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EMOTIONALLY FOCUSED INTERVENTIONS FOR COUPLES WITH CHRONICALLY ILL CHILDREN: A 2-YEAR FOLLOW-UP

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Couples with chronically ill children are particularly at risk for experiencing marital distress. The study presented here is a 2-year follow-up of a randomized control trial that assessed the efficacy of Emotionally Focused Therapy (EFT) in decreasing marital distress in a sample of couples with a chronically ill child. Thirteen couples with chronically ill children who received treatment were assessed to determine if the significant improvement in relationship distress observed at posttreatment and 5-month follow-up would be maintained at 2-year follow-up. Results demonstrated that improvements in marital functioning were not only maintained but, in some cases, enhanced at the 2-year follow-up. This uncontrolled follow-up study provides initial evidence of the longer-term benefits of EFT.

Parents with chronically ill children are at significant risk for experiencing marital distress (Nixon Speechley & Noh, 1992; Quittner & DiGirolamo, 1998). Gaither, Bingen, and Hopkins (2000) have recently written a thorough review of the reciprocal relationship between chronic illness in children and couple functioning. It is clear from their critical appraisal of the literature that there are many conflicting results. Despite the many discrepancies in research findings, it is generally accepted that parents of children with chronic illness are at greater risk of experiencing marital distress than are parents of nondisabled children. However, there remains a dearth of intervention outcome studies for these parents.

Given parents' critical role in providing daily medical care for their child, it is important to assist them when they encounter marital and/or psychological difficulties to enhance their ability to parent their chronically ill child. This was the impetus for a randomized control trial (RCT) that assessed the efficacy of a couple therapy intervention for partners with chronically ill children (Gordon Walker, Johnson, Manion, & Cloutier, 1996). Emotionally focused couple therapy (EFT; Greenberg & Johnson, 1988; Johnson, 1996), a marital intervention that integrates experiential and systemic approaches, has repeatedly demonstrated clinical efficacy in the general population of distressed couples. Emotionally focused couple therapy views distressed relationships from an attachment perspective. It therefore focuses on increasing the accessibility and emotional responsiveness that fosters secure bonding and it gives priority to working with attachment needs and fears. Attachment needs arise with particular force in situations of loss, fear, and uncertainty. Secure attachment, a sense that one can count on loved ones to be there when needed, has been linked to resilience and the ability to deal with stress (Mikulincer, Florian, & Weller, 1993). This approach has achieved results that are superior to other empirically validated approaches. A recent meta-analysis found a 70%–73% recovery rate from distress in the four most rigorous studies on the effects of EFT (Johnson,

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Hunsley, Greenberg, & Schindler, 1999), whereas it has been estimated that only 35% of couples receiving behavioral interventions are no longer distressed at posttest (Jacobson, Follette et al., 1984; Johnson & Lebow, 2000). Emotionally focused therapy for couples has also been used extensively with couples dealing with traumatic stressors (Johnson, 2002; Johnson & Williams-Keeler, 1998).

In the randomized trial with the parents of chronically ill children (Gordon Walker et al., 1996), no differences were found at pretreatment between groups. However, at posttreatment and 5-month follow-up, the treatment group reported significantly greater marital adjustment compared to the wait-list control group. A similar pattern was observed for couples' reported levels of intimacy. As well, objective assessment of the couples' communication patterns indicated significant improvement in the treatment couples as compared to controls.

Little is known in the general marital literature about the long-term effects of marital interventions (Bray & Jourilles, 1995; Johnson & Lebow, 2000). To date, only two studies that have used standardized instruments have investigated the long-term efficacy (> 1 year) of couple interventions on the marital relationship. In one 2-year follow-up, 30% of couples who recovered from marital distress at posttreatment after receiving Behavioral Marital Therapy (BMT) had relapsed (Jacobson, Schmaling, & Holtzworth-Monroe, 1987). Similarly, in their 4-year follow-up study, Snyder, Wills, and Grady-Fletcher (1991) found a 39% deterioration rate and a 38% divorce rate in couples who received BMT. In contrast, they found only a 10% deterioration rate and a 3% divorce rate in couples at 4-year follow-up who received insight-oriented marital therapy (IOMT).

