Original paper

Attachment styles, coping with stress, and social support among cancer patients

Marta Karbowa-Płowens

Faculty of Psychology and Cognitive Sciences, Adam Mickiewicz University, Poznań, Poland

Introduction: This paper presents the role of attachment style in determining an individual's way of coping with stress, which in turn helps to understand the differences in response and adjustment to cancer among cancer patients. Cancer is an illness that causes overwhelming distress, and dealing with it requires social support, among other coping strategies.

Material and methods: Studies show that social support is associated with a decrease in psychological symptoms and a better quality of life in cancer patients. According to attachment theory, one's perception of threat, way of signaling distress, and strategies of coping with it, with special consideration for the ability to use a partner's support, relies on differences in avoidance and anxiety (attachment style dimensions).

Results: People with high avoidance (associated with deactivating attachment strategy) tend not to seek support from others and rely on themselves.

Conclusions: People with high anxiety (associated with deactivating attachment strategy) tend to display strong emotional responses, permanently seek attention and support from others, and yet are less able to feel comforted by them.

Key words: attachment style, stress coping strategies, cancer patients.

Contemp Oncol (Pozn) 2023; 27 (2): 95–100
DOI: https://doi.org/10.5114/wo.2023.130015

Introduction

Trying to describe the psychological situation of cancer patients, researchers and theorists tackling this problem have searched for a term for the mental stress [1–5], and ultimately use the expression "cancer stress" [6]. For the description of a specific set of symptoms caused in the patients and their families (i.e. symptoms of the recurrence of the trauma, symptoms of arousal, or symptoms of avoidance), the concept of traumatic stress [7] is even used. We talk about traumatic stress when a person faces an event exceeding his/her past experiences and coping capabilities. A related threat to life and/or health raises fear and a sense of helplessness, leading to disorganisation of behaviour [8]. Cancer is intertwined with the phenomenon of stress and emotional distress in many ways. On one hand, impairment of the immune system as a result of negative experiences is now well documented with studies [1]. On the other hand, styles of coping with stress are not only connected with the risk of getting sick, but also with the course of treatment, together with the moment of its beginning [3]. Relations between the amount of stress and the disease run in 2 directions: stress may be simultaneously the aetiopathogenic factor of the disease and its consequence [9].

In psychology, the relational approach to stress by Lazarus and Folkman is widely accepted. According to this approach, stress is defined as the *determined relationship between the person and the environment, which is evaluated by the person as burdening or exceeding its resources and threatening his/her welfare* [9]. Paramount importance thus falls to the individual's subjective evaluation, and the mere event has relative value. An important place in the process of coping with stress is taken by generalised immune resources, characterised by Antonovsky [8], which *prevent the transformation of the tension into stress; helping to fight stressors, promoting health and healing processes*. Among them, the author mentions social support – a factor co-determining with personality resources the effectiveness of coping with extremely high stress. Assuming a functional way of understanding social support, we assume that this is an interaction, an exchange process with a different degree of accuracy, that is matching (qualitative and quantitative) between the received support and the required one [8]. Moreover, it turns out that people in varying degrees and in different ways are able to use the support of other people.

The concept of attachment [10, 11] creates theoretical frameworks allowing the history of individual differences in the styles of searching for and using the support of the loved ones by adults to be explained. It gives the possibility to characterise the consequences of these differences for the types of actions initiated in the process of coping with extreme stress. In a broader context this is also connected with the effectiveness of treating cancer.

Material and methods

Attachment theory

An attachment is formed in childhood through the relationship of the child with the main caregiver. It is defined using stages of the emotional relationship

