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ORIGINAL ARTICLE

The effect of cancer patients' attachment orientations on their satisfaction of medical care

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Summary

Purpose: *To assess the effect of cancer patients' attachment patterns on their satisfaction of medical care.*

Methods: *This was a cross-sectional design study performed in an outpatient palliative care clinic. The sample consisted of 100 cancer patients. Participants completed the Greek versions of patients' satisfaction, and attachment orientation to close others (Family, Close Friends, Medical Care Providers).*

Results: *"Information/interaction with health-care professionals" subscale positively correlated with "disease duration". "Availability of care" subscale was negatively correlated with "discomfort with closeness", "anxiety", and "avoidance". "Information/interaction with health-care professionals" positively correlated with "metastasis", "chemotherapy", and "hormonotherapy", while "availability of care" had positive correlations with "education", "chemotherapy", and "hormonotherapy". Multiple regression model showed that "discomfort with closeness" was associated with "information/interaction with health-care professionals". Similarly, "chemotherapy" and "surgery" were positively associated with "information/interaction with health-care professionals". Disease duration was associated with increased satisfaction with "information/interaction with health-care professionals". Predictors of "availability of care" were "discomfort with closeness", "education", and "avoidance".*

Conclusions: *"Chemotherapy", "surgery" and "discomfort with closeness" predicted low satisfaction with "information/interaction with health-care professionals", while "discomfort with closeness" and "avoidance" predicted low satisfaction with "availability of care" and at the same time a high level of "education" predicted patients' satisfaction with "availability of care".*

Key words: *attachment, availability of care, cancer, communication, satisfaction*

Introduction

Patient satisfaction with care in oncology settings has been the subject of many studies [1-4]. With disease progression cancer patients begin to evaluate their quality of care [5]. Information provision about patient's illness, course of treatment, health-care professional's communication skills and patient's well-being, and expectations influence patients' satisfaction and should be evaluated [6-9]. Patient expectations are usually formed by cultural and social norms [10], past experience [11], and present knowledge [12]. Noticeably, patient satisfaction predicts appropriate use of services [13,14] and compliance, which in turn, influence successful treatment outcomes [15]. It is not solely about communication skills and information provision [16], but patient-healthcare professional's relationship is essential in order to reduce disease-related stress and anxiety [17].

Thoughts and images may trigger attachment needs, hence advanced illness may bring to light

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intense attachment needs [18]. Attachment theory pinpoints to patients' past experiences with health-care professionals and has been applied to clinical relationships. Patients threatened by an illness view health-care professionals as a

Additionally, attachment styles can help health-care professionals to understand patients' behavior [20], so that they can be prepared to recognize patients' attitudes and possible communication problems [21].

Patients with anxious attachment styles tend to have a more negative image of themselves, whereas patients with avoidant strategies they are characterized by a negative image of others [22]. The well-being of cancer patients can be affected by the way they feel with their health-care professionals and by any differences in their attachment styles. Trust between anxiously attached patients and health-care professionals can be difficult. They are not very comfortable asking questions and they don't really feel that their clinicians view and treat them as a whole person, thus resulting in fears of rejection and abandonment. Hence, not counting on their health-care professionals may be even more stressful for them [23].On the other hand, avoidantly attached individuals are less likely to pursue closeness and comfort, and is more probable to quest control [24, 25].

The purpose of the present study was to assess the influence of cancer patients' attachment orientations to their satisfaction of care.

Methods

This was a cross-sectional design study performed at an outpatient palliative care unit in Athens, Greece. The unit is approached by cancer patients from all around Greece. All patients suffered from cancer and approached the unit for symptom relief. The study took place between April and July 2014. A convenient sample of 138 patients was drawn from a total of 250 patients treated in the unit during that period, representative to the population of cancer patients in Greece. A total of 38patients were excluded due to unexplained reasons and refusal to participate. The final sample consisted of 100 cancer patients. Criteria for inclusion were: historically confirmed malignancy, age>18 years, ability to communicate effectively with the health-care professionals, provision of informed consent, and knowledge of disease diagnosis. On the other hand, the exclusion criteria were: history of drug abuse, diagnosis of a psychotic illness, or significant cognitive impairment (MMSE<14).