From the above, it is evident that there is a gap in the general literature on the long-term efficacy of couple therapy interventions. With regard to marital functioning, the little research that exists suggests that the type of intervention may be important in long-term outcome. In a recent meta-analysis, IOMT was found to be more effective in marital adjustment at post treatment than BMT or cognitive behavioral marital therapy (CBMT; Dunn & Schwebel, 1995). Although there is little documented evidence that the effects of BMT are sustained over time, IOMT demonstrated long-term efficacy in maintaining both the structure and quality of the couple's relationship, albeit in one study. It is important to note that in their analysis, Dunn and Schwebel included EFT under IOMT. In fact, these two therapies are conceptually quite different (Johnson, 1996). Although short-term follow-ups have been encouraging, there has been no long-term follow-up on the results of EFT. We expect EFT to foster lasting change because it focuses specifically on the key elements of marital distress as identified in recent research (Gottman, Coan, Carrere, & Swanson, 1998). Emotionally focused couple therapy focuses not only on modifying key negative cycles of interaction and emotional responses, but also fosters highly salient bonding events in which partners emotionally engage and respond to each other's needs in a way that builds trust, intimacy, and secure attachment.

This report presents a 2-year follow-up study on the families that were in the original Gordon Walker et al. (1996) study. This study was conducted to remedy the lack of long-term follow-up in the general couple therapy literature, and a lack of long-term follow-up data on EFT in particular. Given the significant results Gordon Walker et al. (1996) found on marital adjustment after EFT, both at posttreatment and 5-month follow-up, it was hypothesized that this improvement would be maintained at 2-year follow-up as measured by the Dyadic Adjustment Scale (DAS) and the Miller Social Intimacy Scale (MSIS). Because the couples in this study were under considerable and recurring stress because of their child's illness, examining the stability of treatment results at long-term follow-up with this population was considered a relatively rigorous test of the long-term effectiveness of EFT with the general population of distressed couples.

METHOD

Participants

Participants included a volunteer sample of couples with a chronically ill child seen at a tertiary care pediatric hospital who had previously participated in an outcome study that assessed the effectiveness of

EFT in alleviating relationship distress. In the original outcome study, couples had to agree to random assignment and both spouses had to agree to participate. They had to be experiencing marital distress as indicated by a DAS score of 110 or lower for the partner who indicated the greater marital distress. A score of 110 has been found to be an appropriate cut off for indicating marital distress in couples with chronically ill children (Gordon Walker, Johnson, Manion, & Cloutier, 1992). To maintain a degree of homogeneity in the sample and provide an operational definition of chronic illness, the illness had to have been diagnosed for a minimum of 12 months, require ongoing parental medical management of the child, and have a risk of mortality. The nine disease groups from the original trial met these criteria: autoimmune disease, cancer, cystic fibrosis, diabetes, epilepsy, kidney disease, muscular dystrophy, severe asthma, and spina bifida. This "noncategorical" illness approach is based on the theoretical model of illness categories being less significant predictors of adjustment outcomes than general family stress variables and disease-related factors (Stein & Jessup, 1982; Lavigne & Faier-Routman, 1992). Although recent research (Holden, Chmielewski, Nelson, Kager, & Foltz, 1997) has found support for the use of both noncategorical and categorical approaches to the study of chronic illness, the main goal of this study was to evaluate the long term efficacy of EFT and not the effects of specific chronic illnesses on children and families. All couples had to be living together with their ill child. Exclusion criteria included marital violence, psychiatric history, excluding depression, a current desire for divorce by either spouse, alcohol or drug abuse, and primary sexual dysfunction in either spouse. In addition, couples could not be involved in any other psychological treatment at the study's onset. Thirty-two couples who met these criteria were block randomized to either the intervention group (16 couples) or to a wait-list control group (16 couples). A detailed description of the participants and methods used in the original study can be found in Gordon Walker et al. (1996).

All couples who originally received EFT were invited to participate in the 2-year follow-up study. Couples who agreed to participate were sent a complete set of the questionnaires from the original study and these questionnaires were collected after a period of 2 weeks in a home visit. The home visit was conducted to decrease the burden for these families in finding child care, often a major difficulty for parents with chronically ill children. Eighty-one percent ($n = 13$) of treatment couples participated in the 2-year follow-up. Of the treatment couples who refused to participate in the 2-year follow-up, one couple had separated, one couple's child was in medical crisis at the time of data collection, and one father simply refused with no reason given. No treatment couple reported receiving psychological intervention for either themselves or their child between the end of treatment and the 2-year follow-up.

Although we attempted to collect data on both treatment and control couples, we obtained valid data on only three of the original wait-list control couples. Of the remaining 13 couples, five had separated at the 2-year mark and refused to participate, three had gone on to receive treatment, one had moved out of the country, and four simply refused any follow-up. We were thus unable to make meaningful comparisons aside from the difference in separation rates between the two groups.

