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CASE REPORT

Marital therapy for couples facing advanced cancer: Case review

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ABSTRACT

Objective: The purpose of this article is to provide a brief review of the empirical literature regarding the impact of advanced cancer on the marital relationship. The link between attachment, caregiving, and care-receiving behaviors are defined. Both are activated and challenged in this population because the continuity of the marital bond is threatened, as well as the balance of reciprocal caregiving, often resulting in heightened marital distress.

Methods: Emotionally focused therapy (EFT), based in a synthesis of systemic, experiential, and attachment theory, is introduced as a marital protocol to both conceptualize and potentially mitigate the level of increased marital distress, and to achieve reciprocal caregiving.

Results: Two case studies are presented and support the benefit of EFT for those couples facing end of life.

Significance of results: The findings from these case reviews advance the literature and offer an empirically validated marital therapy for this population. Such a protocol that emphasizes attachment theory and the inherent link to caregiving and care receiving may serve as a powerful tool to both explain and alleviate marital distress for couples facing end of life. Working models of attachment can contribute significantly to our understanding of why individuals' distress and their experience of emotional support from spouse caregivers vary in the context of end-stage cancer.

KEYWORDS: Advanced cancer, End of life, Impact of cancer, Emotionally focused therapy, Marital intervention

INTRODUCTION

In Canada, approximately 25% of the population will develop cancer in their lifetime, and half of all cancer patients will die within a few years of diagnosis despite advances in early detection and treatment (National Cancer Institute of Canada, 2005). When one member of a couple develops a life-threatening illness, the lives of both partners are likely to be affected (Nijboer et al., 1998, 1999). An estimated 15%–50% of adult cancer patients and their spouses present with clinically significant psychological distress and psychological dysfunction, which can threaten the stability and satisfaction of the marital relationship (Nijboer et al., 1998, 1999; Kissane et al., 1994a, 1994b, 1996a, 1996b; Manne, 1998; Weihs & Reiss, 2000). Moreover, the trajectory of the disease over time causes changes in couples' communication patterns, social roles, responsibilities, and how they adjust to the demands of illness, existential issues, and, ultimately, death (Carlson et al., 2000; Greenstein, 2000; Steinglass, 2000).

Patients facing the end of life frequently express concerns regarding their spouses and families and

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the desire to strengthen relationships, and these concerns can often exceed disease-related concerns, such as pain and symptom management (Brown et al., 2000). However, terminal illness results in significant challenges to the couple's role function in the adjustment to that of patient and caregiver, and the progression of terminal illness can create profound difficulties in both partners, impeding access to psychosocial support when needs are greatest (Kissane, 2000; Kuhl, 2003).

Providing support to couples at this time can result in a reduction of psychological pain and psychosocial distress and may, in fact, provide an opportunity for relational growth during the last stage of life (Mohr et al., 2003; Murillo & Holland, 2004; Hodges et al., 2005). It may, furthermore, ease the process of bereavement, thereby reducing the potential of future complicated grief and mental health difficulties (MacCormack et al., 2001; McWilliams, 2004).

Despite advocacy for the development of marital interventions focused on the specific needs of the advanced cancer patient and his or her spouse (Kissane et al., 1994a, 1996a, 1996b; Kissane, 2000; Shields et al., 2000; Weihs & Reiss, 2000; Harding & Hugginson, 2003; Hodges et al., 2005), there remain only a handful for those facing end-stage cancer, with diverse theoretical origins and small sample sizes (see Donnelly et al., 2000; Mohr et al., 2003; Kuijer et al., 2004; McWilliams, 2004; Northouse et al., 2005, 1995*a*, 1995*b*). As a result, the suffering of distressed couples remains largely underrecognized and undertreated in couples where one is facing terminal cancer (Murillo & Holland, 2004).