Researchers recorded data on: disease status, treatment regimen (i.e. surgery, chemotherapy, radiotherapy, opioids), performance status as defined by the Eastern Cooperative Oncology Group (ECOG) [26], and demographic characteristics (Table 1).The study design included administration of the Greek version of ECR-M16 [27], and the Greek version of FAMCARE-P13 [28]. Both instruments were completed on site.

All participants were informed of the nature of the study and provided a written informed consent. If necessary, they received additional information and/or clarifications. Hospital's ethics committee approved the study (Φ-19/28-03-2013), conducted according to the Declaration of Helsinki Principles and the guidelines for Good Clinical Practice.

Instruments

Participants completed the following self-report measures:

The ECR-M16 [29] is a modified version of the 36-item ECR measuring attachment orientations to close others in patients with advanced cancer. It comprises 16 items in two subscales (attachment anxiety and avoidance). Respondents rate each item on a scale of 1-7 (1: completely disagree, 7: completely agree). ECR-M16 is appropriate for use in medical settings, where health outcomes are influenced by the ability of the patients to seek out, trust, and interact with the health-care professionals. There are no cut-off values to disintegrate ECR-M16 scores into attachment categories. The Greek version of ECR-M16 [27] identified three subscales: "discomfort with closeness", accounting for 33.25%of the total variance, "anxiety", accounting for 17.79% of the total variance, and "avoidance", accounting for 7.72% of the total variance.

The 13-item measure of patient satisfaction (FAMCARE-P13) is a self-report scale assessing patients' satisfaction. The 13 items rate from 1 (very dissatisfied) to 5 (very satisfied) and produce a single score. The Greek version identified two subscales [28]. The first subscale

Table 1. Descriptive statistics of the FAMCARE-P13 and the G-ECR-M16 subscales

	Mean	*Median*	*SD*	*Minimum*	*Maximum*
FAMCARE-P13 subscales					
Information/Interaction	33.14	33.00	4.12	24.00	40.00
Availability of care	23.81	24.00	1.83	16.00	25.00
G-ECR-M16 subscales					
Discomfort with closeness	27.69	26.50	8.73	12.00	55.00
Anxiety	1210	1100	4.73	4.00	27.00
Avoidance	8.04	8.00	3.02	4.00	20.00

was labelled: 'information/interaction with the health-care professionals' (Chronbach α=0.90 ranging from 0.83-.92, p<0.0005), while the second subscale was labelled: 'availability of care' (Chronbach α= 0.87, ranging from 0.81-0.93, p<0.0005).

Statistics

Data were expressed as mean±SD for continuous variables and as percentages for categorical variables. The Kolmogorov-Smirnov test was used for normality analysis of the continuous variables.

Bivariate analyses were conducted using the Student t-test, One-way ANOVA and Pearson's correlation coefficientswere used for the analysis of the relation between the outcome variable (FAMCARE-P13) and the continuous, categorical, demographic and clinical characteristics, respectively.

All demographic, clinical variables and questionnaire's total scores, with a p value<0.2 in bivariate analyses were included in a multiple linear regression model (stepwise method) to arrive at the final model and determine the most significant factors associated with the outcome variable.

All assumptions of linear regression analysis (homoscedasticity, linearity, normality and independence of error terms, as well as multicollinearity of independent variables) were examined. There were no missing data. All tests were two-sided, and a p value<0.05 denoted statistical significance. Analyses were carried out using the statistical package SPSS v. 17.00 (SPSS Inc., Chicago, Ill., USA).

Results

Descriptive statistics

The mean±SD of the FAMCARE-P13 and the G-ECR-M16 subscales showed that for "information/interaction with health-care professionals" was 33.14±4.12, and for "availability of care" was 23.81±1.83. In addition, for "discomfort with closeness" was 27.69±8.73, for "anxiety" 12.10±4.73, while for "avoidance" was 8.04±3.02 (data not shown).

Table 2. Correlations between FAMCARE-P13 subscales and demographic, disease related patients' continuous characteristics

Information/Interaction	*Pearson's (r)*	*p value*
Discomfort with closeness	-0.163	0.105
Anxiety	-0.241	0.016
Avoidance	-0.170	0.091
Disease duration	0.380	<0.0005
Age	0.106	0.294
Availability of care	*Pearson's (r)*	*p value*
Discomfort with closeness	-0.211	0.035
Anxiety	-0.191	0.051
Avoidance	-0.267	0.007
Disease duration	0.145	0.149
Age	0.163	0.106

Table 3. Comparisons between "Information/Interaction" and demographic, disease related patient's categorical characteristics

