A Qualitative Examination of Attachment Styles in Women with Advanced Cancer Receiving Palliative Care

Neda Shahvaroughi-Farahani[1] (MSc), Hossein Eskandari[1] (PhD), Maral Hasan-Larijani[1] (MSc), Ahmad Borjali[1] (PhD), Mohaddeseh Rajabi[2] (MSc), Vahid Kaveh[3] (MD)

1. Department of Clinical and General Psychology, Faculty of Psychology and Educational Sciences, Allameh Tabataba'i University, Tehran, Iran
2. Department of Psychology, Palliative Care Ward, Firoozgar Hospital, ALA Cancer Prevention & Control Center (MACSA), Tehran, Iran
3. Department of Hematology and Medical Oncology, Faculty of Medicine, Iran University of Medical Sciences, Tehran, Iran

Submitted: 12 March 2019
Accepted: 22 April 2019

Int J Behav Sci. 2019; 13(1): 1-7

Corresponding Author:
Maral Hasan-Larijani,
Department of Clinical and General Psychology, Faculty of Psychology and Educational Sciences,
Allameh Tabataba'i University
Tehran, Iran
E-mail: larijani.maral@gmail.com

Abstract

Introduction: The primary purpose of "palliative care" is to ensure the highest quality of life in terminally ill patients. Regarding this issue, paying attention to and being aware of the patient's attachment style may contribute to a proper understanding of their needs as well as challenges, and can be seen as a critical factor in overcoming high-stress conditions. Thus, the aim of the present study is a qualitative examination of the role of attachment styles in women with advanced cancer receiving palliative care.

Method: In the present qualitative study, nine women suffering from advanced cancer who had been referred to palliative care in Firoozgar Hospital in Tehran, from January to March 2018, were selected through purposive sampling. To gather the data, the Adult Attachment Interview (AAI) was employed, and the data was analyzed through content analysis method.

Results: According to the results, the attachment of most participants was insecure (33% dismissive insecure attachment and 55% preoccupied insecure attachment).

Conclusion: Due to the stressful nature of the final stages of life in the palliative care context, paying attention to an individual's attachment style by caregivers and health care team may be crucial.

Keywords: Attachment, Advanced Cancer, Palliative Care, Qualitative

Introduction

The term "palliative care" is a broad concept which involves the management of the physical, psychological, social, spiritual, and existential needs of people with advanced illnesses and focuses on diseases in which remaining time is limited or they are resistant to treatment [1]. Cancer is one of such diseases and its diagnosis is still associated with an inescapable death even though a great number of people with cancer are treated [2]. The main purpose of palliative care is to ensure that the highest possible quality of life is obtained for the individuals whom, as consequences of their illness, may experience worse mental, social, and spiritual suffering compared to their physical condition [3]. Therefore, heeding these facets may contribute to the health and the quality of life of the patients, their families and even the healthcare team. Furthermore, considering the patient's attachment style may enable therapists and the patient's family to gain a deeper understanding of his/her needs and the challenges in palliative care [4].

Based on the attachment theory, attachment is a fundamental and an essential requirement [5], referring to a relatively stable emotional bond between two individuals [6]. According to Bowlby, attachment bond is a complex behavioral system that leads to relaxation and reduction of an individual's negative affective states during stressful periods

and at the same time, provides a basis for creation of an integrated, healthy, and realistic sense of self [7]. Accordingly, in a separate line of research on adult attachment patterns, using the Adult Attachment Interview (AAI) [8], four attachment styles associated with the attachment behavior of infants in adult relationships have been termed as free (autonomous), dismissive (avoidant), enmeshed (preoccupied), and unresolved [9].

Attachment and the quality of the early relationship between the child and the caregiver is indicative of an important context that can reveal a stressful environment and an early loss [10,11] which itself is associated with illness [12], meaning that stress may suppress the immune system and increase the vulnerability to infection [13]. Studies show that there is a significant relationship between preoccupied attachment style and infectious diseases and cancer [14–16]. Moreover, an insecure attachment style is associated with the experience of more negative emotions in adulthood [17], which is also observed in patients with cancer [18]. In addition, the attachment style and the quality of early relationships affect the individuals' current relationships [10,11], and it has been held that interpersonal challenges follow the maladaptive attachment schemas [19,20].

Accordingly, it seems that the study of attachment styles and the quality of private relationships, as key factors in emotional regulation while experiencing a stressful situation, [21] as well as rich sources of social support that can increase adaptability to illness and medical care as a stressor [22], is critical. Further, the mentioned concept may be employed to understand the pattern of the physician-patient relationship [23], illness behavior [21], therapeutic compliance [4], cancer compatibility [14], mental health and quality of life [24], the perception of pain [25,26], and explanation of patients' death anxiety [27].