CANCER AND THE MARITAL RELATIONSHIP

Cancer, as with any other negative life event, impacts the marital relationship. It is well established that couples frequently experience feelings of anger, shame, or guilt over the course of chronic illness and that a physically healthy partner may be reluctant to express powerful emotion to avoid upsetting his or her ill partner (Rolland, 1994). This notion, supported by earlier work that measured couples' distress when one faced recurrent cancer, demonstrated that marital tension was due to a number of factors, including grief, withdrawal, somatic distress, preoccupation with self, feelings of injustice, fears surrounding disease trajectory, and the possibility of death (Chekryn, 1984; Friedman et al., 1988; Hannum et al., 1991; Swensen & Fuller, 1992). This was further confirmed in 50% of an Australian sample of cancer patients in palliative care who reported significant clinical distress, broadly comprised of existential suffering, grief, fear, unhappiness, and psychiatric disorders (Kissane, 1994b). Distress in spouse caregivers was found to be 35% (Kissane, 1994a), and endured for as long as 18 months in other longitudinal studies (e.g., Ell et al., 1988).

Although there is a dearth of research with regard to emotional support and advanced cancer, several studies have found that, in general, supportive needs increase as the dying patient's functional state decreases (Blank et al., 1989). Of note, Morasso et al. (1999) found that emotional support needs were unmet in 51.7% of their sample of 89 terminal patients and that there was an association between unmet emotional needs and increased levels of distress. In a longitudinal study of couples' adjustment to breast cancer, Northouse et al. (1998) reported that those couples who were facing advanced disease reported significantly higher levels of emotional distress, role problems, and greater decreases in marital satisfaction and family functioning than couples with early stage disease. Moreover, these problems persisted over time.

The literature on the association between advanced cancer and the marital relationship, although mostly cross-sectional, suggests bidirectional implications: First, it demonstrates that poor marital quality is associated with greater psychological morbidity in cancer patients and that poor marital quality is associated with greater psychological morbidity in spouses of cancer patients (Kissane et al., 1994a; Kissane, 2000; Eton et al., 2005). For example, Kissane et al. (1996a, 1996b), in a longitudinal study of adult families caring for a dying patient, classified five types of families: Two classes, namely, "supportive" and "conflict resolvers," were considered functional in communication, cohesion, and conflict resolution. In contrast, "hostile" and "sullen" families were dysfunctional, the first characterized by high conflict, low cohesion, and low expressive communication and the latter by repressed anger and higher levels of depression. High rates of psychological morbidity occurred among these families, with the rate postbereavement rising to 30% at 6 weeks following death. Finally, "intermediate" families showed moderate levels of cohesiveness, yet were also more prone to psychological morbidity.

Eton et al. (2005) demonstrated that female spouses of men with prostate cancer who had poorer marital quality and less social support from their husbands reported more depression and intrusive and avoidant thoughts. The authors suggest that the negative responses of husbands may be most detrimental to spousal mood and that a strong marriage and more nurturance from a husband may help to sustain a spouse's mood through this difficult period.

In summary, couples and families that report good family and couple functioning also have lower levels of distress, depression, anxiety, and psychological morbidity (Spiegel et al., 1983; Vinokur & Vinokur-Kaplan, 1990; Baider et al., 1996, 1998; Kissane, et al., 1996a, 1996b; Manne et al., 1997; Baider & Kaplan De-Nour, 2000; Eton et al., 2005; Kayser, 2005), and more adaptive coping (Anderson & Albertsson, 2000). Therefore, the ability of the partners to create a positive emotional environment may, in turn, facilitate the successful regulation of emotional and physiological functioning, attenuating the overall impact of disease (Steinglass, 2000, p. 6).

However, as with any negative life event, cancer also presents an opportunity for growth. As such, patients and spouses may seek increased avoidance or proximity and closeness in response to diagnosis and disease progression, and this can lead to either increased levels of isolation and distress or higher levels of psychological and cohesive marital adjustment (Leiber et al., 1976; Friedman et al., 1988; McWilliams, 2004).