At the time of the original RCT, the 13 treatment couples who participated in the 2-year follow-up had a mean socioeconomic status (SES) index of 55.15 ($SD = 13.17$), which translates to a middle-class SES. This index is based on a combination of level of income and education for the total Canadian labor force (Blisshen, Carroll, & Moore, 1987). The mean age was 37.7 years ($SD = 5.1$) for husbands and 35.0 years ($SD = 4.8$) for wives. Couples were married for a mean of 9.8 years ($SD = 5.3$). They had a mean of 2.2 children ($SD = 0.7$), and the mean age of their ill child was 6.1 years ($SD = 3.0$) and had been chronically ill for a mean of 4.4 years ($SD = 2.1$). Although the sample was primarily Caucasian, no detailed information was gathered on ethnic makeup.

Measures

Dyadic Adjustment Scale (DAS). This self-report instrument measures marital adjustment (Spanier, 1976). The DAS consists of 32 items that make up the total scale score. The range of total scores on the DAS is from 0 to 151, with lower scores indicative of lower marital adjustment. Criterion validity of the DAS has been demonstrated using a sample of 218 married and 94 divorced persons (Spanier, 1976) in the general population, and in 316 married spouses with chronically ill children (Gordon Walker et al., 1992). Reliability

of the instrument has been demonstrated with a coefficient alpha of .96 (Spanier, 1976). The data of the lower scoring spouse on the DAS at pretreatment, the primary outcome measure, was used as a more sensitive indicator of marital functioning than averaging a couple's score (Baucom & Kaplan Mehlman, 1984).

Miller Social Intimacy Scale (MSIS). The MSIS is a self-report measure of intimacy in interpersonal relationships (Miller & Lefcourt, 1982) with a reported Cronbach's alpha = .91 and found high test-retest reliability ($r = .96, p < .001$). Mean scores were found to differ significantly between distressed ($M = 154$) and nondistressed ($M = 126$) couples.

Parent Stress Index. The 19-item Life Stress Scale from this parent self-report measure was used as an index of the amount of stress outside the parent-child relationship experienced by the parent (Abidin, 1995).

Emotionally Focused Couple Therapy Intervention

A detailed description of the EFT intervention, the therapists and their training, and an overview of the integrity of therapy implementation can be found in Gordon Walker et al. (1996). Briefly, EFT, a synthesis of experiential and systemic approaches to intervention, was modified for couples with chronically ill children. Therapists were sensitized about the stresses and needs of families with chronically ill children and provided with medical background information of the different diseases represented in the study. Throughout the therapy process the impact that the child's illness may have had on the spouses as individuals, or on their relationship was emphasized when appropriate. Consistent with past EFT studies, sessions were provided over ten 90-min periods held every week, or every second week, depending on the couple's preference. Both spouses attended all 10 treatment sessions together.

RESULTS

Analyses for all variables were conducted using the data from the lowest scoring partner on the DAS at pretreatment. Males were the lowest scoring partner in 7 couples and females in 6 couples.

Marital Adjustment (DAS) and Intimacy (MSIS)

Two repeated measures analyses of variance (ANOVA) were conducted assessing the maintenance of the intervention on decreasing marital distress and increasing intimacy. The repeated measure was the time of the assessment (pre-, post-, 2-year follow-up) and the dependent variables were the DAS scores and the MSIS scores. The two dependent variables were analyzed separately because of sample size restrictions.

The repeated measures ANOVA on the DAS demonstrated a significant main effect of Time, $F(2,11) = 17.5, p = .000$. Two-planned a priori repeated contrasts were utilized to investigate treatment and maintenance effects. Results revealed that there was a significant difference between pretreatment and posttreatment scores on the DAS, $F(1,12) = 20.0, p = .001$. Moreover, there was no difference between DAS scores at posttreatment and 2-year follow-up, $F(1,12) = 0.0, p = .988$ indicating that maintenance was achieved. No significant time effect was found on the MSIS. Means and standard deviations for the DAS and MSIS can be found in Table 1. It should be noted that there were differences in DAS scores between partners at pretreatment ($M = 6.6, SD = 3.8$), post-treatment ($M = 6.1, SD = 4.6$), and follow-up ($M = 9.6, SD = 10.9$) with the most pronounced differences and variability across couples seen at follow-up.

