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CHRONIC ILLNESS IN COUPLES: A CASE FOR EMOTIONALLY FOCUSED THERAPY

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The onset of chronic illness is one of the most pervasive health problems facing North Americans today. Only recently have researchers and clinicians seriously examined chronic physical conditions in the context of close relationships. This article briefly reviews the literature on chronic illness in adult couples. Initially, the focus is on the reciprocal link between close relationships and chronic physical conditions. A number of clinical approaches for working with chronic illness in couples are outlined, a particular case is made for the utility of emotionally focused therapy, and a case study is presented.

The onset of chronic physical illness is one of the most pervasive health problems we face today. Recent statistics indicate that chronic physical conditions, including heart disease and cancer, are among the leading causes of death in North America (Anderson, 2002). Although much is known about confronting illness and disease, surprisingly little research has focused on chronic illnesses in couples. In fact, only recently have researchers and clinicians seriously examined chronic physical conditions in the context of close relationships.

This article briefly reviews the extant literature on chronic illness in adult couples. Initially, the focus is on the reciprocal relationship between close relationships and chronic physical conditions. A number of clinical approaches for working with chronic illness in couples are then outlined, a particular case is made for the utility of emotionally focused therapy (EFT; Johnson & Greenberg, 1985; Johnson, 1996), and a case study is presented.

THE ASSOCIATION BETWEEN CLOSE RELATIONSHIPS AND CHRONIC ILLNESS

In the literature on chronic illness in couples, research has focused predominantly on three main categories of variables: relationship status, relationship quality, and specific relationship behaviors. Relationship status refers to whether or not a couple is married, relationship quality (also called relationship satisfaction) refers to the extent to which partners are satisfied with their relationship, and specific relationship behaviors are such phenomena as critical remarks, hostile interactions, and attachment responses. These relationship variables are in no way exhaustive, nor are they intended to be; they merely reflect, in a broad sense, the foci of research in this area (for reviews, see Kiecolt-Glaser & Newton, 2001; Schmaling & Sher, 2000).

The Impact of Close Relationships on Chronic Illness

Relationship status. Epidemiological research has demonstrated that being married is protective against chronic health conditions. When compared to unmarried couples, married couples tend to have lower

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mortality rates (Berkman & Syme, 1976) and higher survival rates once a chronic illness is diagnosed (Goodwin, Hunt, Key, & Samet, 1987; Gordon & Rosenthal, 1995). Married partners also tend to show greater compliance to medical regimes (Goodwin et al., 1987), and separated or divorced partners experience lower immune function than their married counterparts (Kiecolt-Glaser et al., 1988). It is unclear, however, whether merely having a spouse is protective in all instances. In distressed couples, conflict may adversely influence health by restricting partners' ability to seek support (Coyne & DeLongis, 1986). It may also be that unmarried individuals are at greater risk for developing chronic health conditions because they tend to have restricted social contacts and experience increased loneliness (Burman & Margolin, 1992; Schmaling & Sher, 1997).

Relationship quality. Another line of inquiry has examined the link between relationship quality and chronic illness. Marital quality has been shown to predict survival following congestive heart failure (Coyne et al., 2001). Low levels of marital quality have also been linked with disease symptomatology and negative health outcomes (Greene & Griffin, 1998; Marcenes & Sheiham, 1996). Moreover, the findings of Kiecolt-Glaser et al. (1987, 1988, 1993, 1997) indicate that marital distress is associated with reduced immune system function, which, in turn, is associated with physical illness, disease, and compromised health.

Certain researchers (e.g., Coyne & Bolger, 1990) have proposed the negative effects of distressed relationships outweigh the positive effects of supportive relationships. Indeed, Weissman (1987) found the rates of major depression to be about three times higher in unmarried individuals than in happily married individuals, whereas the odds of being depressed were about 25 times higher in individuals experiencing marital dissatisfaction. Although this study examined depression, it may indeed have relevance for physical illness. Other recent findings suggest the negative aspects of relationships are independent of positive aspects (Kiecolt-Glaser & Newton, 2001).