ADVANCED CANCER AND THE MARITAL RELATIONSHIP FROM AN ATTACHMENT PERSPECTIVE

Attachment theory, developed by John Bowlby (1969, 1973), integrates insights about affect, cognition, and behavior in close relationships and may serve as a powerful tool to explain marital distress for couples facing the end of life and to explain when advanced cancer poses as a significant threat to the marital bond and when it serves as an opportunity for further growth and development. Although attachment styles may be represented on a continuum based of avoidance of intimacy and clinging to a secure base (Weinfeld et al., 1999), Bartholomew and Horowitz (1991) proposed a four-category model as secure or insecure (low or high anxiety, low or high avoidance). Insecure attachment styles were further subdivided as fearful, preoccupied, or dismissing (Bartholomew, 1990). Characteristically, secure adults are more open to new information, as in the expression of positive and negative emotions, and can both seek and give comfort more effectively, promoting empathic responses from their partners. Anxious adults, however, experience separation from attachment figures as catastrophic and have an intense need for support, affection from their partner, and a vigilant interpretation of their partner's behaviors as a threat. Moreover, they are demanding of their partner for time and attention and can exhibit intense emotionality, such as anger. Avoidant adults, on the other hand, feel hostile and avoid both seeking and giving support to the partner when attachment needs arise to oneself or one's partner, thus dismissing threats and hurts to oneself. They tend to intellectualize or exhibit a restricted emotionality and focus on activities and tasks. Two complementary systems within attachment theory are relevant to the context of advanced cancer: The attachment system and the caregiving system.

ADVANCED CANCER AND THE ACTIVATION OF THE ATTACHMENT SYSTEM

Bowlby (1969, 1973) proposed that attachment behavior evolved to mitigate conditions of danger or threat by ensuring that close proximity is maintained between infants and their caregivers. This theory asserts that seeking and maintaining contact with significant others (attachment figures) are an innate and primary motivation in humans across the lifespan. Secure bonds with attachment figures provide comfort and serve as an emotional regulatory device in times of threat. Attachment theory suggests that close relationships in adulthood are influenced by earliest childhood experiences with parents or primary caretakers, as they serve to form internal "working models" of attachment relationships. Under threatening circumstances, the working models become activated and shape interpretations of what is happening in the current relationship. These working models contain information about "self" ("Do I deserve care?") and others ("Can I trust them to provide care?"). Individuals with a negative "self" model can be conceptualized as high on attachment anxiety, because they fear being rejected by others. They tend to react to separation from or unavailability of an attachment figure with anxious preoccupied clinging and pursuit. Individuals with a negative model of others can be conceptualized as high on attachment avoidance. They do not trust their partners to provide help and tend to react with detachment to separation from an attachment figure. Thus, one's degree of "attachment anxiety" and "attachment avoidance" influence his or her behavior in close relationships and his or her reactions to separation or threat to the attachment bond.

Advanced cancer carries a threat of separation and loss, both emotionally and physically, and, accordingly, can be considered as activating, in both partners, separation distress and attachment behaviors, aiming to restore a sense of safety and security (Shields et al., 2000; McWilliams, 2004; Tan et al., 2005). When these attachment insecurities and behaviors are expressed in the context of a secure marital bond, they are adequately addressed within the relationship and may lead to additional relational growth. However, within the context of an insecure bond, they may lead to maladaptive patterns of interaction that, in turn, maintain separation distress.

ADVANCED CANCER AND THE ACTIVATION OF THE CAREGIVING SYSTEM

Although attachment processes are thought to operate throughout the life cycle, Shaver et al. (1988) defined two key differences between adult romantic love and the initial bond between the infant and his or her primary caregiver. First, romantic love includes sexuality. Second, an adult romantic relationship is egalitarian, and both partners serve as attachment figures and caregivers, compared to the asymmetrical initial relationship between infant–primary caregiver. Similar to the function of the infant's caregiver, a caregiving response in an adult relationship is activated to provide a "safe haven," which meets needs of security and relief of distress, and a "secure base," which serves as an anchor for developing autonomy and exploration of the environment. Ideally, in the adult relationship, both partners seek care and provide care equally. However, when one partner becomes medically ill, this balance is interrupted, and the ill partner requires disproportionately more caregiving without being able to fully reciprocate.

According to Feeney (1996), caregiving responses appear to be organized along two dimensions of responsiveness and compulsiveness. The first indicates the level of sensitivity to a partner's need. The second indicates the level of involvement and control in giving care. Research on dating (Kunce & Shaver, 1994) and married (Feeney, 1996) couples demonstrated that the attachment and caregiving systems are closely linked, so that secure attachment was related to a favorable caregiving style, high on responsiveness and low on compulsiveness. Both attachment style and caregiving style predicted relationship satisfaction.