	Information/Interaction		
	Mean	*SD*	*p value*
Family status			0.284
Partner	33.06	4.15	
No partner	35.67	2.52	
Gender			0.500
Male	33.42	4.01	
Female	32.86	4.26	
Education			0.865
Primary	33.41	3.96	
High school	32.92	4.18	
University	33.28	4.46	
Grade			0.173
I	35.00	3.69	
II	33.02	4.34	
III	33.21	3.71	
ECOG			0.163
0-1	33.78	3.98	
2-3	32.62	4.21	
Metastasis			0.009
No	34.92	3.63	
Yes	32.55	4.13	
Chemotherapy			<0.0005
No	37.90	2.23	
Yes	32.61	3.95	
Radiotherapy			0.950
No	33.09	4.02	
Yes	33.15	4.18	
Hormonotherapy			0.005
No	32.61	3.95	
Yes	35.56	4.15	
Surgery			0.176
No	34.33	3.79	
Yes	32.88	4.17	
Cancer location			0.370
Gastrointestinal	31.96	3.96	
Urogenital	33.38	4.10	
Lung	33.21	4.46	
Breast	34.67	4.22	
Other	33.00	3.95	
Husband-wife	32.76	4.26	
Caregiver			0.341
Children	32.94	4.10	
Relative-friend	34.86	3.68	

Univariate analyses

Correlations between FAMCARE-P13 subscales and patients' continuous characteristics found that "information/interaction with health-care professionals" was positively correlated with disease duration (r=-0.380, p<0.005). On the other hand, "availability of care" was negatively correlated with "discomfort with closeness" (r=-0.211, p=0.035), "anxiety" (r=-0.191, p=0.051), and "avoidance" (r=-0.267, p=0.007) (data not shown).

Moreover, comparisons between FAMCARE-P13 subscales and patients' categorical characteristics showed that "information/interaction with health-care professionals" was positively correlated with "metastasis" (p=0.009), "chemotherapy" (p<0.0005), and "hormonotherapy" (p=0.05) (Table 2). The same analysis for "availability of care" revealed statistically significant positive correlations with "education" (p=0.016), "chemotherapy" (p<0.0005), and "hormonotherapy" (p=0.025) (Table 3).

Multivariate analyses

A multiple regression model examined the contribution of demographic and clinical variables, as well as patients' attachment orientations to their satisfaction with care. The stepwise model examined the strongest contributors to patients' satisfaction.

Increased values of "discomfort with closeness" (*Beta coefficient ± SE*:-0.167±0.08; p=0.060) were associated with low levels of satisfaction with "information/interaction with health-care professionals". Similarly, patients who had been administered chemotherapy and undergone surgery were associated with low levels of satisfaction with "information/interaction with health-care professionals" (*Beta coefficient ± SE*: -5.39±1.12; p<0.001, and *Beta coefficient ± SE*: -2.11±.88; p=0.019, respectively). Only disease duration was associated with increased satisfaction with "information/interaction with health-care professionals" (*Beta coefficient ± SE*: 0.091±.17; p<0.001). Moreover, predictors of "availability of care" were "discomfort with closeness" (*Beta coefficient ± SE*: -0.14±0.06; p=0.019), education (*Beta coefficient ± SE*: 0.89±0.45; p=0.047), and "avoidance" (*Beta coefficient ± SE*: -0.04±0.02; p=0.049). More specifically, increased "discomfort with closeness" and "avoidance" were predictors of low satisfaction with "availability of care". On the other hand, a higher level of education was predictor of increased satisfaction with "availability of care" (Table 4).

Discussion

Satisfaction with care is subjective to patient's personality, expectations, and well-being. When outcomes do not meet patient's expectations, and/or have treatment side-effects are less satisfied with care [30]. On the other hand, when they are given adequate information, feelings of control and autonomy can be increased [19]. When patients want/ask to participate in treatment decisions, they need to have adequate information on the proposed treatments as well as on their current status and disease prognosis [31].

Understanding a patient's attachment style has a positive impact on the patient-healthcare professional connection [32,33]. Health-care professionals need to be thoughtful and responsive to patient's attachment–related needs and motives in order to adjust their communication skills to the patient's attachment style [34].