Specific relationship behaviors and chronic illness. The manner in which partners interact has also been linked to chronic illness and disease. Hostile interactions and contemptuous facial expressions, for example, have been associated with a number of health problems (Ewart, Burnett, & Taylor, 1983; Gottman, 1994; Levenson & Gottman, 1985). As well, critical remarks by intimate partners are known to adversely affect disease activity and the ability to cope with chronic illness (Manne, 1999; Zautra et al., 1998), and have been linked to decrements in endocrine and immune system function (Kiecolt-Glaser et al., 1993, 1997; Malarkey, Kiecolt-Glaser, Pearl, & Glaser, 1994). A recent review of health in families indicated that conflict and criticism are among the most important risk factors for a variety of health outcomes (Weihs, Fisher, & Baird, 2002).

The provision of social support is another variable associated with illness and health (Helgeson & Cohen, 1996; Sarason, Sarason, & Gurung, 1997). In the context of couples, a limited number of studies have shown that having a supportive partner is associated with decrements in pain medication use and incidence of rehospitalization (Kulik & Mahler, 1989) as well as enhanced recovery after surgery (King, Reis, Porter, & Norsen, 1993). Not surprisingly, having caring, supportive spouses can lead to improved immune function (Carrère, Gottman, & Ochs, 1996). Other researchers have focused on partners' ability to cope with chronic physical conditions. Lyons, Mickelson, Sullivan, and Coyne (1998) proposed a type of coping known as communal coping:

> A process in which a stressful event is substantively appraised and acted upon in the context of close relationship . . . [it] occurs when one or more individuals perceive a stressor as 'our' problem [a social appraisal] vs 'my' or 'your' problem [an individualistic appraisal], and activate a process of shared or collaborative coping. (p. 583)

Although no studies to our knowledge have examined how communal coping affects chronic illness, this line of inquiry holds considerable promise, especially from an applied perspective.

Research on chronic pain further supports a link between couples' interactions and physical well being. In comparison to partners with unsolicitous spouses, partners with solicitous spouses report higher levels of pain (Lousberg, Schmidt, & Groenman, 1992; Turk, Kerns, & Rosenberg, 1992) and pain behavior (Romano et al., 1995). Similarly, spouses' punishing responses have been associated with increased pain-related behaviors (Schwartz, Slater, & Birchler, 1996). Other studies have found a positive link between partners' involvement (e.g., positive reinforcement) and adherence to medical regimens (Schmaling & Sher, 1997).

The positive association between solicitous behavior and pain outcomes is seemingly at odds with the results of studies linking social support to health. Turk et al. (1992) posited that this relationship is moderated by relationship quality; in dissatisfied couples, solicitous responses may be misinterpreted and appraised as unhelpful. From an attachment perspective, it may be that insecurely attached individuals perceive solicitous behaviors as threatening, which may, in turn, exacerbate their experience of pain. Although speculative, future research could examine these possibilities.

To summarize, numerous studies have shown that relationship status, relationship quality, and specific relationship behaviors are associated with chronic illness and disease. Although beyond the scope of this article, it is important to note that several investigations have observed gender differences in many of the aforementioned links (e.g., women tend to have higher levels of physiological reactivity in response to marital conflict; see Kiecolt-Glaser & Newton, 2001).

The Impact of Chronic Illness on Close Relationships

Just as close relationships affect chronic illness, chronic illness affects close relationships in a variety of ways. Several studies have revealed that patients and their intimate partners experience adverse psychological reactions to the onset of chronic illness. For example, there is evidence that physical illness may decrease, increase, or be unrelated to marital satisfaction (see Schmaling & Sher, 2000). Researchers such as Burman and Margolin (1992) have attributed these disparate findings to illness type (e.g., cancer vs. heart disease) and characteristics within each illness (e.g., severity and chronicity).

That chronic illness may enhance relationship quality is an important finding warranting additional consideration. Chronic illness is typically considered to be a negative life event. Undoubtedly, patients and their intimate partners are required to cope with chronic health conditions, which, in turn, can lead to changes in the way they interact. Conditions such as chronic pain may severely limit the type of activities in which a couple can engage. Other diseases (e.g., multiple sclerosis) are degenerative and gradually restrict partners' ability to function. Treatments such as chemotherapy are themselves highly aversive and can lead to negative health consequences. How, then, can chronic illness improve relationship satisfaction?

