Attachment Styles of Specialist Physicians and The Relationship between Attachment Styles and Specialization Field

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Abstract

Aim: The aim of this study is to evaluate the attachment styles of specialist physicians and to examine the differences in attachment styles according to their specialty and whether they are placed in their first preference in the medical specialty exam (TUS).

Methods: A total of 92 physicians were included in the study. Individual information collection forms and the Relationship Scales Questionnaire (RSQ) were administered to all participants. Participants were asked about their gender, their specialization field, and whether their current specialization field was their first choice in the Medical Specialization Exam (TUS). Specialization fields were divided into 4 groups: surgical specialties, internal medicine specialties, basic medical sciences, and family medicine specialization.

Results: Among all participants, 14.1% exhibited secure attachment, 57.6% displayed fearful attachment, 32.6% demonstrated preoccupied attachment, and 3.3% had dismissive attachment. There was no significant difference in attachment styles based on the participants' genders. There was no significant difference in attachment styles based on whether they entered their first choice in the Medical Specialization Exam (TUS). There was no significant difference in attachment styles based on the specialization fields in which the participants received their education.

Conclusions: Among expert physicians, anxious attachment was the most common attachment style. Although there was no statistically significant difference in attachment styles based on physicians' specialization fields, family medicine and internal medicine practitioners exhibited a higher rate of secure attachment compared to those in the basic medical and surgical sciences. Determination of other possible motivational factors as well as attachment styles could provide guidance and insight to the physician in this choice that will affect her/his whole life.

Keywords: *Attachment styles, medical education, specialization field*

1. Introduction

Attachment is defined as an emotional bond established between an infant and their caregiver during the early stages of life, characterized by a seeking of closeness with the caregiver, and marked by consistency and continuity.[1] According to attachment theorists, once established as secure or insecure during infancy, attachment tends to show minimal variation throughout life. The prior psychological experiences of individuals with their caregivers give rise to enduring cognitive models and caregiving maps that persist into adulthood.[2] An individual's sense of personal competence and positive self-worth relies on the development of secure attachment. Secure attachment fosters healthy emotional and social development while shielding an individual from stress-inducing conditions. Different attachment patterns assume various forms at different stages, influencing an individual's life experiences.[3]

Adult individuals are characterized by one of the four dominant relationship styles derived from attachment theory: secure attachment, fearful attachment, dismissive attachment, and preoccupied attachment. These relationship styles are learned ways of interacting that persist throughout life, especially during vulnerable periods. Individuals with a secure attachment style tend to evaluate themselves and

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others positively. They display more accepting and intimate behaviors because they perceive both themselves and others as valuable. Individuals with a fearful attachment style, on the other hand, tend to evaluate both themselves and others negatively. Despite desiring intimacy in their relationships, they avoid social situations and close relationships due to a lack of trust in others and a fear of rejection. Individuals with a preoccupied attachment style tend to view themselves as unworthy but perceive others in a positive light. In this attachment style, a person's self-worth is contingent on others accepting them, leading them to make excessive efforts to gain approval in their relationships. On the other hand, individuals with a dismissive attachment style see themselves as valuable and lovable but tend to evaluate others negatively. These individuals have an excessive sense of self-reliance but avoid close relationships because they don't trust others enough to engage with them.[4-5]

Attachment theory is employed to explore career orientation, decision-making processes, and more. Recently, it has also become a subject of research to understand the interpersonal aspects of medical care, psychotherapeutic relationships, and the patient-clinician relationship.[5-6-7] During and after medical education, numerous factors come into play in an individual's choice of specialization. Factors such as working hours, the prestige of the specialization, the duration of the specialization program, interest in research, inclination towards long-term relationships with patients, doctor-patient interactions, patient diversity, expected income, and a focus on public health can influence a person's choices in specialization[8]. An individual's attachment style can shape their inclination to engage in long-term relationships or otherwise mediate a person's choice of specialization. Some studies conducted on medical school students have shown that the longitudinal desire for patient care has a significant impact on their choice of primary care specialties.[6-9-10]

Learning about the attachment styles of physicians or patients can be useful as a way to better understand the dynamics of the patient-doctor relationship. While many studies have begun to explore the relationship between medical care and clinical treatment and patients' attachment styles, only a few have examined clinicians' attachment styles.[6-11]

Previous studies were conducted among medical school students, and we wanted to compare the results by evaluating the attachment styles of the specialist physicians who made their choices. In addition, we wanted to investigate whether there is a difference between specialist physicians who entered their first choice and those who did not.