Nevertheless, few studies have examined the role of attachment styles in a palliative context. The results of these studies suggest that attachment theory can be used to facilitate family relationships [28] and to determine factors affecting depression and frustration in patients with advanced cancer [29]. In this regard, Tan and her colleagues [30], and Petersen and Koehler [31] have tried to apply the attachment theory to analyze interpersonal processes in palliative care. Also, Milberg and her colleagues [32] studied the significance of "secure base" from the perspective of patients and their relatives in home care. They found that mediation of security (for example, providing a familiar environment or the growth of trust in caregivers) in end-stage patients creates a sense of control, inner peace, and hope, and helps the patients to cope with their last days. It can be concluded that the provision of a stable and secure relationship can help end-stage patients to better deal with their conditions. This can be explained by the fact that the feelings of security and stability, as it is the case for children, can support the patient's cognitive and emotional exploratory behavior by attending sufficiently to the existential questions appearing at the end of life [33].

Likewise, familiarity with what lies behind the patient's behavior, wishes, and needs may result in increased responsiveness of the caregiver which leads to the improvement of the patient's quality of life in palliative care. For instance, patients with an enmeshed attachment pattern can maintain their emotional balance having very stable and predictable support [30]. Therapists and physicians, who recognize and consider different attachment styles, can understand better and can decrease the patient's conflicting symptoms and behaviors in light of their insecure attachment style and as a result, adopt an appropriate care approach. Studies indicate that understanding the patient's attachment style has a beneficial effect on the therapeutic relationship between the patient and physician and increases the caregiving outcomes [34,35].

Considering what was stated earlier and the importance of attachment styles in health psychology--as an indicator that has always been emphasized in the field of the risk of physical illness and maintaining and improving quality of life, mental health, and patient adaptability-this concept has so far been under-represented at the end of life and palliative care context in Iran. The literature does not clarify the attachment style among women with advanced cancer. Besides, in most studies, self-report instruments have been used which can influence their responses. Therefore, there seems to be a need for a study that can build a connection between the research and clinical viewpoints and deeply examine attachment pathology and the patient's initial relationship in palliative care. Accordingly, the present study employed the AAI to examine the attachment styles qualitatively in women with advanced cancer receiving palliative care.

Method

The present study was a qualitative study and its population, consisted of all adult women with advanced cancer who had been referred to palliative care at Firoozgar Hospital in Tehran from January to March 2018. Using related tests such as CT-Scan, MRI, and clinical examination, the population had been diagnosed with advanced cancer (metastasis) by an oncologist over the past six months. The participants were selected through purposive sampling method, which continued until data saturation.

The inclusion criteria consisted of the disease stage (advanced and metastatic), gender (woman), marital status (with at least one marriage record), and age (between 30 and 60). Among the other criteria for joining the interview, the ability to speak and the absence of cognitive-perceptual disorders, which were approved by a psychiatrist and the other members of the patient health care team can be mentioned. Having an Iranian nationality and the willingness to participate in this research were considered as the other criteria. Among the criteria for excluding patients from this study, we can refer to the brain metastatic, which influences their answers. Moreover, patients with a history of psychotherapy were excluded from this study.

In this study, AAI was employed which is a semi-

structured interview. It evaluates people's mental representations of attachment and perceived family experiences associated with attachment. To do so, individuals were divided into four attachment styles: secure, dismissive, preoccupied and unresolved [36]. The psychometric properties of AAI were first evaluated by George et al. [8]. Also, AAI classification stability was shown [37]. The related literature also confirms that AAI has both a satisfactory validity and an appropriate discriminated validity [38,39]. Moreover, the content validity of this interview was examined in a study by Lorito and Scrima [40]. The AAI consists of 20 questions and on average lasts for 60 minutes.

At the beginning with regards to the inclusion and exclusion criteria, the participations were selected through a purposive sampling among the women with advanced cancer who had been referred to the palliative care in Firoozgar Hospital in Tehran from January to March 2018. Prior to interviewing, explanations were given about the confidentiality of the issues discussed, the purposes of the study, and audio file preservation and the participants were ensured that the information would only be used for the purposes of study without mentioning the identity of the participant. The rights to leave the interview at any time and to withdraw from the research were among the other ethical considerations that were observed. Data collection continued to reach relative saturation. Finally, 9 people were interviewed as the participants of this study.