Rolland (1994) proposed that chronic health conditions, like any other life challenge, present an opportunity for growth. Although chronic disorders can change the nature of a relationship, reframing an illness as a challenge to be overcome and/or "our" versus "my" or "your" problem (Lyons, Sullivan, & Ritvo, 1995; Lyons et al., 1998) can help couples cope in a more positive light. Berg-Cross (1997) proposed that illness might provide partners with an opportunity to communicate and bond and, as a result, grow as a couple.

Chronic illness may also affect partners' roles and responsibilities. Helgeson (1993) found that spouses assumed additional responsibilities following the illness of their intimate partners. In a similar vein, Michela (1986) demonstrated that patients who became more dependent on their spouses initially reported higher levels of marital satisfaction, whereas spouses reported significantly less marital satisfaction. This suggests that chronic illness may place a burden on caregivers and adversely affect the quality of their relationships (Coyne et al., 1987).

In terms of social support, Helgeson (1993) found an inverse relationship between spousal distress and the support spouses provided. This result is central to understanding the reciprocal link between chronic illness and close relationships. In this investigation, chronic illness affected patients' and partners' adjustment, which subsequently influenced the support provided to patients. It would thus seem that reduced support on the part of spouses exacerbates patients' physical symptoms, which, in turn, undermines social support, and so on. This finding also has important clinical implications; if patients do not feel that they are being supported by their partners, this would certainly have to be addressed over the course of therapy. Other studies of social support have linked the degree of visibility of chronic health conditions with support provided by intimate partners (Fontana, Kerns, Rosenberg, & Colonese, 1989; see Lyons et al., 1995).

To summarize, chronic illness influences close relationships by altering relationship quality, roles and responsibilities, and social support. What is important to underscore is that the onset and course of chronic illness does not necessarily have a detrimental influence on couples. Although chronic health conditions can affect patients, intimate partners, and relationships in a variety of ways, it can do so in a positive light.

Before moving on, it should be noted that the majority of studies cited thus far are correlational in

nature. Although they provide insight into the association between chronic illness and close relationships, they do not allow any definitive conclusions to be drawn about the direction of the proposed links. Future studies in this area would therefore do well to employ prospective, experimental, and/or cohort designs.

ATTACHMENT BEHAVIOR IN THE CONTEXT OF CHRONIC ILLNESS

Since Bowlby's (1980) seminal work on attachment, research in this area has flourished (see Cassidy & Shaver, 1999). More recently, it has been proposed that attachment behaviors play a central role in chronic illness (Maunder & Hunter, 2001). Specifically, it appears that insecure attachment styles are associated with the onset and exacerbation of chronic health problems. Feeney and Ryan (1994), for example, found that, when compared with securely attached individuals, those with an anxious/ambivalent attachment style reported significantly more physical symptoms and negative affect. Avoidantly attached individuals also visited health professionals less often than did securely attached individuals. Research on defensiveness and repression (similar to an avoidant attachment style) indicates that individuals who repress negative emotions experience elevated levels of physiological arousal and multiple health problems (Esterling, Antoni, Kumar, & Schneiderman, 1993; Weinberger, 1990). In children, although inconclusive, there is evidence that insecure attachment is associated with chronic health conditions (McCallum & McKim, 1999).

Not only could individuals with an avoidant attachment style be at risk for developing chronic illness and exacerbating health problems, they appear to be much less likely to access and use support from intimate partners. Kotler, Buzwell, Romeo, and Bowland (1994) found individuals with an avoidant attachment style to have coping styles characterized by the suppression of negative affect and avoidance of support-seeking behavior. This fits with the theoretical postulate linking insecure attachment to loneliness (Rubenstein & Shaver, 1980), and concurs with the results of Kiecolt-Glaser, Garner, Speicher, Penn, and Glaser (1984), who found loneliness to be associated with a variety of negative health consequences. It also concurs with the results of studies linking social support to numerous health benefits (see Helgeson & Cohen, 1996; Sarason et al., 1997).

Not surprisingly, the loss of an attachment figure has been linked with increased mortality rates and incidence of chronic health problems (Gottman, 1994; Kennedy, Kiecolt-Glaser, & Glaser, 1988). The loss of a partner is not limited to the death of a spouse, however. Certain studies have shown that divorce and separation are highly stressful life events that increase vulnerability to and the incidence of chronic illness and pain (Creed, Craig, & Farmer, 1988; Kennedy et al., 1988). Moreover, insecure attachment has been positively associated with traumatic grief symptoms following the death of a spouse (Van Doorn, Kasl, Beery, Jacobs, & Prigerson, 1998). In short, attachment behaviors, especially those associated with insecure attachment, appear to play a central role in the onset and course of chronic illness. The processes through which this occurs remain unclear but appear to be mediated by stress regulation, affect regulation, and ability to engage in health-promoting behavior. Although research in this area is still in its infancy, results clearly suggest that understanding attachment behavior is central to understanding chronic illness in couples.