In the literature, we could not find any study investigating the attachment styles of physicians who graduated from medical school, passed the Medical Specialization Examination (TUS), and worked as specialist physicians, and examined the relationship between the department and attachment styles. In this direction, we planned to conduct this research.

2. Materials and methods

Our study is a cross-sectional and descriptive study. All participants were administered an individual information collection form and the Relationship Scales Questionnaire (RSQ). Participants were asked about their gender, their specialization field, and whether their current specialization fields were their first choices in the Medical Specialization Exam (TUS). Specialization fields were categorized into four groups: surgical specialties, internal medicine specialties, basic medical sciences, and family medicine specialization.

In our study, the Relationship Scales Questionnaire consisting of 17 questions was used to determine the participants' attachment styles. This scale was validated and demonstrated reliability in Turkish by Sümer and Güngör (1999).[12] The scale is a 7-point scale ranging from 1 (Doesn't Describe Me at All) to 7 (Describes Me Completely). The 7th and 17th questions on the scale are reverse-coded, and the 5th question is both reverse-coded and forward-coded. The questions used for each attachment style are as follows:

- Secure Attachment: Questions 3, 7 (reverse-coded), 8, 10, 17 (reverse-coded).
- Fearful Attachment: Questions 1, 4, 9, 14.
- Preoccupied Attachment: Questions 5 (reverse-coded), 6, 11, 15.
- Dismissing Attachment: Questions 2, 5 (reverse-coded), 12, 13, 16.

Arithmetic means obtained from the questions that make up attachment styles were used to classify participants. Participants were assigned to the attachment style to which they had the highest score. In case of equal scores, participants were included in both attachment styles.

According to the power analysis conducted before the study, our sample size was determined as 61 participants with a 95% confidence interval and 90% power. Ninety-two specialist physicians participated in our study.

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In our study, the statistical software package SPSS 19.0 was used. The frequencies of the obtained data were examined. Shapiro-Wilk test was applied to evaluate the normality distribution of the scale scores. Since the obtained values are $p<0,05$, a normal distribution was not provided. Therefore, non-parametric tests were applied. Mann Withney U and Kruskal Wallis tests were applied for 2-variable and 3-variable comparisons, respectively. A p value less than 0.05 was accepted as significant.

2.1. Sociodemographic Data Form:

This questionnaire was developed by the researchers for use in this study to determine the sociodemographic characteristics of the participants. Participants were asked about their gender, their specialization field, and whether their current specialization fields were their first choices in the Medical Specialization Exam (TUS).

2.2. Relationship Scales Questionnaire (RSQ):

Developed by Griffin and Bartholomew (1994). This scale was adapted into Turkish by Sümer and Güngör (1999). The Relationship Scales Questionnaire consists of 17 items and aims to measure four attachment styles. Participants were initially asked to rate how well each item described themselves on a 7-point scale (1=does not describe me at all, 7=completely describes me). The secure and dismissive attachment styles are measured with five items each, while the preoccupied and fearful attachment styles are measured with four items each. Participants are categorized into the attachment style group in which they scored the highest based on the scores obtained from the sub-scales. In the validity and reliability studies conducted by Sümer and Güngör on the Turkish adaptation of the scale, it was found that the Relationship Scales Questionnaire consists of four factors: secure, dismissive, fearful, and preoccupied. Additionally, the reliability coefficients for all dimensions of the scale were calculated between 54 and 61 using the test-retest method.[12]

3. Results

In our study, there were a total of 92 participants, consisting of 52 females and 40 males. Among the participants, 26.1% were from surgical specialties, 21.7% were from internal medicine, 23.9% were from basic medical sciences, and 28.3% were from family medicine. The number of participants who chose their specialization as their

first choice in the TUS exam was 54 (58.7%), while the number of those who did not choose it as their first choice was 38 (41.3%) (Table 1).

Among all participants, 14.1% had secure attachment, 57.6% had fearful attachment, 32.6% had preoccupied attachment, and 3.3% had dismissive attachment (Table 2). There was no significant difference regarding the participants' attachment styles based on their gender (Table 3).