between 2 people, or as the behavioural and motivational system, which is the product of evolution and is organised under the influence of experiences. Attachment in childhood provides the child with care and protection in times of danger (biological function). The conviction about the unwavering availability of the caregiver in connection with their responsive and sensitive care in moments of distress and concern experienced by the child, constitutes its internal sense of security (psychological function). This function, consisting of the solace-bringing reduction of unpleasant stimulations of the child by the contact and attentiveness offered in close proximity and its effectiveness in meeting the needs and regulating the child's emotions, is defined by the metaphorical term of "safe haven" [12]. Thanks to optimal interaction with the caregiver, the child develops the internal resource of a sense of security and confidence, so that even if it is lost for a moment, it can be recovered. This resource opens up a way of getting to know the environment for the child, and this function is called *safe base (of exploration)*. It should be emphasised that this is the case only in reference to an optimally functioning welfare environment. Interferences or deficits in care lead to constitution of insecure attachment patterns, which require "psychologically burdensome" adaptation to the way of functioning of the caregiver, so that it is possible to achieve relative closeness to them [12, 13]. The adaptation takes place not only on the behavioural level. The way of experiencing and expressing emotions (especially negative ones) in the presence of the caregiver is compatible to the baby's reactivity to them [14]. This implies the ability of the child to predict the caregiver's reactions and the results of its own actions, and the planning of the right responses based on this knowledge (to some extent unconscious).

Cumulative experiences concerning the course of interaction with the caregiver are stored in the form of mental representations associated with affect – internal working models of attachment. These models are the central point of the theory, because they allow the understanding of individual differences in attachment and their transfer to other relations [15]. Working models of attachment content determines the style of perception and interpretation of interpersonal events, with the method by which the system of attachment functions (at various levels: emotional, behavioural, and cognitive) – its reactivity and regulation [16, 17]. Working models of attachment serve as a guide in contact with other people, determining our way of understanding their motivation, intentions and goals. They also influence the way of experiencing and the expression of our needs in these relations. The fact that models created in the pre-verbal period have a sensomotoric nature, they are unconscious, and therefore quite resistant to change is important. Attachment is the primary regulator and organiser of emotional, cognitive, as well as physiological and neuropsychological phenomena. Experiences of this relation (ship) are considered to be the matrix of later self-regulatory possibilities [13].

Attachment styles in adulthood

The concept of attachment was created in the context of relations of children and their caregivers, so it is not surprising that at first it was used mostly in this area. As a theory of personality development, however, it is also applied to explain the interpersonal and intrapsychic aspects of the functioning of adults. The most direct transfer to the ground of love relations in adulthood was made by Hazan *et al*. [11]. They described romantic love within the framework of attachment processes, and their conceptualisation of partners' attachment styles was made by an analogy to the models of attachments described by Ainsworth *et al*., observed in infants [12]. Styles of attachment mean *permanent differences in the way of thinking, feeling and behaviour in relationships with people close to us, rooted in individual differences within the working models of self and others* [17].

Because tools used for the diagnosis of the attachment styles in adults are heterogenic, they give rise to systems of classification of attachment which are not always congruent – 3 of 4 categories, based on 2 or 3 dimensions [18]. The 4-category system, based on 2 dimensions will be presented below. These dimensions are interpreted once as fear and avoidance [19] and another time as models of self and others [20, 21].

Secure style

People presenting this style have a feeling that they are loved and worthy of love (positive model of self). They expect from other people care, kindness, acceptance, and responsiveness (positive model of others, low anxiety), so they do not avoid physical closeness, intimacy, and interdependence in the relationship (low avoidance). The desire to establish a close relationship with the other person does not exclude the need of autonomy, which is manifested in the search for balance in the implementation of these 2 motives in the relationship. They have a quite stable feeling of self-worth, relatively independent of the opinions of other people.

Preoccupied style

These people do not feel valuable and worthy of love (negative model of self). They perceive others in a positive light (positive model of others), but due to their low self-esteem they are afraid of rejection or abandonment. The reasons for the potential rejection from others (high anxiety) are perceived by the people in themselves. The source of their self-acceptance is approval from important people, with whom the person really wants to establish a close relationship (low avoidance of intimacy). A person striving for intimacy when intensified by a fear of rejection takes on an extreme form, often leading to the resignation of their own autonomy.

Fearful-avoidant style

People with this style are characterised by the combination of negative models of self and others – perceived as unreliable, prone to rejection (high anxiety). Their protection from rejection is the avoidance of engaging in close relationships (high avoidance of intimacy). The positive self-esteem of these people is dependent on the acceptance of others.

Dismissing-avoidant style

People with this style have positive models of self and negative models of others. In order not to suffer disappointment from other people, who are perceived as irresponsive and unworthy of trust, they avoid engagement in close relations (high avoidance of intimacy), distance themselves psychologically, and limit the expression of their own feelings in the service of meeting their need for independence and autonomy.