Nonetheless, caregiving is not just an attribute of a caregiver: It is a relational process, because the caregiver's behavior is being interpreted and therefore received in a variety of ways by the care receiver, depending on either gender's working model of attachment. In contrast, the care receiver's attachment model impacts his or her degree and clarity of expressing needs. For example, a care receiver high on attachment avoidance may fail to express needs and therefore challenge the caregiving task. The mutuality of caregiving and care receiving in adult attachment relationship was supported by the work of Feeney and Hohaus (2001), who demonstrated that quality of care and its positive impact on the couple's bond are maximized when the caregiver is high on responsiveness and the care receiver is securely attached.

Caregiving and care-receiving patterns are particularly salient in a couple where one partner has advanced cancer. Advanced cancer does not only carry a threat of separation and loss, thus activating attachment insecurities and behaviors, but also often carries a shift in roles and responsibilities and forces a new structure in which, instead of reciprocal caregiving, an asymmetrical pattern appears, in which the healthy partner becomes a "caregiver" and the sick partner becomes the "care receiver."

Indeed, spouses are often identified as the primary caregivers of individuals with advanced cancer (Kissane, 2000; Northouse, 2005), and a large body of literature identified the multiple caregiving tasks involved (Braun et al., 2004; Rabow et al., 2004; Davies, & Higginson, 2004), especially given the consistent decline in public and community sources (Kissane et al., 1994a). In view of the evidence that supports the notion that the caregiving balance is especially challenged in the case of advanced cancer, it makes sense that insecure attachment and low levels of responsive care are both linked to a lower quality of ongoing care and less willingness to provide future care (Feeney & Hohaus, 2001; Westmaas & Silver, 2002). In an insecure attachment bond, care receivers will react more negatively to receiving help. Insecure individuals high in attachment avoidance may resent having to rely on others. Insecure care receivers high on attachment anxiety may be more sensitive and critical of the caregiving offered. In contrast, caregivers within an insecure attachment bond may provide care that is low on responsiveness and/or high on compulsiveness and, therefore, negatively perceived by the care receivers.

A small number of studies have examined marital functioning as it relates to the couples' attachment style and emotional support in cancer populations that support the notion of the between attachment style, caregiving and -receiving. In four case studies, female breast cancer patients who rejected spousal attempts to provide reassurance elicited avoidant or hostile responses in their partners (Gates, 1980). Vinokur and Vinokur-Kaplan (1990) studied 274 women with breast cancer and found that "negative emotional support" or "critical responses" from their spouses was associated with increases in patients' depressive symptoms. Kayser (2005), in a study of cancer patients and their partners, found two styles of marital coping, "mutual responsive coping" and "disengaged avoidant coping." The latter coping style was found to result in increased couple distress. Shields et al. (2000) examined the moderating role of marital attachment security in 28 older couples and found that in men, an avoidant attachment style in either partner was associated with lower martial satisfaction relative to a secure or anxious attachment style in either partner. For women, a secure attachment style (in self or partner) or a husband with an anxious attachment style was associated with greater marital satisfaction than was an avoidant attachment style in either partner. Of note, cancer increased the association between avoidant attachment style and lower marital satisfaction, suggesting gender-response differences. Hunter et al. (2006) examined the impact of attachment style and emotional support in 67 end-stage cancer patients and found that both high levels of attachment anxiety and attachment avoidance were associated with lower levels of emotional support that adversely influenced patients' negative affect. Attachment anxiety was found to be associated with higher levels of distress. Among 158 patients with breast, colon, or lung cancer, Manne et al. (1997) examined positive and negative dyadic responses and demonstrated two types of negative responses: "withdrawal" and "overcritical statements," the latter resulting in decreased marital functioning and satisfaction and significantly greater marital distress relative to couples that engaged in more positive emotional support.

The disrupted balance of attachment security and reciprocal caregiving may be best addressed with a therapy that draws from an attachment perspective. A couple-based marital intervention that incorporates attachment theory in the protocol is emotionally focused couple therapy (EFT; Johnson, 2002, 2004).