Table 1

Personal information of our participants

		Number (n)	Percentage (%)
Gender	Male	52	56.5
	Female	40	43.5
Branch	Surgery	24	26.1
	Internal	20	21.7
	Basic medicine	22	23.9
	Family Medicine	26	28.3
Was it your first choice in TUS?	Yes	54	58.7
	No	38	41.3

Table 2

Attachment styles of participating physicians

	Number (n)	Percentage (%)
Secure attachment	13	14.1
Fearful attachment	53	57.6
Preoccupied attachment	30	32.6
Dismissive attachment	3	3.3

When we look at the attachment styles of the participants based on their fields of specialization, the rates of secure attachment were found to be 8.3% in surgical sciences, 25% in internal medicine, 19.2% in family medicine, and 4.5% in basic medicine (Table 4).

According to the results of the Kruskal Wallis test conducted to examine the relationship between participants' fields of specialization and attachment styles, there was no statistically significant difference regarding participants' attacment styles based on specialization field (Table 5).

There was no significant difference observed in terms of attacment style between participants who made their first choice in the Medical specialization exam (TUS) and those who did not (Table 6).

Table 3

Comparison of participants' attachment styles by gender

	Female			Male			Mann Whitney U	
	Number (n)	Percentage (%)	Mean Rank	Number (n)	Percentage (%)	Mean Rank	U	p
Secure attachment	6	11.5	47.69	7	17.5	44.95	978.00	.418
Fearful attachment	30	57.7	46.46	23	57.5	46.55	1042.00	.985
Preoccupied attachment	18	34.6	45.58	12	30	47.70	1088.00	.642

Table 4

Attachment styles of participants according to their specializations

		Secure attachment	Fearful attachment	Preoccupied attachment	Dismissive attachment
Surgery	No (n)	2	16	9	0
	Percentage (%)	8.3	66.7	37.5	0
Internal	No (n)	5	10	6	1
	Percentage (%)	25	50	30	5
Basıc	No (n)	1	13	7	2
	Percentage (%)	4.5	59.1	31.8	9.1
Family medicine	No (n)	5	14	8	0
	Percentage (%)	19.2	53.8	30.8	0

Table 5

The relationship between participants' specialty and attachment styles

	Surgery	Internal	Basıc medicine	Family medicine	Kruskal Wallis	
	Mean Rank	Mean Rank	Mean Rank	Mean Rank	H	p
Secure attachment	49.17	41.50	50.91	44.15	4.783	.188
Fearful attachment	42.33	50.00	45.82	48.23	1.432	.697
Preoccupied attachment	44.25	47.70	46.86	47.35	.365	.947
Dismissive attachment	48.00	45.70	43.82	48.00	4.201	.241

Table 6

The relationship between being the first choice in TUS and attachment styles

	Yes			No			Mann Whitney U	
	No(n)	Percentage (%)	Mean Rank	No(n)	Percentage (%)	Mean Rank	U	p
Secure attachment	8	14.8	46.19	5	13.2	46.95	1043.00	.823
Fearful attachment	29	53.7	48.30	24	63.2	43.95	929.00	.369
Preoccupied attachment	20	37	44.46	10	26.3	49.39	1136	.283
Dismissive attachment	1	1.9	47.15	2	5.3	45.58	1732.00	.367

4. Discussion

This is the first known study to evaluate the attachment styles of specialist physicians and to examine the difference between attachment styles, first choice in TUS, and specialty. According to our results, we found that specialist physicians most commonly had anxious attachment styles (%57.6 fearful, %32.6 preoccupied). Among the participants, %14.1 had secure attachment styles. The rate of dismissive attachment was quite low at %3.3. There was no significant difference in attachment styles between both female and male physicians according to gender. In a study conducted by Erözkan with university students, it was reported that male students had more secure attachment styles compared to female students, while female students tended to have more fearful attachment styles. Approximately 55% of the general population has secure attachment styles.[13] According to our results, the prevalence of attachment styles was different from those found in the general population.

The field of attachment theory can influence career orientation and decision-making.[5] We had hypothesized that individuals with a sense of personal competence, positive self-worth, and secure attachment are more likely to win their first choice in the TUS exam. According to our results, however, we did not find a significant relationship between the status of entering the first choice in TUS and attachment styles. In addition, when we evaluated the attachment styles of physicians specializing in surgical sciences, internal sciences, basic medicine and family medicine, there was no significant difference between departments and attachment styles.