WORKING WITH COUPLES FACING CHRONIC ILLNESS

Although a multitude of approaches have been developed for working with distressed couples (Gurman & Jacobson, 2002; Halford & Markman, 1997), relatively few have been specifically applied to couples who are facing chronic illness (see Ruddy & McDaniel, 2002). Although there is a paucity of research on the clinical efficacy of treatments aimed at helping couples in which one or both partners are chronically ill, many approaches hold considerable promise in this regard. Existential therapy (Lantz, 1996), family systems therapy (Rolland, 1999), medical family therapy (McDaniel, Doherty, & Hepworth, 1992, 1998), feminist collaborative therapy (Skerrett, 1996), and cognitive–behavioral therapy (Schmaling & Sher, 1997) have all been discussed in the context of chronic illness in couples.

What is striking about these various approaches is that, although they share certain commonalities, they differ—sometimes to a radical degree—in terms of their focus. For example, existential therapy (Lantz,

1996) focuses on the meaning and the purpose couples assign to their illness, and how this pertains to their intimate life. Rolland (1999), in his family systems–illness model, takes a systemic perspective and focuses on chronic illness in a developmental context. Similarly, in medical family therapy (McDaniel et al., 1992, 1998), a biopsychosocial approach is integrated into a systemic framework, and a specific aim is to foster collaboration between families, therapists, and health care professionals. The feminist collaborative approach discussed by Skerrett (1996) emphasizes mutuality and accountability to oneself and one's partner. Other approaches, such as cognitive–behavioral couples therapy and behavioral family management (Schmaling & Sher, 1997), focus on cognitive and behavioral aspects of chronic illness, and use basic techniques, such as communication training and problem solving. This list of interventions is in no way exhaustive; it is merely intended to highlight a variety of approaches for working with couples facing chronic illness.

What should be noted is that illness in not a result of poor relationships; it can potentially affect any couple. Nevertheless, research has shown that improving relationships can buffer against the onset and/or course of physical illness and disease, and this is a fundamental goal of each of the aforementioned therapeutic approaches. Thus, the development of specific interventions aimed at couples facing chronic illness can be considered a very positive step forward, indeed.

A Case for EFT

Another therapeutic approach that is particularly salient for working with chronic illness in couples is EFT (Johnson, 1996; Johnson & Greenberg, 1985). As a theoretical framework, EFT is an integration of experiential and systemic approaches, and focuses on intrapsychic processes (i.e., how partners process their emotional experiences) and interpersonal processes (i.e., how partners organize their interactions into patterns and cycles). As such, it addresses patients' and partners' experience of chronic illness as well as relationship dynamics. This systemic focus is consistent with the work of Rolland (1994) and McDaniel et al. (1992, 1998).

The emphasis on emotion in EFT is another reason why it is particularly well suited to working with chronic illness in couples. Although emotional responses are a core dimension of any relationship, they are especially important for partners facing chronic physical conditions (Johnson & Williams-Keeler, 1998). According to Rolland (1994), intense, heightened emotions, such as anger, shame, and guilt are very commonly experienced by one or both partners over the course of a chronic illness. Couples may also experience powerful emotional reactions as they grieve the loss of their previously "normal" relationship or, in certain instances, as partners grieve the potential death of their intimate partners. Moreover, physically healthy partners may refrain from expressing powerful emotions in the hope of not upsetting their ill partner. By providing a safe place and framework for dealing with emotional reactions, EFT can greatly benefit both patients and their intimate partners in facing chronic illness.

Emotionally focused therapy also validates and normalizes each partner's experiences. A diagnosis of chronic illness is a highly stressful negative life event. In the EFT process, each partner's feelings can be validated, expanded, and reprocessed. As Johnson (1996) notes, "It is assumed that, given their experience, individuals have coherent and valid reasons for constricting emotional processing and interactions with their spouse" (p. 9). Clinicians such as Rolland (1994) have long argued that normalizing partners' reactions to chronic illness is not only therapeutic, but beneficial to helping partners adjust to chronic health conditions.