Initially, the recorded interviews were transcribed in Word software. Then, they were reviewed several times in order to gain an insight into the feelings and experiences of the participants and the key phrases from each interview that represented specific codes were identified. Following the code extraction, the researcher carefully studied the concepts and categorized the codes based on their similarity. Finally, a comprehensive description of the individual attachment style was presented. For analyzing the data, content analysis was employed.

In order to evaluate the credibility and dependability of the research findings, the two methods of member check and the peer reviewer were used. Following the completion of the individual data analysis, the findings were checked with the participants, and the data were also analyzed one more time by psychologists in the palliative care in Firoozgar Hospital and compared with the results of the researcher.

Results

In this study, nine women with advanced cancer who were qualified for participation in the study with regards to the research criteria were interviewed. The average age of the participants was 44.2 years; the youngest and oldest participants were 33 and 54 years old respectively. A more detailed account of the participants' demographic characteristics is given in Table 1.

First, based on adult attachment theories, each type of attachment was divided into two categories of narrative coherence and narrative content (experiences related to attachment). Then, for each type of attachment, specific open codes were considered. Finally, the key phrases for each interview in accordance with the mentioned model were presented and each individual's attachment was clarified based on its frequency. In Tables 2 to 4, the coding of the participants' attachment styles is explained.

- Secure Attachment Style

- The use of wide range of emotional and influential words:

No. 2: "The Turkmens have a custom [which dictates] that whatever form God has given to your face, you should not touch and change it; your face should remain the same, and you have to die as you were born. But I did pluck my eyebrows when I was young. My family and my husband's family were upset; they said {that} "this is a sinful act". Then I took a Qur'an course and I became a Kari (someone who has the ability to read the Holy Qur'an with a pleasant voice). Later, I became very penitent for having plucked my eyebrows, dying my hair and things like that. I had changed and I was more into religion when it (cancer) happened to me. At first, I was horrified, but I finally accepted it. Perhaps, if I had been as I used to, I wouldn't have accepted mastectomy. I thank God so much for this. God gave me this awareness and then this happened to me."

- Creative problem solving:

No. 2: "My husband was unemployed in those early days. I cooked traditional dishes, and lowered their price {for people} to buy from us." (Table 2)

Table 1. Participants' demographic information code

	Cancer Type	Age	Marital Status	Education	Job	No. of Children
1	Breast	36	Married	Diploma	Housewife	1
2	Breast	45	Married	Middle school	Housewife	3
3	Breast	54	Separated	Diploma	Retired	3
4	Breast	42	Separated	Middle school	Housewife	2
5	Colon	33	Divorced/ married	Diploma	Housewife	1
6	Colon	53	Married	Associate's degree	Retired	0
7	Ovarian	46	Married	Middle school	Housewife	3
8	Ovarian	37	Divorced/ married	Middle school	Housewife	4
9	Cervix	52	Married	Middle school	Housewife	5

Table 2. Secure Attachment Style

Theme	Category	Open code	Frequency
Secure Attachment	Narrative Coherence	Easy access to memories and remind them	1
		understandable and logical connections while expressing statements	
		Mentioning both positive and negative things at the same time	
		Responses relevant to the topic	
		Expression of experiences in a concise and integrated way	
		Use of the wide range of emotional and influential words	
	Narrative Content	Expressing good memories	
		Creative problem solving	
		Looking for others' support	
		Having sufficient supportive sources to deal with distress	
		Awareness of the impact of initial relationships of attachment and appreciating it	
		Use of the high-level defense mechanisms (such as humor and sublimation)	
		Stable intimate relationship	

- Dismissive Attachment Style

- Difficulty in remembering events:

No 1, 8 and 9: "I don't remember / I can't remember (in response to the request for expressing childhood memories related to parents)".

- Expression of hardships and bad memories without proper emotional expression:

No. 1: "My brother died when he was 12 years old. I think I was eight. We didn't understand anything. At first they didn't tell us. Then we saw that he didn't come home. Then we found out (without emotional expression)".

- Idealization of parents:

No. 9: "I loved my dad. He was definitely a great man."

- Use of general and vague sentences:

No. 1: "Both are good (While describing parents), like all other parents in other villages."

No. 8: "It was good (in response to describing her relationship with her parents)."

- Normalizing negative experiences:

No. 1: "He just died. He shouldn't have died like this (brother's death)"

- Emphasis on personal power and independence:

No. 9: "I try to do my own work. I'm more comfortable alone. I was alone in chemo-therapy and surgery as well."