EMOTIONALLY FOCUSED COUPLE THERAPY

EFT for couples was formulated in the early 1980s by Johnson and Greenberg (1985, 1995). EFT is a short-term (8–20 sessions), structured approach that is well supported by empirical outcome studies (Baucom et al., 1998). It has been shown to be an effective treatment for couples and families facing sexual abuse histories, depression, management of chronic illness in the family, eating disorders, and PTSD (Johnson & Lebow, 2000). EFT is an integration of an interactional and family systems approach (e.g., Minuchin & Fishman, 1981), with an affective and experiential approach (e.g., Rogers, 1951) that also draws upon attachment theory (Bowlby, 1988). It views relational distress as being maintained by the manner in which individuals process their emotional experience and the patterns of interactions they engage in. EFT emphasizes the reciprocity between emotional experience and patterned interactions, resulting in a vicious cycle of hurt and distress. The goal of therapy is to restructure a couple's interactional pattern by accessing and processing the emotions underlying the positions taken by each partner. This process fosters more flexible positions and reorganizes the couple's attachment bond from insecure to secure.

A major premise of EFT is that emotions are the primary organizers of intimate relational experience, influencing both interactional tendencies and patterns and perceptions of the self and others or events. This is particularly important in the context of advanced cancer, because it triggers strong emotions such as anger, grief, and shame and in distressed couples; these emotions are often not accessed, articulated, or shared, thus increasing a sense of isolation and separation. The EFT approach encourages the shared processing of such emotions. In addition, the EFT approach fosters a normalizing stance to the insecurity that results from a cancer diagnosis. Partners are assisted in articulating and accepting attachment insecurities and emotions and in restructuring their interaction based on the new understandings (Kowal et al., 2003). Lastly, in an EFT framework, problems are externalized (instead of considered as "his" or "her" problem) and reframed as the common enemy, allowing couples to collaborate in facing their problems. This facilitates the adaptation for couples facing advanced cancer to adopt a collaborative stance, instead of the common asymmetrical caregiving pattern.

TWO CASE EXAMPLES OF EFT IN COUPLES WHERE ONE IS FACING ADVANCED CANCER

The benefit of a modified EFT protocol for couples facing end-stage cancer is demonstrated in the following case examples, in which an EFT-trained marital clinician works with one couple from a modified EFT perspective. Both couples provided written informed consent in participating in this phase I study that received ethics approval through the Toronto Academic Health Sciences Council (TAHSC) for Human Subjects Research. Names and other personal information were modified to protect the identity of each couple.

Case I: Clinician LM; from unresponsive to Reciprocal Caregiving

Bill and Jane were seen for a total of nine sessions. Referral was made by a staff psychiatrist who had been working individually with Jane for 1 year, following her diagnosis with metastatic Stage IV colon cancer. At the time of our first meeting, Jane and Bill were in their mid-30s, had been married for 4 years, and lived with their 2-year-old daughter. Jane became symptomatic during her pregnancy:

Six months following the delivery of their child, she was diagnosed. During our initial session, Jane revealed that she had undergone four major surgeries and chemotherapy this past year and was in a period of stabilization.

In the first few years of this couple's partnership, they described a strong bond and numerous loving and adventurous times together. Following the birth of their child and Jane's concurrent diagnosis and treatments for advanced cancer, they became trapped in a negative cycle of interaction. I explored the impact of Jane's illness on their relationship and how both partners experienced their relationship currently. Jane spoke of the challenging shift for her of becoming someone who needs care. Jane shared her fear about depending on others and being more comfortable in the role of a caregiver, thus tending to disengage and avoid disclosing her needs. Jane's difficulty in being in the role of a care receiver was amplified by Bill's caregiving behavior. Jane spoke about her difficulty trusting that Bill will always be there for her, that she knows she has been a great burden to him, and that when he is tired, "Nothing else matters but your own fatigue and if I have a need, you are angry with me." When tired, Bill becomes avoidant, preoccupied, and dismissive to Jane's needs, endorsing them as unreasonable and obsessive. Bill spoke of being exhausted from work and childcare, and when there are medical setbacks, feeling hopeless and angry: "Sometimes I am so angry, I leave the house." In exploring what this is like for Jane, Jane describes feeling that, "I don't matter. I feel uncared for and I am just a bother. If he was tired, he'd need to sleep and his anger is too much for me, so I withdraw."