Emotionally focused therapy is empirically validated and associated with relatively large treatment effects (Johnson, Greenberg, & Schindler, 1996). Clinical experience indicates that EFT is effective in treating adult couples experiencing extreme distress because of chronic illness and trauma (Johnson, 2002; Johnson & Williams-Keeler, 1998). Gordon Walker, Johnson, Manion, and Cloutier (1996) demonstrated the effectiveness of EFT in an intervention study of couples with chronically ill children. Specifically, EFT affected depression and the "burden" associated with illness in these families. In a follow-up study, improvements in marital functioning were not only sustained after 2 years, but were actually enhanced in certain couples (Cloutier, Manion, Gordon Walker, & Johnson, 2002). Ostensibly, many of the basic issues facing parents of children with chronic illness (e.g., intimacy, communication, attachment, and intense emotional reactions) are faced by adult couples in which one partner is chronically ill.

Emotionally focused therapy's focus on attachment also makes this approach extremely relevant for couples facing chronic illness. Attachment behaviors are salient to any intimate relationship, but are particularly germane in the face of adversity and highly distressing situations, for example, dealing with chronic illness (Johnson, Makinen, & Millikin, 2001; Maunder & Hunter, 2001). The previously cited literature on attachment and chronic illness suggests that insecure attachment carries with it a number of negative health consequences. Thus, by helping partners become more securely attached, each is able to experience the other as a sense of security, protection, and comfort (Johnson, 1996). Moreover, in their theoretical model of attachment and disease, Maunder and Hunter (2001) propose that attachment security affects the development of chronic illness through stress regulation, affect regulation, and altered help-seeking behaviors. They also propose that insecure attachment may lead to increased use of "external regulators" (e.g., substance abuse and eating behaviors). The basic tenets and goals of EFT concur with this model, most notably in terms of helping patients and spouses process their emotional experiences (i.e., regulate their affect) and seek comfort, safety, and support from each other (i.e., engage in health-promoting behaviors). In turn, both of these should decrease patients' and spouses' physiological stress response, which should subsequently protect against the development and/or exacerbation of chronic health conditions.

A final reason for using EFT is the manner in which couples' difficulties are conceptualized within this framework. Typically, difficulties in couples, whether they are framed by clients as the problem of one or both partners, are collaboratively reframed in terms of patterns of interaction. One of the underlying goals of EFT therapists is to help partners externalize their conflict (White & Epston, 1990). Reframing negative patterns of interaction as collaborative problems—and not as the problem of one or both individuals—allows partners to take responsibility for the evolution of their relationship and conceptualize their conflict as a common enemy (Johnson, 1996). Externalizing conflict is congruent with the previously described notion of communal coping (Lyons et al., 1995, 1998). Recall that in communal coping, patients collectively face difficulties or problems together. The same type of reconceptualization of difficulties is taken in EFT. That externalization can greatly benefit couples in dealing with chronic illness has also been proposed by Rolland (1994) who argued that by adopting a collaborative stance, externalization serves as a reminder that individuals are not an illness and their relationships are more than a chronic physical condition.

In short, EFT is a useful framework for working with couples facing chronic illness, because it helps partners to process their emotional experiences, especially in terms of regulating negative affect, and assists them to actively seek safety and comfort from each other. When combined with a systemic focus and an emphasis on validating and normalizing each partner's experience, this approach should help reduce partners' physiological stress response thereby protecting against chronic illness and disease. Moreover, it allows for patients and their partners to externalize negative patterns of interaction and better deal with concrete problems stemming from chronic health conditions. Thus, the goals of EFT in working with chronic illness in couples are to normalize and validate each partner's experience, to help partners process their emotional experiences, to externalize negative interaction cycles, and to help partners seek safety, security, and comfort from each other (i.e., create a more secure attachment bond).

AN EFT CASE EXAMPLE

In the following case example, the utility of EFT for working with a couple facing a chronic physical condition is demonstrated. Initially, background information about the couple is presented, as are details about the chronic physical condition with which this couple was confronted. This is followed by a transcript in which the clinician, an experienced EFT couple therapist, works with this couple from an EFT perspective.