- Experience of rejection from parents and lack of emotional access to parents:

No. 1: "My mom and dad were on the farm every day from morning until sunset. They used to come home too tired. My older sister was taking care of us and she used to beat us. When she got married, I was so happy."

- Denying or diminishing the importance of the impact of attachment and the initial painful experiences:

No. 1: "Such things happen for everyone in life (brother's death)"

No. 1: "Everyone was like this in villages (lack of relationship with parents)"

- Avoiding emotional closeness and not looking for intimacy (emotional avoidance):

No. 8: "I have no intimate friends. I'm not intimate with my sisters and mom, as some are; we don't have any specific problem with each other but we're not intimate either." (see table 3)

Table 3. Dismissive attachment style

Theme	Category	Open Code	Frequency
Dismissive Insecure Attachment	Narrative Coherence	Use of general and vague sentences	3
		Difficulty in remembering the events	
		Expression of hardships and bad memories without proper emotional expression	
		Idealization of parents	
		Use of the low number of negative emotional words	
		Normalizing negative experiences	
	Narrative Content	Emphasis on personal power and independence	
		Not experiencing positive emotions properly	
		Experience of rejection from parents	
		Denying or diminishing the importance of the impact of attachment and the initial painful experiences	
		Avoiding emotional closeness and not looking for intimacy (emotional avoidance)	
		Expressing painful memories emotionless and in a completely rationalized way	
		Parental death or a lack of emotional access to parents	
		Use of the withdrawal, denial, repression, isolation of affect, and rationalization as defense mechanisms	

- Preoccupied Attachment Style

- Extreme engagement in past events and bad memories:

No. 4: "I constantly remember the moment I was given Nahid's death news (her 21 year old daughter), and the time of her burial. I picture the time when she was committing suicide. I blame my husband for my daughter's suicide. He always used to hurt and forced her."

- Rumination and negative repetitive thoughts:

No. 4: "My mother is the reason for all the problems in my life. I can't forgive her at all (the patient repeated this issue several times during the interview)"

- Feelings of guilt and constant criticism:

No. 6: "I've always had a guilty conscience; I feel guilty for troubling others a lot. You know, when I was 11 years old, my mother died and my dad got married. My stepmother annoyed me so much that I went to my sister's home and lived there for nearly 20 years. I was careful not to do anything bad. I was always ashamed and I have a guilty conscience now."

- The conflict between rebellion and dependency:

No. 5: "Although I am very dependent on him, when he makes me angry, I do things that I know he doesn't like and makes him upset. I think it is because of my high dependence on him."

- Fear of losing:

No. 3: "I always kept silent in order to avoid my husband getting upset."

No. 5: "I'm always stressed that my husband may abandon me; I'm very dependent on him."

No. 7: "I don't want anyone to get upset because of me."

- Inconsistency in parenting and periodic rejection:

No. 7: "I don't know what happened to my real parents. I spent my childhood in an orphanage. There were lots of kids. They could not manage to take care of everyone there. That's why most of the time they didn't know we were feeling bad. We had to make a noise so they would come. But sometimes it was good."

- Tendency to magnify their distress:

No. 5: "I'm dying; no one takes care of me. I feel so bad. when I am at home, I become angry and upset because of my husband and when I am here, I become upset since Parastoo (her daughter) is away and my husband doesn't visit me. I'm so miserable. I can't do anything (she cried with a loud noise)."(Table 4)

Content analysis results revealed that 1 individual (11% of the sample group with advanced cancer) had a secure attachment style, 3 (33%) had dismissive and the 5 others, equal to 55% of the participants, had a preoccupied attachment style. The results of the content analysis of the attachment styles are presented separately in Table 5.

Table 4. Preoccupied attachment style

Theme	Category	Open code	Frequency
Preoccupied Insecure Attachment	Narrative Coherence	Use of the high number of negative emotional words	5
		Incoherent and confusing narrative	
		irrelevant responses	
		Long answers	
		Extreme engagement in past events and bad memories	
		Fluctuations in the evaluation of experiences and contradictions in speech	
		Extreme self-analytic style	
	Narrative Content	Rumination and negative repetitive thoughts	
		Use of negative emotion-focused coping strategies that increase tension and distress	
		Displacement of the roles	
		Feelings of guilt and constant criticism	
		Presence of an anxious mother	
		Numerous yet contradictory and clingy relationships	
		The conflict between rebellion and dependency	
		The inability of caregivers to reduce child's tension (Parents who cannot have a supportive role)	
		Fear of losing	
		Inconsistency in parenting and periodic rejection	
		Tendency to magnify their distress	