Results

The presented beliefs about self and others are not only accompanied by the characteristic for particular types of attachment behavioural tendencies, implemented in times of stress (as the already mentioned aspiration to or the avoidance of closeness and intimacy). A distinct feature of each particular style is also the corresponding strategies for emotional regulation [22], the way of experiencing and expressing distress, and reacting in response to its occurrence [23].

Attachment, stress, and social support

The attachment system is mostly activated by signals of threat – real or symbolic – of external or internal origin [10, 24]. This leads not only to behaviours of searching for closeness and support of the attachment figures, but the mere invoking of memories concerning the course of interactions giving a sense of security with the given person meets the same soothing and restoring comfort functions as their physical presence [24]. This statement is true when the previous history of relations with the attachment figure was characterised by warmth, love, and most of all adequate support and help in need. As we know, such a model of relations is not universal. Let us follow the consequences secondary attachment strategies have for the process of searching support. Secondary strategies are appropriate to the nonsecure styles, which are the ones assuming deactivation and/or hyperactivation of the attachment system [25]. The term "secondary strategies" shows the failure in obtaining closeness and care of a partner. In this case, the direct search for closeness, open communication of needs, and relying on the availability of the partner (differentiators of the safe style) turned out to be ineffective for various reasons, which raised the necessity to develop a different strategy of management and the specific state of mind allowing a subject to cope with the distress growing in these conditions.

Discussion

Mikulincer *et al*. [25], among the factors contributing to the deactivation of strategies, list the repeated lack of attention, rejection, or hostile reactions of the partner; the risk of punishment in response to the attempts of searching for closeness; violence or abuse by the partner; direct or indirect disclosure of the demands of the partner for the greater independence of the other person or expectation that he/she will suppress the expression of their own needs and all signs of weakness.

The hyperactivation of the attachment system is favoured, according to the authors, by the following conditions: inadequate and unpredictable caring actions of the partner, which are not complementary responses to the needs and searching for help by the other partner; intrusive care, which undermines the self-regulatory competence owned by the person and serves as a punishment for the attempts at autonomous coping; communicating by the partner – directly or indirectly – that thee individual is incompetent and weak; and traumatic experiences or experiences of abuse that took place during separation from the partner. As the authors further indicate, the described conditions create a kind of ambivalence, consisting of the alternating experiences of reinforcements and punishments from the partner. However, avoiding the partner is even more dangerous for an individual who often shows deficits in self-regulation.

The essence of deactivation of the system is *denying the need to attach and compulsive self-reliance*. Such people reject information about threat and the need for closeness and support of the partner. Staying in the relationship, they try to draw from it what they need, while keeping a psychological distance, control, and independence. They are reluctant to engage in intimacy, reveal themselves, allow interdependence, or give emotional commitment. It is characteristic for them to ignore or deny their own needs (especially those engaging attachment, e.g. the need for care) and suppress the expression of negative emotions, as well as the suppression of thoughts and feelings connected with attachment (especially those concerning their own weakness or dependency). In general, all contents that could activate the attachment system are blocked. This is also connected with the omission of important information about psychological or physical threats. This strategy constitutes the dismissing-avoidant style and is consistent with the already quoted description of a specific perception of self (appearing to themselves as strong and not susceptible to injury) and other people (assessed as untrustworthy).

Hyperactivation of the attachment system consists of intensification of the primary strategy, i.e. intensive monitoring of a partner's actions and a continual search for closeness with them, which sometimes takes on the form of controlling behaviours and excessive "sticking" to the partner with the co-existent desire to "melt with him in unity". It is worth noting that this may lead to the deliberate or unconscious exaggeration of problems and threats of a mental or physical nature, intensification of the expression of experienced distress, and manifestation of personal hopelessness and dependence in order to draw the partner's attention and to "provoke" them to help. These people are characterised by the desire for constant attention, closeness, and care from the partner. Moreover, this strategy is connected with the difficulty to control the spreading of a launched wave of negative thoughts and feelings that expose the person to frequent exposure to very strong negative emotions and increases the availability of thoughts connected with the threat. This strategy is right for the preoccupied style.