This interactional pattern or cycle was articulated to the couple as one they unconsciously cocreated, which came to occupy a space between them and contribute to their marital distress. As dictated by the EFT protocol, the goal of the first sessions was to reframe their negative cycle of interaction as their common enemy, rather than viewing each other as the enemy. In addition, as often useful in this population, the cancer, the physical pain, and the multiple surgeries were also validated as disrupting and traumatic experiences and reframed as their common enemies, challenging their ability to connect to each other. The couple quickly endorsed this reframing, Bill saying: "We had the baby, which for normal couples is a major change, but then there is more change with the disease. We've crammed all of this into just two and a half years."

Within the new perspective of working together against a common, valid enemy, it was easier for them to access and explore the emotions behind their reactions to each other. Bill revealed the helplessness and inadequacy behind his dismissive reaction to Jane's needs: "Waking up and hearing her crying in pain at three in the morning and there is nothing I can do," and expressed his longing to be close again: "I am so sorry for disappointing you. I so desperately want you to be better and for us to be close. I love you and neglect is not on my list." Their sense of working together was sustained. Jane described feeling, "Less defensive, … There is more room for us. … Our relationship is more fluid. … Before, we tried to get onto the dance floor to do the salsa, like two people in armor. … All we could hear was the clanging of the metal. … We couldn't dance together." By the seventh session, Jane was experiencing significant pain in her upper spinal column and faced medical investigations to rule out metastases to her spinal column. Jane told Bill that he was, "Stepping up to the plate. … It makes a huge difference. … You are really helping." She also spoke of her relief to know that she had his support, and that, "I can count on it. … It feels like you can see what's going on and that's important to me, … to be seen." This experience reinforced new ways of caregiving and care receiving in their relationship.

However, confirmation of metastatic growth in Jane's spinal column represented a significant medical setback and threatened their renewed bond. Jane had to undergo spinal surgery, radiation for pain management, and 6 months of chemotherapy to, it was hoped, give her more time. This medical crisis left Jane once again experiencing Bill's anger and his inability to care for her. Bill described his depletion and exhaustion at this time and that he had, "Nothing to give." Jane spent a week in her parents' home recovering after surgery, no longer feeling safe with Bill. The therapy setting allowed them to explore the fears that underlined their reactions to the medical crisis. A profound change event occurred when Jane, instead of withdrawing, revealed her vulnerability to Bill, telling him, while sobbing, that she did not want to be dying of cancer, and that she would give anything to be the fun-loving and adventurous wife she had once been, planning a future, building on their dreams, and raising their child. She expressed empathy and understanding to Bill around the pressure of her disease on him and his fears around the loss of her and his shattered dreams. In response, Bill reached for her, holding her, and reassuring her of his capacity now to be with her, to walk beside her, to reframe their ways of finding meaning, and time together, for whatever time they had. Bill also shared that his avoidance of her during times of greatest need when she is so ill was related to his terror of loss of her.

This change event allowed both Jane and Bill a renewed sense of a "safe heaven" and "secure base," both crucial for the management of the experience of end-stage cancer. It allowed them to make realistic plans for assistance in home care, such that more of their time could be shared together, including reviewing their life together, pictures of earlier trips, and revisiting their many happy memories, as well as creating a legacy for their daughter.

Case II: Clinician RN; from Compulsive to Reciprocal Caregiving

Johna (44 years old) and Dora (29 years old) were seen for a total of 16 sessions. They were referred to marital therapy by a psychiatrist, who had been working individually with Dora for 6 months, after she was diagnosed with metastatic ovarian cancer. Dora was treated with chemotherapy and a hysterectomy, followed by an insertion of a percutaneous nephrostomy tube due to urinary obstruction. She has been unable to return to gainful employment because of significant pain around the nephrostomy tube and symptoms of surgically induced menopause. Postsurgery, a watchful waiting cancer management approach was taken.

The information gathered in the first few sessions revealed that the couple had been married for 12 years without children. This was Johna's second marriage and, from his first, he has two adult children, who live with their mother abroad. Their relationship had been satisfying; however, postcancer, Dora complained about Johna's controlling manner in relating to her. Indeed, Johna can be characterized as a compulsive caregiver. He had terminated his employment shortly after Dora's diagnosis, explaining that she needed his care and that he cannot tolerate being at work while Dora is ill at home. His care for Dora was intensive, occupying most of his day. He did not allow other family members or friends to contribute, explaining that only he can provide the best care, and the couple gradually became socially isolated. He stated that caring for Dora is what he enjoyed doing the most: "I devote my life to protect her," and denied any needs of his own. In fact, when Dora expressed her concerns that he should be doing things for himself, Johna experienced that as a rejection: "She is trying to get away from me."