Wil and Andrea Sands were referred by a psychologist, who had been working individually with Andrea for 4 years, soon after she was diagnosed with a slow-growing benign brain tumor. The referral letter described the marital relationship as extremely distressed, with Andrea thinking of leaving her husband.

Mr. and Mrs. Sands were a striking couple. Both were tall and slender, Wil with white hair and blue eyes and Andrea with very short black hair. She wore tinted glasses, and as she spoke, I (AL) was aware she could not completely control one side of her mouth. The first session was focused on building an alliance

with each partner, and obtaining the marital history, information about family-of-origin relationships, as well as their experience with Andrea's illness.

Wil took the lead, and I learned that they had been married for 25 years and had one child, a son who had recently joined the military. They lived in a small community where Wil owned a garage with his brother and Andrea had worked as a hairdresser. Their relationship had been good in the past; they had considered each other best friends, and although they squabbled now and again, they were always able to resolve problems.

It was on their son's 15th birthday that Andrea learned she had a brain tumor. It was determined that it was growing slowly and was not malignant, but it was large and situated in a place where complete surgical removal might not be possible. Two years of observation followed, during which time Andrea, who suffered extreme headaches, stopped working and had her driver's license revoked. When she went out by herself, she experienced panic attacks. She began individual therapy with a psychologist who helped her to process the terror she felt about the tumor. She learned to manage and control her panic.

A year before I met the couple, Andrea underwent complicated brain surgery. The surgeon had prepared the couple for the chance of paralysis, and Andrea emerged from surgery with a drooping eyelid and minor facial paralysis. Nonetheless, the surgery was very difficult and Andrea was hospitalized for 6 weeks. Andrea commented that she was so relieved that her bodily function was intact. She also indicated that the facial disfigurement was not a problem for her, and Wil declared that he never noticed it, adding that she looked as beautiful as ever to him.

Wil had gone to great lengths to support his wife during the years of her illness. He was constantly by her side in the hospital, drove her to her numerous appointments, took her shopping, and brought her flowers. He built a gazebo in their back garden for her enjoyment. However, approximately 6 months after her surgery, as Andrea slowly began to take over the reins of the household, she told her therapist that she felt that Wil was deliberately avoiding her. He was working longer and longer hours at the garage, often leaving the house at 5:30 a.m. and not returning until after 7:00 p.m. Andrea accused Wil of avoiding her, but he insisted he was simply working to meet the demands of his business. Andrea's complaints had little effect on Wil's working schedule.

I explored how each partner experienced the relationship at the present time. Andrea's focus was on Wil. She described his long work hours, and elaborated that when he was home, he was either touchy, exploding easily, or sullen and withdrawn. She worried greatly about his emotional and physical well being because she felt that he was pushing himself too hard. She reported that he had had numerous colds in the last few months, and his physician commented that his blood pressure was up at his last check-up. She added, "I don't think I make him happy anymore."

Wil saw things very differently, and as he described his experience in the relationship, the couple began to enact the cycle that maintained their current distress. He described his wife as extremely sensitive and quick to anger about things that would never have bothered her before. "She rags me out about little things. I even have to eat what she tells me to for God's sake! I feel like I'm treading on eggshells all the time. I try to do things for her. I help her with her physiotherapy at night; take her for all her appointments. I massage her feet at night. I spent a fortune and nearly broke my back building the gazebo . . . but I can never please her."

Andrea gripped the arms of her chair and glared at her husband. The sides of her neck became red. "I never wanted a gazebo. 'Mr. High and Mighty' does whatever he likes around the house now, no one is interested in *my* opinion anymore. And you don't come home for supper. You breeze in at lunchtime, eat, and leave me without so much as a hug. I feel like I have to beg 'Mr. High and Mighty' for his time now," she said angrily. As she said this, Wil sighed and looked out of the window. "See?" shouted Andrea. "See? He just tunes me out!"

"That's not true and you know it," sighed Wil. "I'm doing my best. I come home for lunch every day even though I know you'll get me for something. I come in with a bunch of flowers and you shout at me for not taking off my shoes as I come in. There's simply no pleasing you."

Wil described how he had tried to placate his wife by apologizing and offering hugs but, eventually, he would withdraw and "creep into my igloo," as he put it, and avoid her. His avoidance of Andrea served only

to exacerbate her anger. She would find reason to pick at him. On two occasions Wil exploded into violent anger when he yelled at Andrea, once smashing the salad bowl into pieces on the kitchen floor. After these explosions, Wil was inaccessible for days. He explained, "I go to a place where I hate to be. I feel really low and unhappy."