An interesting case includes the people characterised by the anxiety-avoidant style, who apply both strategies in an incomplete, chaotic and random manner. On one hand, they often cope with an emotionally difficult situation by distancing themselves from the partner, because they are afraid of his/her unavailability, while on the other, they want love and support, which is why they look for their closeness. This kind of functioning in relation to attachment is considered to be the most psychologically burdensome, because in principle it is the marker of ineffectiveness both of the primary strategy and of the 2 described secondary strategies.

The presented differences in the method of organisation of the attachment system are coupled with the competence of the individuals in their effective signalling of the need for help and in using the support of others. They are also closely associated with the style of perception of the threat and reacting in an environment of stress. Empirical reports confirm the existence of the relationship between the styles of attachment and the types of response to stress [23, 26, 27].

Using the reports of other authors and relying on the 2-dimensional model of attachment (dimension of anxiety and avoidance) Ein-Dor *et al*. [24] report in their article the characteristics diversifying the attachment styles: perception of threat, way of signalling distress, and strategies of coping with it, with special consideration for the ability to use a partner's support.

As is indicated by the authors, people who get high results on the already mentioned dimension of anxiety are "sensitive" to the perception of potential threats and usually assess them as greater than people with low anxiety, especially in unclearly determined or new situations. They are characterised by strong and quickly actuated reactions to ambiguous signals of threat and prompt informing others about their own concerns. If the environment does not respond with support, these people then increase their effort of obtaining attention and thus usually reduce the distance and maintain the closeness when they experience something stressful or emotionally burdensome. Focusing on their own distress and experienced internal tension goes hand in hand with the frequent use of passive strategies of coping, concentrated more on their emotions than on constructively solving the problem [27]. As the studies on the relations between attachment and hypochondria show, anxiety-avoidant patients intensively demand care from medical staff, and at the same time they perceive the received care as inadequate [28]. Manifestation of anger and discontent because of this, in connection with permanent attention seeking, may provoke rejecting reactions of doctors and nurses, capturing the patient's frustration and his/her previous convictions.

However, we should distinguish the declared need for support from its actual implementation. It turns out that it is characteristic for these people's ambivalence between approach and avoidance to increase both when the partner shows his/her feelings and strives for closeness, as well as when he/she signals withdrawal from the relationship and the need for distance [29]. Although highly anxious people (with respect to the feeling of attachment) present themselves as weak and requiring care and help in order to gain the attention and love of others, they also have many concerns about the potential reaction of the partner, which in turn motivates them to avoid closeness. As was shown by Mikulincer's studies [30], the tendency to decrease self-esteem in these people is strengthened in conditions of threat to the relationship with a close person. With high probability it can be assumed that the disease of one of the partners is a challenge for the relationship, which may intensify the already high concerns that the partner will leave them.

People with high results on the avoidance dimension (those using mostly strategies of the attachment system deactivation) present a quite different model of functioning. Firstly, they rarely evaluate the events in terms of threats (or they minimise their importance); secondly, troubled with anxiety or distress they do not allow their exploitation (what is more, it is characteristic for them to deny negative emotions, suppressing unpleasant thoughts and memories and distraction from the threat). They do not signal to the environment their need for help, and they try to cope with emotional difficulties on their own. Their main strategy of coping with stress is distancing and reducing the tension by avoiding confrontation with the problem and their own emotions [27]. According to research by Szymczak [31], patients with lung cancer, like people with the safe attachment style, do not exacerbate the anxiety response in the situation of threat (waiting for surgical treatment).

It is worth noting that the essence of the repressive style of defence against negative emotions and impulses, which is characteristic for these people, is blocking access of the unpleasant contents of consciousness. As a result, in the subject's experience there is no feeling of anxiety, which does not mean its complete reduction [32]. This fear is manifested indirectly, in high physiological arousal (in increased heartbeat and in elevated electro-dermal activity) while talking about experiences of attachment and while imagining their own emotions in interactions causing anger with the partner [33–35]. What is important, the deactivation strategy "breaks down" in conditions of very strong stress, confronting the person with great anxiety [36], for which no coping strategies have been developed. In the case of people with a high result on the avoidance scale, for whom independence and self-reliance are important components of the positive self-image, and the feeling of control and influence on events constitute their identity, all situations threatening this image will provoke habitual strategies of regulation, leading to a defensive increasing of self-esteem [33]. So, it can be assumed that since cancer, especially during the chronic period, is connected with *the necessity to limit the previous professional activity, disturbances within the accomplishment of the objectives, difficulties in accomplishment of social and family roles*... [4, 33] and confronts an individual with their weaknesses as well as with a dependency on others (medical staff, family, etc.). For this reason, this situation is specifically psychologically difficult for people with the avoiding attachment style, who, as it can be assumed, will paradoxically then intensify

the tendency to sustain the feeling of independence and self-sufficiency by refraining from seeking help from others.

