being responsive and available to the child, only interfering when the child seeks the attachment figure or when there is any sign of threat. It is activated by internal and external cues along with the attachment figure's perception of frightening, dangerous or stressful situations. Internal cues include hormones, cultural beliefs, parental general state (i.e., if the parent is sick or tired) and other behavioral systems, while the external cues include the state of the environ-

ment, the state of the infant and his/her behavior (Cassidy, 2016; George & Solomon, 2008).

Within that role, the caregiver must decide what actions to take, continually scanning the environment to evaluate all sources of information, such as the child’s signals, any perception of threat or danger, organizing and selecting a response (George & Solomon, 2008). On the other hand, caregivers who ignore and neglect the other’s experiences and needs, who do not notice or are insensitive and unresponsive to the cues show a lack of synchronicity in their role as safe havens, as protectors and supporters (Feeney & Woodhouse, 2016).

In sum, the secure base presents three primary features: Caregiver’s availability when necessary, support to exploration without unnecessary interference and encouragement and acceptance to exploration. While the first feature concerns the caregiver being available as a secure base when needed, the second one involves support to exploration without unnecessary interference, since an invasive behavior is an inhibitor of exploration, thus revealing an insensitive and unresponsive caregiver. The third characteristic refers to encouraging and accepting exploration because it enhances enthusiasm for it, as well as the other’s confidence.

Caregivers unable to provide adequate secure base are insensitive to the partner’s feelings, invade the explorations of others, fail in encouraging others in their autonomy and exploration or respond in a disconnected and unattuned manner. This can lead to feelings of being misunderstood, disrespected or burdensome, increasingly distressed, thus opposing to providing a secure base to the caretaker (Feeney & Woodhouse, 2016; Mikulincer & Shaver, 2007). A central idea revolves around the relationship between the individuals’ experiences and their caregivers and the former’s abilities to, later, make affectional bonds. The patterns of relationships build models of the self and others, because of the availability of the caregivers to

the children’s needs, and it is how the attachment figure is going to respond to individual’s necessity of proximity and safety that defines secure attachments (Bowlby, 1997).

Caregiving and Doctor-Patient Relationship

Dealing with the suffering of others as a caregiver can elicit two emotional reactions: Empathic compassion and personal distress. Empathic compassion focuses on the compassion for the other’s needs and suffering, with the concern of alleviating it for the benefit of the sufferer; while in personal distress, in self discomfort, the alleviation frequently means that the caregiver helps by ignoring, or fleeing the situation only to mitigate the own unpleasant emotional situation. Compassion supports caregiving without any direct payoff to the caregiver (unconditional caregiving), but in personal distress the goal is to help so it can lighten the caregiver’s discomfort (Mikulincer & Shaver, 2007).

The researchers pointed out that caregiving requires intra- and interpersonal regulation, once it involves emotion regulation processes, self-regulation, and interpersonal regulation. Emotion regulation prevents the caregiver from feeling overwhelmed by anxiety when dealing with the dyad, and not being the one who needs the caretaking instead of providing care. Self-regulation is necessary, making it clear that the other’s needs take precedence over the personal ones. This means, listening sensitively and responsively to the other’s needs and assisting in the best way possible. The interpersonal regulation’s role relates to synchronizing and coordinating the dyad, that is, to be present, responsive and attentive to the relationship, not too close as to invade nor too distant to the point of losing connection.

It is important to stress that only when there is a sense of security when the attachment figure can be prepared to be sensitive to its partner, other-

wise he or she may feel compelled to protect his/herself first instead of the other in need. Hence, feeling secure protects the caregiver from feeling overwhelmed or threatened by the other's needs or opportunities. As in the attachment system, the caregiving system can be activated throughout the lifespan. During infancy, parents are the primary caregivers, but in adulthood, romantic partners usually are called to this role to provide comfort, support, and security in times of need. Their availability is a crucial determinant of the quality and stability of the relationship (Mikulincer & Shaver, 2007).