Whereas this couple had always been able to find their way out of problems in the past, they were now trapped in a criticize/pursue versus a defend/withdraw negative interaction cycle. Each partner was left feeling angry, unhappy, and distant from the other. This cycle was articulated to the couple and identified as responsible for the current marital distress. I also validated the traumatic experience they had endured together, and the heroic efforts the couple were making to deal with the circumstances they had been dealt.

In a subsequent session, I explored the emotions that primed the response of each partner to the other. Wil continued to describe how anxious he was in the company of his wife. She seemed to always be angry, always checking on him, always nagging him. He never seemed to get anything right. She was even cross with him for buying a new dishwasher as a surprise for her. I asked Andrea about her reaction to the dishwasher and she snapped, "I'm not important anymore."

Wil: Of course you are important! That's precisely why I bought the damn thing. (He turns to the therapist) You see? I can't win.

Therapist: You've been trying as hard as you can to make things OK, to make things all right for Andrea. And when you hear she's upset, you hear her disappointment, then you feel kinda . . .

Wil: I think I'm letting her down. I've truly tried to make things OK for her, make her happy, and I . . . I guess I'm not giving her what she needs.

Therapist: When you say that, Wil, there's a catch in your voice. When you say you're not giving her what she needs, it's like it's really painful for you to say that.

Wil: Well, yes, I guess I can't help her. I can't make it better for her. I . . I feel like I'm letting her down.

Therapist: So when you see Andrea is not happy with you, like you're letting her down, is that when you withdraw, you creep into your igloo?

Wil: (In a small voice) It's better if I just keep away.

Therapist: It hurts so much to feel that you're failing her that you stay away, there's nothing else you can do.

Andrea: He's avoiding me. He never comes home. We used to be so close and now he's away all the time. And he doesn't want my input. Let's not worry about what *I* think about kitchen appliances. Let's not worry what *I* want in the back yard. I won't be around much longer anyway.

Therapist: So, Andrea, you're struggling to cope with all the awful things that have been happening in your life. And you see him staying long hours at the garage, at home he's in a place where you can't reach him, and then he doesn't include you in important decisions. And for you, this adds up to him not wanting you and needing you anymore?

Andrea: (Her eyelids are pink) It's pretty clear to me. I never wanted a gazebo in the back yard. I told him it would throw shade on the clematis. But he doesn't listen to me.

Therapist: (Softly, empathically) That must be hard for you, Andrea, to not feel listened to, not considered, not valued?

Andrea: (Tears welled up and spilled down her cheeks) Yes, I don't feel precious to him. I've tried so hard to be brave. I have never once complained about how I look now. My hair! It was my best feature. They cut it all off. Wil always said it was my crowning glory. I can't drink anything without dribbling down my face. We haven't made love for 3 years.

Wil: (Visibly shaken, he leaned forward and put his hands on her knees) I had no idea you felt this way. I thought you'd been handling all this amazingly.

Andrea: I am trying to be amazing. But I can't carry on doing this by myself anymore. It's too hard.

Therapist: You've been struggling to deal with so much. So many changes, so much loss. But it's all too much, too much for one person to bear. And you worry Andrea, with all the pain and trouble this illness has caused, and all the changes in your appearance, you worry that he . . .

Andrea: (Sobbing into her tissue) Yes. He doesn't want me anymore. I look awful now. I'm still feeling sick. I can't be cheerful and happy all the time. And he's avoiding me.

Therapist: And when he's not there, when he seems to be avoiding you, Andrea, for you this kinda show you that it might be true, yes? That maybe he doesn't care for you? That he doesn't want you here anymore?

Between sobs and gulps, Andrea shared her fears with us. When she returned home from the hospital, she felt defective and broken. She felt like a burden. When she saw that Wil had rearranged the family room, she began to wonder if he had expected her to die during surgery. She even speculated that he was angry she had not died and described feeling that she had been nothing but a burden for so long. Feeling like a burden, defective and broken, she read his gestures, such as the gazebo, which was intended to surprise and delight her, as signs that he was moving on and putting his own plans into their home. Inside her angry defence, she was hurting, vulnerable, and needy.