People with low scores on both dimensions (safe style) exhibit the following pattern to cope in the situation of stress: they rightly recognise their own condition, are capable of both seeking solutions and implementing in their life constructive coping actions, as well as using the emotional and instrumental support of other people [27]. These people have an optimistic vision of events in a stressful situation. They are convinced that they can cope with distress, the external obstacles can be eliminated, and the emotional balance can be, sooner or later, recovered [36].

Conclusions

Deepening the knowledge on the topic of the quality of individual differences in attachment may turn out to be especially helpful in the situation of experts helping cancer patients. Attachment styles define the way of communicating needs and emotions to the environment and the strategies of coping with stress (including its exploration and accepting the support of relatives). We should keep in mind that the increased or decreased signalisation of distress is not always a conscious choice of the patient. Sometimes this is the "habitual" way of functioning, shaped in early childhood, thus being out of an individual's control. In light of the presented data, 2 tasks may be indicated, which are ahead of the medical staff in contact with cancer patients: especially the need to clearly communicate to patients who deactivate their attachment system in a stressful situation the intention to provide care and support; and to relate with patience and forbearance towards the "demanding" of care by people hyper-activating the attachment system and to strengthen their competence in self-coping with stress.

The author declares no conflict of interest.

References

1. Andersen BL, Kiecolt-Glaser JK, Glaser R. A biobehavioral model of cancer stress and disease course. Am Psychol 1994; 49: 389-404.
2. Basińska B. Radzenie sobie z konfrontacją stresową a kontinuum zdrowie-choroba nowotworowa. Psychoonkologia 2001; 8: 25-33.
3. Chojnacka-Szawłowska G. Strategie radzenia sobie z zagrożeniem a stopień zaawansowania choroby nowotworowej w okresie jej diagnozowania. Psychoonkologia 2001; 8: 9-17.
4. De Walden-Gałuszko K. Wybrane zagadnienia psychoonkologii i psychotanatologii. Psychologiczne aspekty choroby nowotworowej, umierania i śmierci. Wydawnictwo Uniwersytetu Gdańskiego, Gdańsk 1992.
5. Norton TR, Manne SL, Rubin S, et al. Ovarian cancer patients' psychological distress: the role of physical impairment, percieved unsupportive family and friend behavior, percieved control, and self-esteem. Health Psychol 2005; 24: 143-152.
6. Piskozub M. Neotyczno-duchowy wymiar osobowości w procesie radzenia sobie ze stresem onkologicznym. Psychoonkologia 2010; 1: 1-13.
7. Baran J. Zastosowanie koncepcji stresu traumatycznego w badaniach dzieci z chorobami nowotworowymi i ich rodziców. Psychoonkologia 2009; 1-2: 28-32.
8. Sęk H. Wprowadzenie do psychologii klinicznej. Wydawnictwo Naukowe Scholar, Warszawa 2003.
9. Heszen I. Kliniczna psychologia zdrowia. [W:] Psychologia kliniczna. Sęk H (red.). Wydawnictwo Naukowe PWN, Warszawa 2005; 222-243.
10. Bowlby J. Przywiązanie. Wydawnictwo Naukowe PWN, Warszawa 2007.
11. Hazan C, Shaver PR. Romantic love conceptualized as an attachment process. J Pers Soc Psychol 1987; 52: 511-524.
12. Ainsworth MDS, Blehar M, Waters E, Wall S. Patterns of attachment: a psychological study of the strange situation. Erlbaum, Hillsdale, New Jersey 1978.
13. Stawicka M. Autodestruktywność dziecięca w świetle teorii przywiązania. Wydawnictwo Uniwersytetu A. Mickiewicza, Poznań 2008.
14. Schaffer HR. Psychologia dziecka. Wydawnictwo Naukowe PWN, Warszawa 2007.
15. Sroufe LA. Emotional development: the organization of emotional life in the early years. Cambridge University Press, New York 1995.