It is noteworthy that, although the caregiving behavior is pre-programmed, it is also relational-engendered (Feeney & Woodhouse, 2016).

Those who are given to us as our caretakers or attachment figures are always imperfect. Some are better than others. Some are cheerful and resilient, and some are depressed, weary, and preoccupied. All are different in their moods, and emotional states and in the stresses to which they are vulnerable, better at some times and in some types of situations and worse in others (Costello, 2013, p.3).

These same authors, along with, for example, Adshad and Bluglass (2001) and Collins and Ford (2010) highlight how the attachment figures build their caregiving capacities from their attachment relationships. From that stance, individuals develop mental representations of themselves as caregivers, as well as of the care recipients, forming working models of oneself and the others. These working models guide the caregiving behaviors, delineating their expectations, feelings, and actions. Thus, secure representations facilitate secure care, providing a secure base from which to explore, and a safe haven one can return to when needed, thus resulting in secure attachment types.

Research (Biringen et al., 2000; Bosquet & Ege-land, 2001) posits that partners engaged in mutually emotional available and rewarding interactions

tend to be associated with sensitive maternal representations and states of mind, and, it shows, therefore, how impairing can it be when there is maternal unavailability. Studies (McCarthy & Maughan, 2010; Mohr, Cook-lyon & Kolchakian, 2010) also point out links between positive and negative internal working models, which result in secure or insecure attachment types to the romantic partnership. These studies corroborate the idea that a poorly responsive caregiving system leads to negative mental representations of the self and of others, impairing the individual's capacity to stay attuned, sensitive and responsive to the dyad (Luke, Maio & Carnelley, 2004; Mikulincer & Shaver, 2007).

Communication is essential for the dyad to build a sense of felt security. In other words, communicating all sensations, organizing, being delighted by, teaching the care-receiver is crucial to the role of providing a secure base (Mikulincer & Shaver, 2007; Wallin, 2007).

The Doctor-Patient Relationship and the Caregiving System: Being there in Times of Need

Illness puts the individual through the "unthinkable": Death, finitude, immobility, impotence. At this moment, the body no longer belongs to the person, experiencing slavery of mind and body (Botega, 2006).

One goes from subject of intentions to subject of attention, facing sensations such as threats to the own integrity; separation anxiety; fear of strangers; guilt and fear of retaliation or of losing control, the love or the approval of people around; fear of losing (or harming) any part of the body, fear of dying.

Illness may have the role of the means to express the need of being touched, heard and welcomed. It is the moment when communication is possible, and that is why sometimes it can be difficult to receive treatment precisely because the

disease can have a secondary gain for the patient: He/she can communicate his/her distress and be welcomed. Moreover, sometimes it is difficult to trust the caregiver when the patient own need was not attended or heard (Campos, 2007).

In the same way, healthcare professionals, including doctors, find themselves facing the patient’s pains, expectations and frustrations. On the doctor’s role all hopes are put about restoring the patient’s health, or that of the loved ones. It is upon the doctor to receive all the patient’s and the families’ ambivalent feelings, both of gratitude for caring, but also of anger and guilt for the patient’s suffering and aggravation of the disease (Kovács, 2010) The physician still has the reputation of being the “one who has all the knowledge”, of having the hierarchical rigidity of knowledge, of keeping an emotional distance so he/she can perform his/her work. Even the medical education leans to the tenet that emotions cloud thoughts, confirming to the doctors that “a certain measure of insensibility is not only an advantage but a positive necessity in the exercise of a calm judgment” (Ofri, 2013, p.4).

Balint (2005) thought that the doctor is the most prescribed medicine for the patient. However, it should be done wisely because of its side effects. According to CREMESP (2001) the quality of the doctor-patient relationship is based upon a humanized care (good enough interpersonal relationship, time spending and attention to the patient); on the physician listening to the patient (clarifying any questions and understanding expectations); on the doctor giving straightforward, detailed diagnosis and treatment explanation to the patient (for the patient’s comprehension of the risks and benefits); on the patient’s autonomy in choosing his/her treatment; as well as on the physician always updating his/her knowledge in conferences and similar professional events; being available to the patient; understanding the boundaries of medicine; referring the patient to other professionals if necessary and being part of actions to improve working conditions.