In a previous study conducted with second year medical school students, the rate of secure attachment was found to be similar to the general population, and it was reported that those with secure attachment were more likely to choose primary care specialties[6]. Family medicine and internal medicine specialties, compared to basic medical sciences and surgical specialties, are more likely to involve frequent and extended interpersonal relationships. Therefore, it is assumed that the rates of secure attachment may be higher in these groups.[6] According to our results, although there was no statistically significant difference between branch selection and attachment styles, the secure attachment rate of family physicians and internal medicine physicians was higher. When evaluating the secure attachment rates among the four groups of physicians, it is noteworthy that the lowest rate was found in basic medical sciences This observation supports the assumption that specialties involving extended relationships with patients are more likely to demonstrate secure attachment style, since basic medical sciences specialty requires less interaction and shorter term relationships with patients.

There could be several reasons why we found a lower rate of secure attachment among our participants, which differs from other studies. Firstly, the relatively small sample size in our study could be one of the reasons. Secondly, adult attachment models change over time and can be especially unstable in high-risk and clinical populations.[14] Although the origins of adult attachment seem to stem from early caregiving experiences, it is believed that adults' outcomes are not entirely determined by them.[15-16] Thirdly, individuals can develop relationship-specific attachment styles that can adapt to different interpersonal experiences.[15] Our participants consisted of physicians who graduated from university and specialized in any branch. Many years of difficult working conditions and clinical experience may have influenced the attachment styles of physicians and may partly explain the difference in results. However, based on our study, we cannot distinguish whether the participants had insecure attachment styles from the beginning or whether these attachment styles developed as a reflection of practicing a demanding and exhausting profession for many years. We cannot adjust our results to the patient-physician relationship. These findings may reflect an individual's romantic or close interpersonal relationships. Furthermore, an individual's overall attachment orientation may only be applicable to specific individuals and relationships. For instance, an individual who exhibits an insecure attachment style in romantic relationships might develop a different attachment style in their professional life.[15-17] The attachment system has an important role in activating human capacities that promote survival. In adulthood, it is believed that insecure attachment patterns can have adaptive functions and may provide some advantages in a professional context. Anxious attachment is reported to facilitate being alert to possible dangers, rapidly responding to threat signals, and effectively taking action to diffuse a threat. In a study examining the behaviors of adult groups, it was observed that individuals with avoidance attachment escaped more quickly from a room filled with non-toxic smoke emanating from a malfunctioning computer, while individuals with high attachment anxiety noticed the smoke more quickly than other groups.[16-18]

We observed a high prevalence of anxious attachment in a profession that involves caregiving. Secure attachment enhances adults' tendency to provide care and increases their sensitivity to the needs of others. Individuals with fearful attachment, when combined with self-focused tendencies and concerns about being unable to reach out to others when needed, can interfere with sensitive caregiving. However, it is overly simplistic to suggest that secure attachment always supports effective caregiving or that insecure attachment necessarily leads to inadequate caregiving.[15-17] Research has shown that individuals with anxious attachment are also willing to engage in prosocial behaviors, including concern for the welfare of others, caregiving behaviors, and other community-oriented actions.[19]
Looking at the main specialty fields separately and assessing the relationship between the first choice in the TUS and attachment style is a strength of our study. The relatively small sample size is a limitation of our study. The use of a single assessment scale is another limitation. In addition, the lack of a assessment scale that evaluates the mental status of the participants an the lack of clinical interviews are among the limitations. The lack of statistically significant analyzes is also one of the limitations. Another limitation is not assessing the relationship between different attachment styles and specialization choice, neglecting to consider other important factors such as prestige, financial rewards, lifestyle, and intellectual challenge in

specialization choice.

5. Conclusions

According to our findings, the most common attachment style among physicians in any specialization was anxious attachment, and there was no significant relationship between the specialization field and attachment styles. However, although not statistically significant, the rate of secure attachment was higher among family physicians and internal medicine specialists compared to physicians in basic medical sciences and surgical specialties. Choosing the right field of specialization is of great importance in the future life of the physician, for her/his productivity, and the healthy maintenance of the patient-physician relationship. Determination of other possible motivational factors as well as attachment styles could provide guidance and insight to the physician in this choice that will affect her/his whole life. Further and more comprehensive studies on this subject may contribute to physicians in determining their professional life and future.

Statement of ethics

This study was conducted in accordance with the ethical principles of the Declaration of Helsinki and was approved by Başkent University Medical and Health Sciences Research Ethics Committee on 16.02.2021 with the approval number E-94603339-604.01.02-11640

Conflict of interest statement

Author declare that they have no financial conflict of interest with regard to the content of this report.

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