16. Pietromonaco PR, Feldman-Barret LF. Attachment theory as an organizing Framework: a view from different levels of analysis. Gen Psychol 2000; 4: 107-110.
17. Collins NL, Guichard AC, Ford MB, Feeney BC. Working models of attachment: new development and emerging themes. W: Adult attachment: theory, research, and clinical Implications. Rholes WS, Simpson JA (red.). Guilford Press, New York 2004; 196-239.
18. Stein H, Koontz AD, Fonagy P, et al. Adult attachment: what are the underlying dimensions? Psychol Psychother 2002; 75: 77-91.
19. Brennan KA, Clark CL, Shaver P. Self-report measures of adult romantic attachment: an integrative overview. [W:] Attachment theory and close relationships. Simpson JA, Rholes WS (red.). Guilford Press, New York 1998; 46-76.
20. Bartholomew K, Horowitz LM. Attachment styles among young adults: a test of fourcategory model. J Pers Soc Psychol 1991; 61: 226-244.
21. Griffin DW, Bartholomew K. Models of the self and other: fundamental dimensions underlying measures of adult attachment. J Pers Soc Psychol 1994; 67: 430-445.
22. Kobak R, Sceery A. Attachment in late adolescence: working models, affect regulation, and representation of self and others. Child Dev 1988; 59: 135-146.
23. Kemp MA, Neimeyer GJ. Interpersonal attachment: experiencing, expressing, and coping with stress. J Couns Psychol 1999; 3: 388-394.
24. Ein-Dor T, Mikulincer M, Shaver PR. Attachment insecurities and the processing of threat-related information: studying the schemat involved in insecure people's coping strategies. J Pers Soc Psychol 2011; 101: 1-16.
25. Mikulincer M, Shaver PR. Attachment in adulthood: structure, dynamics, and change. The Guilford Press, New York 2007.
26. Armsden GC, Greenberg MT. The inventory of parent and peer attachment: individual differences and their relationship to psychological well-being in adolescence. J Youth Adolesc 1987; 16: 427-54.
27. Mikulincer M, Florian V, Weller A. Attachment styles, coping strategies, and posttraumatic psychological distress: the impact of the Gulf War in Israel. J Pers Soc Psychol 1993; 64: 817-826.
28. Noyes R, Stuart SP, Langbehn DR, et al. Test of an interpersonal model of hypochondriasis. Psychosom Med 2003; 65: 292-300.
29. Mikulincer M, Shaver PR, Bar-On N, Ein-Dor T. The pushes and puls of close relationships: attachment insecurities and relational ambivalence. J Pers Soc Psychol 2010; 98: 450-468.
30. Mikulincer M. Adult attachment style and affect regulation: strategic variations in selfappraisal. J Pers Soc Psychol 1998; 75: 420-435.
31. Szymczak J. Style przywiązania a lęk u chorych na raka płuca zakwalifikowanych do leczenia chirurgicznego i u osób zdrowych. Psychoonkologia 2001; 9: 53-62.
32. Mikulincer O, Orbach I. Attachment styles and repressive defensiveness: the accessibility and architecture of affective memories. J Pers Soc Psychol 1995; 68: 917-25.
33. Mikulincer M. Adult attachment style and individual differences in functional versus dysfunctional experiences of anger. J Pers Soc Psychol 1998; 74: 513-524.

34. Dozier M, Kobak RR. Psychophysiology in attachment interviews: converging evidence for deactivating strategies. Child Dev 1992; 63: 1473-1480.
35. Roisman GI, Tsai JL, Chiang KHS. The emotional integration of childhood experience: physiological, facial expressive, and self-reported emotional response during the Adult Attachment Interview. Dev Psychol 2004; 40: 776-789.
36. Shaver PR, Mikulincer M. Attachment styles. [W:] Handbook of individual differences in social behavior. Leary MR, Hoyle RH (red.). Guilford Press, New York 2009; 6: 2-81.

Address for correspondence

Marta Karbowa-Płowens, PhD
Faculty of Psychology and Cognitive Sciences
Adam Mickiewicz University
Poznań, Poland
e-mail: karbowa@gmail.com

Submitted: 16.10.2022
Accepted: 30.06.2023