The doctor-patient relationship is considered light technology; therefore, it must be carefully thought-out and updated and fast as the modernization of the hard machinery itself. The tendency of modern medicine, increasingly technological and restricted by guidelines, lessens the spontaneity of care. The doctor-patient relationship takes place as a special encounter, formed by two unique individuals, so the pairing of each doctor with each of his/her patients is singular (Grillo, 2016).

As aforementioned, to be a care provider is to be available to the patient when he/she needs it the most, which is paralleled with what the attachment theory states about the caregiving system. Researchers (Adshead & Guthrie, 2015; Wilhelm & Tietze, 2016) show that attachment patterns influence the relationships with healthcare professionals (i.e., doctors) and if they are missing or deficient they lead to weaker adherence and illness management. Other studies (Micelli, 2009; Tan, Zimmermann & Rodin, 2005) posit that an empathic stance towards the patients may result in therapeutic success, meaning empathic responsiveness to attachment needs and threats. Therefore, the observation of the patient’s attachment patterns may improve the doctor-patient relationship and increase healthcare outcomes.

Final Considerations

The attachment theory states that human beings have paralleled attachment caregiving and exploratory systems. When the attachment system or the exploratory system is activated, the caregiving system is also activated, whereas if the attachment system is activated, the exploratory is deactivated. The attachment system is the tendency individuals have of seeking proximity of a stronger and wiser attachment figure when perceiving any signs of (real or fantasized) threat. The exploratory system is the curiosity-driven experience that occurs when individuals feel secure enough in their environment. The caregiving system is the counterpart of

both the attachment and the exploratory systems. It is the protective, secure-seeking behavior of the attachment figure in the relationship with the care seeker.

The caregiving system consists of two major characteristics: Providing safe haven to which the individual can go back when feeling threatened, and a secure base from which he/she can explore the environment. Both characteristics depend on the caregiver's availability, sensitivity and responsiveness to the individual. If the attachment figure demonstrates to be available, sensitive and responsive to the individual's need, then he/she can feel safe to deactivate his/her attachment system and explore the environment. Alternatively, if the caregiver is sensitive and responsive to not intrude in the individual's exploring, then he/she can feel empowered, curious and full of energy to continue learning new skills and reaching for his/her autonomy.

The caregiving system can also be experienced in the doctor-patient relationship. Doctors must deal with distress, suffering, death on a daily basis, while providing to the patient's safety and care. Taking care of their patients in times of need is equivalent to activate doctors' own caregiving system to protect and secure the patient's health and wellbeing. Communication is a crucial feature in that dyad, given that the doctor must notify the necessary information, and simultaneously connecting and being open to what the patient brings. An open and available doctor potentially means a more open, present, secure and confident patient. On the other hand, an unavailable and unreliable doctor potentially means a more insecure, distrustful and unavailable patient. Providing a secure base can be a role for the doctor: being able to welcome the patient's suffering and at the same time having the skills to treat him/her. However, it can take an emotional toll. So, it is essential that the professional doesn't perceive this relationship as a threat to his/her own safety, so he/she can be available and responsive to the patient's needs.

Being dyadic specific, the attachment system is directly connected to the caregiving system. When one is activated the other is also triggered. For this purpose, the attachment theory approach in the doctor-patient relationship can improve the caretaking matter at intake. The doctor's role as activated caregiving system in the doctor-patient relationship implies him/her as part of the attachment dyad, and all the vicissitudes imbued into it. Moreover, paraphrasing Costello (2013), caretakers have their own attachment issues influencing their caregiving system. Therefore, more studies are still needed in the field, especially those that encompass the perspective of the doctor as a caregiving system.

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