Table 5. Comparison of attachment styles among participants

Attachment Styles	Patient Code	Frequency	Percentage
Secure	2	1	11.11
Dismissive Insecure	1/8/9	3	33.33
Preoccupied Insecure	3/4/5/6/7	5	55.55

Discussion

The aim of the present study was to qualitatively examine a concept that is very significant in palliative care: attachment style. Since the concept of attachment at the final stages of life and the palliative context have received less attention in Iran, employing the AAI to this study aimed at the qualitative investigation of attachment styles in women with advanced cancer who had referred to the palliative care of Firoozgar Hospital.

To answer the question of the study, content analysis was conducted based on a semi-structured attachment interview. The findings demonstrated that a majority of these people had an insecure attachment; the most frequent attachment style was preoccupied attachment style with 5 patients with advanced cancer (55%), and next frequent style was dismissive attachment style with 3 patients (33%).

To expound the findings, the recurring patterns of attachment styles across the sample individuals should be referred to. The unavailability or insensitivity demonstrated by these women's caregivers is evident in their attachment interviews. This high percentage of insecure attachment can be indicative of the potential impact of this concept on cancer, which is in line with previous research [13]. An important point in this regard is the attachment style of more than half of the sample size which is preoccupied in association with physical diseases and cancer that has also been found in the past [14,15]. In explaining this finding, it should be noted that insecure attachments can be considered as defenses helping infants or adults to keep anxiety at a manageable level and achieve a moderate level of security [41]. The investigated sample required this defense in light of the disturbing relationships in their lives. These individuals have endured anxiety and negative emotions during their developmental history, which has always been associated with the weakening of their immune system. At the same time, one of the other most prominent findings of this research is the presence of dissociation in the participants which is a cause of the traumatic experience. Trauma does not occur in a vacuum; the preoccupied participants of the study have not found anyone who could have helped them to integrate emotions, and thus their painful emotions have become traumatic. Actually, the individuals have to dissociate the painful emotions of their experience, which results in the gap in the individual's experience [42]. In other words, dissociation is one of the costs that people with insecure attachments have to pay.

Likewise, the loss of one or both parents in the childhood of 5 of the 9 sample individuals are completely compliant with the attachment theory, which suggests that early loss of parents leads to depression in adulthood and probably more vulnerability against physical illness. On the other hand, the presence of dismissive attachment (avoidant) among women with advanced cancer can indicate poor screening behaviors that lead to advanced cancer due to their lack of attention to their physical symptoms. This finding is consistent with the Andersen study [43].

There were several limitations in conducting this study including the difficulty of interviewing end of life patients and discontinuing the conversation due to their physical condition. Also, the patient's death after the first interview and ethical challenges were among the limitations.

Hence ensuring generalizability, the replication of the current study with a similar population with other diseases in the end stages is suggested. It is also suggested that variables associated with the concept of attachment in palliative context to be studied. Additionally, based on the findings of this study, attention should be paid to the attachment style variable in case formulation during the treatment of cancer patients, and attachment-based therapy should be employed to reduce the harms caused by insecure attachment style in these patients.

Likewise, considering the impact of the individual's attachment style on his or her current relationship, it is suggested to have a better physician-patient relationship. Cancer patients' individual differences based on their attachment style are taught to physicians and health care team that leads to better services and ultimately improves the quality of life of the patients and their families, which is one of the main goals of palliative care. Furthermore, the health care team can be trained how to recognize the attachment styles of the patients and how to behave based on them. These findings are also effective in the treatment and remind us that most of these patients are likely to be fragile and vulnerable. As a result, attachment-based therapy and therapies that are focused on emotions and the therapeutic relationship can be suitable for health care teams.

Conclusion

By considering the results of this research (the insecure attachment of women with advanced cancer receiving palliative care as a stressful condition at the end of life), understanding the patient's behaviors, emotions, wishes, and needs can help caregivers and the health care team to treat the patient more appropriately. Achieving a proper understanding of the patients' needs based on their attachment style leads to better services and ultimately improves the quality of life of the patients and their families, which is one of the main goals of palliative care.

Acknowledgement

The authors would like to express all their gratitude to the ALA cancer prevention and control center (MACSA). Also, they would like to acknowledge the contributions of the other psychologists and staff of the palliative care in Firoozgar Hospital. Finally, they would like to thank all the cancer patients who participated in this research. Certainly, without their help, this study could not have been accomplished.

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