Dora also described Johna as insensitive to her needs, saying that, "He's always trying to fix me or the situation, but never gives me what I really need, never really is there for me." She experienced him "like a truck coming through the door," whenever he would attempt to help her or seek proximity to her, and defended herself by "going numb" and shutting Johna out, describing that she can't even hear his words, its just becoming a "loud white noise."

However, the quality of care in the relationship was also impacted by her own attachment style, as she admitted feeling reluctant to express her needs to Johna, thus making his task much more challenging. The negative dynamic of their caregiving and care-receiving styles left both partners feeling angry and hurt. Dora stated that: "Johna needs me to be sick, keeps pulling me down, and is happy when I'm upset," and she felt controlled, "like a trapped bird, drained, and unsafe around him." She often expressed a wish for them to "take a break from each other," and talked about a fantasy of "the trapped bird, breaking away from her cage and flying away." Johna was deeply hurt when Dora expressed this wish; he felt unimportant, unappreciated, and experienced Dora as ungrateful and overcritical of him.

The first sessions were designed to create an alliance with both partners and to reframe their negative cycle of interaction as their common enemy. In addition, the cancer, symptoms of surgical menopause, fatigue, and physical pain were also reframed as their common enemies, denying them the ability to feel physically and emotionally connected to each other. These initial sessions were challenging, as the caregiving imbalance shaped our sessions as well: Johna was dominating the sessions and Dora was often sitting with her eyes closed or staring at the window. My attempts to engage Dora or to validate her experience were experienced by Johna as a rejection of his "truth" and as a criticism of his caregiving. Using the EFT emphasis of empathy and "slowing down" and carefully tracking experiences and interactions in therapy, this dynamic started to shift. A powerful metaphor of their vicious cycle was formed together in therapy, talking of Dora as an injured, fragile bird, held in Johna's big, protecting hands, and of how at times, his hands were holding her too tight. They both identified deeply with this metaphor, and Johna dared to acknowledge that his hands were getting tired of holding Dora.

The couple then worked hard in therapy to express their underlying, hidden emotions and fears. Most importantly, I worked with them, as the EFT protocol suggests, choreographing interactions in therapy, to re-create a dynamic in which they are able to comfort each other in new ways, replacing the maladaptive ways of compulsive caregiving and avoidant care receiving. Dora took the lead in session 4, emerging out of her shell, and shared with me and Johna her current experience in her body. She talked about the experience of the doctors "poking inside her body," of feeling penetrated, invaded, and disowned from her body, of how she feels she cannot control her body, how her body became a separate, unpredictable entity that keeps betraying her. She talks about how she craves a loving touch but cannot get her body, with the pain and the hot flushes, to like it. Johna was able to listen to her account and talked about how, "For the first time, I am able to see the scars inside of her." Dora allowing Johna access to her inner pain and needs was an important first step in increasing the security of their attachment bond and in facilitating sensitive caregiving and more open care receiving in their relationship.

In subsequent sessions, the couple discussed, for the first time, their fears of the future. Dora spoke of her fear of her impending mortality and about her sense of guilt should Johna lose her. Johna responded by sharing similar fears and reassured Dora that he wants to be by her side no matter what. Dora expressed how hard it is for her to believe Johna will be there for her. Staying with this challenge, Dora further expressed her sense of "self" as defected, undeserving of love, able only to inflict pain on others. Putting this in the context of their relationship, Dora spoke of how its better to push Johna away than let him be close, as pushing him away protects him and protects herself, because he will end up eventually leaving her, realizing how defective she is. Expressing these core fears is not an easy task, and the EFT protocol calls for the processing of the experience of articulating such fears in therapy. Indeed, when inquiring about her experience, Dora responded by saying how scary and shameful it is for her to show Johna her vulnerability. At that point, Johna reached for Dora and said, "But this makes me love you even more" and reassured her again that "I will never leave you." He also revealed how special it makes him feel that Dora shared her fears with him. Now, Johna was able to care for Dora and comfort her in the way she needed and wanted.