As far as we know, this is the first study examining the effect of cancer patients' attachment orientations to their satisfaction of care. The present study provides data indicating the important con-

Table 4. Multiple regression analysis (stepwise method) of FAMCARE-P13 subscales and demographic and disease-related patients' characteristics

	Reference category	*Beta coefficient*	*SE*	*R^2 change*	*p value*
Information/Interaction					
Chemotherapy	No	-5.39	1.12	0.141	<0.001
Disease duration	---	0.91	0.17	0.152	<0.001
Surgery	No	-2.11	0.88	0.044	0.019
Discomfort with closeness	---	-0.08	0.04	0.024	0.060
Availability of care					
Discomfort with closeness	---	-0.14	0.06	0.071	0.019
Education	High school	0.89	0.45	0.029	0.047
Avoidance	---	-0.04	0.02	0.024	0.049

tribution of attachment to satisfaction with care, suggesting its application for the investigation of the attachment orientations in cancer patients' satisfaction with care.

The correlations between FAMCARE-P13 subscales and patients' continuous characteristics revealed a statistically positive correlation between "disease duration" and patients' satisfaction with "information/interaction", and "availability of care". On the other hand, "discomfort with closeness", "anxiety", and "avoidance" had statistically negative correlations with "availability of care". These findings are in accordance with previous studies, mentioned in the introduction, thus further supporting that well-being and medical outcomes, in this case longer disease duration (hence longer survival), are important variables to patients' satisfaction. Contrary, patients who had low scores on attachment (discomfort with closeness, anxiety and avoidance) were less satisfied.

Comparisons between FAMCARE-P13 subscales and patients' categorical characteristics showed quite different results. First, patients with no metastatic disease (i.e, better well-being, and treatment outcomes) were more satisfied with "information/interaction with health-care professionals". The same stands for patients who hadn't received chemotherapy, while patients who had received hormonotherapy were more satisfied with "information/interaction with health-care professionals", possibly due to less side-effects. Quite similar results were observed from the comparisons between "availability of care" and patients' categorical characteristics. More specifically, patients with a high level of education, patients who haven't undergone chemotherapy but have been administered hormonotherapy were satisfied with "availability of care".

These results are supported by evidence that information on potential side-effects is crucial. Knowing in advance the side-effects that may be faced with, and how to manage them, can improve adherence to treatment and satisfaction [17,35].

Apart from the level of education no other demographic characteristics were associated with satisfaction. This can be interpreted by the fact that while patients' values are individual and show great variance, demographic factors may not necessarily be predictive and can change.

Furthermore, multiple regression analysis revealed that predictors of satisfaction with "information/interaction with health-care professionals" were chemotherapy, disease duration, surgery, and "discomfort with closeness". Regarding satisfaction with "availability of care", the predictors were: "discomfort with closeness", education, and avoidance. These findings are, in a way, similar to those resulted from the univariate analysis, except anxiety that was not present in the multiple regression. Although Lo's et al. study [5] revealed two factors (anxiety and avoidance), their results showed that "discomfort with closeness" was related to both "anxiety" and "avoidance", but finally kept anxiety and avoidance. The validation analyses of ECR-M16 in Greek population showed that while "discomfort with closeness" was highly correlated with "avoidance" it appeared to be a distinct factor. A possible explanation is that avoidant individuals withdraw results from their discomfort with closeness, hence their necessity for independence [36,37]. Those who feel restless with relationships avoid them because they are afraid that close relations may make them feel anxiety and/or rejection [38]. During the disease, patients may be seeing a variety of health-care professionals, thus, bearing in mind that some patients don't feel connected to their clinicians, the attachment theory emphasizes that an attachment figure (e.g. health-care professional) is distinctive and invaluable.

A shortcoming of the present study is the heterogeneity of the cancer diagnoses. Maybe a study focusing on a specific cancer type (e.g. gastrointestinal cancer) comes up with different findings. In addition, although the measures used have been standardized, there are inherent limitations in self-assessment questionnaires that need to be considered. Nevertheless, the present study provides new insight in doctor-patient communication as it focuses on patients' attachment styles and their satisfaction of medical care.

Health-care professionals need to pay attention to patients' attachment patterns who are not completely satisfied with the care they received. By doing so and identifying causes of dissatisfaction may improve adherence and compliance to treatment. Since health-care communication skills can be taught and learned, they can be applied to clinical practice in order to improve patient satisfaction and care, keeping in mind their attachment styles.

Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments.

Conflict of interests

The authors declare no conflict of interests.

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