As she continued to talk, Wil put his head into his hands, and when she finished, he raised his head and we could see his tears. He told her, "You are my other half, my stabilizer, my shock absorber! I don't care if your face has changed. Not for me, only for you. You're still my Andy. I need you. I need you so I can go on."

We learned in this session that underlying their positions in the negative relationship cycle, Wil was feeling he was letting Andrea down and finding himself at a loss to please her. He described feeling anxious and uncertain, "at sea," as he described it. Frightened of doing the wrong thing, he kept his distance. His distancing stance, in turn, fed into her fear that he might abandon her. Two important change events occurred in this session. First, a softening occurred as Andrea was able to set aside her angry defence and her heroic efforts to be "amazing" in the face of her ordeal, and share the painful, vulnerable feelings that she herself was no longer precious to him. Second, withdrawer re-engagement took place as Wil reached for his wife, comforted, and reassured her, while also telling her about his helplessness and the sense of failure he felt about not being able to help her be happy.

In further sessions, the couple spent more time telling the story of the surgery and its aftermath. They were able to directly and openly discuss their fears with one another. Andrea, no longer needing to be "amazing," was able to tell him how small, frightened, and defective she felt, and asked him for comfort and support. Wil instantly responded to her by holding her and reassuring her that to have her with facial paralysis was much better that not having her at all. He later described the horror of the day of her surgery, waiting outside with their son and praying that she would survive the operation. He told us that he still had flashbacks to the scene in which his grown up son was sobbing uncontrollably in the waiting room when the operation took much longer than predicted. We continued to work on helping him express his needs and assert himself with his wife, and this was accomplished in subsequent sessions.

During our 12th session, the couple reported that they had averted a fight. They went on to describe an incident in which each partner was able to unlatch from the negative cycle and instead respond differently to each other. It was November, and Wil was spending longer hours at the garage. Andrea walked over to the garage to bring him his lunch one day and had seen him talking to a pretty young woman. When Wil arrived home that night, she was cold and critical. Wil's first reaction was to head down to the basement to his workshop, but he immediately came back to the kitchen and told his wife: "I'm going to guess that you felt a bit hurt today when you brought my lunch down and I was tied up with a customer. It was so nice of you to bring over my lunch, and no customer means to me what you do, Andy."

He reached out and hugged his wife, and Andrea replied: "I see why you want to be at the garage so much, with all the good-looking ladies around." But she looked at him, returning his hug, and said: "We are doing different steps to our dance these days aren't we? I did feel really hurt and angry, it's true. Thank you for the hug, I love you." In this session I highlighted and validated the risks and changes the couple were making. Wil told Andrea that when he understands she feels vulnerable and hurt, she seems much less scary,

and he feels much more important to her, much safer. The couple were planning a vacation in Nassau in the next few weeks and we decided to meet in the new year for a follow-up visit.

What this case study illustrates is the clinical effectiveness of EFT in working with a couple confronted with a chronic physical condition. It demonstrates how, through a combination of experiential and systemic approaches, the couple are assisted in processing their emotional experiences within the context of their relationship cycle. It also demonstrates how each partner's emotional experiences are normalized and validated, and how by conceptualizing problems in terms of an attachment framework, the couple are able to seek comfort, safety, and security from one another and, ultimately, interact in more adaptive, healthier ways.

CONCLUSION

In conclusion, a brief review of the literature on chronic illness in couples suggests the link between chronic health conditions and close relationships is reciprocal in nature. That is, just as close relationships affect the onset and course of chronic illnesses, chronic illnesses influence close relationships. Research further reveals that chronic illness does not only affect individuals inflicted with chronic health conditions, it affects their intimate partners as well as their relationship and patterns of interaction. Although recent studies have started to provide valuable clues regarding the processes by which chronic illness and close relationship are related, additional research is needed. A particularly fruitful avenue for future research is to further explore attachment behaviors in the context of chronic physical conditions. From an applied perspective, a number of theoretical approaches may be used to work with couples facing chronic illness and disease. Because of the paucity of empirical data regarding the clinical efficacy of these approaches, it is not yet possible to ascertain which are most effective. Nevertheless, there is reason to believe that EFT is particularly germane in this regard, especially when one considers its previously demonstrated efficacy in helping parents of chronically children, integration of systemic and experiential approaches, and focus on creating safety, security, and comfort in relationships.

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