It was then time to allow Dora to explore her ability to act as Johna's caregiver and to move the couple toward reciprocal caregiving. This was created gradually, for Dora didn't have much experience in this role in their relationship. For example, in sessions where they both cried together, grieving the loss of their dream to have children and where Johna revealed his sense of failing to be a good provider for Dora, Dora was asked if she can imagine herself comforting Johna; we then elaborated on what it would be like for her to provide care for him. This was a frightening idea for Dora, suggesting to her that Johna is weak, if he needs her care, and therefore bound to end up not being strong enough to stay by her side and that he would leave her. Indeed, comforting Johna was almost as big a risk as allowing him to comfort her.

The couple then consolidated their new dynamic of reciprocal caregiving and used it to renegotiate old problems in their relationship. They successfully tackled conflict issues, such as the negative interaction between Johna and Dora's family and the degree of sexual intimacy, and addressed new issues as they came, such as making a decision together about Dora's joining a new treatment clinical trial. In their last therapy session, Johna was on his way to a job interview for a job he is passionate and excited about, and Dora, for the first time, was on her way to a medical appointment with her oncologist on her own, demonstrating their renewed ability to provide a "safe haven" and a "secure base" for each other.

CONCLUSIONS

Most individuals with advanced cancer require some degree of assistance. Previously independent adults may have difficulty accepting emerging limitations and the resulting need for assistance from others. How effectively individuals cope with the illness may depend, in part, on how able they are to seek and accept help from their spouses or other family caregivers and on how comfortable their caregivers are in providing help. Help-seeking behaviors as well as caregiving behaviors are closely related to the security of the couple's attachment bond. Thus, an intervention designed to address attachment insecurities and needs, such as EFT, can create a positive change in terms of receptivity to care receiving, the caregivers' experience of caregiving, the bond between the care receiver and caregiver, and perceived quality of life for both the caregiver and care receiver.

The case studies presented illustrate the clinical effectiveness of EFT in martially distressed couples where one is facing the end of life. In emphasizing the quality of the attachment and emotional involvement between spouses, EFT can address both patients' and partners' experience of chronic and terminal illness as well as their relationship dynamics, including caregiving and care receiving. The focus on safety, trust, and contact facilitates accessibility and emotional responsiveness in partnerships, with the potential to shift insecure styles of caregiving to more reciprocal caregiving, thereby increasing marital satisfaction.

The clinicians were able to assist the couples in identifying their relationship cycles and to process their emotional responses within this context. The additional challenge of the end of life clearly poses as a traumatic life event, amplifying attachment and caregiving and receiving needs and activating the premorbid attachment and caregiving systems of each partner. In the first case, the caregiver, when challenged with his partner's illness and disease progression, either became dismissive and angry or avoided caregiving. In the second case, the partner, a compulsive caregiver, infantilized the cancer patient. Normalizing and validating the partner's emotional experiences and the profound impact of facing the end of life in the context of this theoretically based model allowed the couples to find safety, security, trust, and supportive care from each other. Ultimately, it facilitated the couples in creating new and different ways of finding meaning in their time together and beginning to prepare for the ending of their physical union. Only through follow-up after patient death will we be in a position to determine if the family bereavement process is less complicated because of this intervention. As McWilliams (2004) eloquently stated, it is likely more painful to say goodbye when one if vaguely aware of not having said a satisfactory hello to their partner.

Our experience demonstrates that this therapy is effective with individuals with advanced cancer, with differing degrees of functioning. Patients with severe pain, speech difficulties, or problems with memory and concentration and their partners were able to benefit from this therapy and find a new balance of caregiving and care receiving. Although the number of optimal sessions may vary, depending in part on the severity of marital distress, a minimum of nine sessions is recommended. The consolidation of new relational patterns may be difficult to establish in the context of a dynamic and aggressive illness, and therefore follow-up sessions, when new medical challenges arise, are recommended. Furthermore, the scheduling of sessions needs to adjust fluidly to the dynamic of cancer, such as during times of patient treatment. The location of the session may change from clinical office to home or hospital room.

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