There were no statistically significant correlations between the number of life stressors identified by parents as measured by the Parent Stress Index, Life Stress Scale and marital satisfaction or intimacy as measured by the DAS and the MSIS at pretreatment, posttreatment, or 2-year follow-up.

Clinical Treatment Effects

It is important that, in addition to statistical treatment effects, the clinical significance of treatment effects be assessed (Jacobson, 1985; Kazdin, 1986) to determine whether observed differences are large enough to be able to make a real difference to individuals (Hollon & Flick, 1988). Two criteria were considered when determining clinical significance (Jacobson & Revenstorf, 1988): Proximity to the clinical cutoff for distress, and the magnitude of change as a function of therapy. To determine the first criteria,

TABLE 1
Means and Standard Deviations of the Dependent Variables (N = 13)

	Pretreatment		Posttreatment		2-year follow-up	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Measures ^a						
Dyadic Adjustment Scale	99.15	8.55	108.38	12.5	108.31	13.17
Miller Social Intimacy Scale	126.31	16.80	134.54	20.02	133.46	16.96

^aLower scores are indicative of greater marital distress and lower intimacy

Jacobson and Truax (1991) suggested that when norms are available and distributions of normative data overlap, a cutoff score is calculated by determining the halfway point between the two means (distressed and nondistressed). Past researchers have utilized Spanier's (1976) norms to determine a cutoff score on the DAS, however, Spanier's norms are different than those found for parents in general (Houseknecht, 1979) and for parents of chronically ill children (Gordon Walker et al., 1992). Gordon Walker et al., (1992) present DAS normative data on couples with chronically ill children for marital adjustment ($M = 118$) and marital distress ($M = 110$). The present study utilized these norms to calculate a clinical cut-off score of 114. The second criterion of clinically significant change, the reliable change index, is the difference between pretreatment and posttreatment scores divided by the standard error of the difference. A difference of 4.48 (conservatively rounded to 5) points on the DAS was considered necessary for a change score to be deemed reliable and not a result of measurement error alone. The reliable change index in combination with the clinical cut off was used to reflect the percentage of couples who recovered, improved, remained unchanged, or deteriorated. At posttreatment, 2 couples (15.4%) had recovered, 8 couples (61.5%) had improved, 2 couples (15.4%) remained unchanged and 1 couple (7.7%) deteriorated. Results from the 2-year follow-up show 3 couples (23.1%) had maintained the gains, 5 couples (38.5%) made further gains (i.e., recovered), 4 couples (30.8%) still had no change from their prescore or returned to their prescore and one couple (7.7%) deteriorated to lower than their prescore.

Separation Rates

Although data were not available for the entire original control group who did not receive the intervention, it is important to highlight the proportion of these control couples compared to the treatment couples that had separated at the 2-year follow-up. Only 6% (1 of 16) had separated in the treatment group at the 2-year follow-up whereas 38% (5 of 13) of the control couples had separated. Three of the 16 control couples entered therapy following the initial study and are, therefore, not included in the calculation of separation rates. The one treatment couple who separated reported when interviewed that the intervention helped them separate harmoniously and felt that without it they would have been very antagonistic toward each other.

DISCUSSION

This is the first study to examine the long-term efficacy of an EFT intervention and to examine this efficacy for couples who are coping with a chronically ill child, thus placing them at continuing risk for marital distress. Results from the original study demonstrated that EFT interventions led to both statistical and clinical improvements in marital functioning in these distressed couples (Gordon Walker et al. 1996). This study found that these treatment effects were largely maintained over a 2-year follow-up. There is also some support to suggest that several couples experienced an enhancement effect after the termination of therapy. Specifically, 61.5% (8 couples) had improved by posttreatment, and 15.4% (2 couples) had

recovered. By the 2-year follow-up, five additional couples had recovered. For these five couples, there was an apparent enhancement of the effects of treatment over time. Combined, 76.9% (10 couples) had improved or recovered at posttreatment and 61.5% (8 couples) had improved or recovered 2 years posttreatment. It should be noted that these numbers do not include the one couple who had separated at the 2-year follow-up. Even so, the rates of clinically relevant improvement are noteworthy.

It is important to discuss why EFT was apparently able to foster such long-term effects, even with couples facing a significant on-going stressor, whereas other therapies, such as BMT, have not. Emotionally focused couple therapy fosters highly salient bonding events in which partners emotionally engage and respond to each other's needs in a way that builds trust, intimacy, and affiliation with the other spouse. Bonding interactions redefine the relationship as a secure base and a safe haven (Cassidy & Shaver, 1999) where the couple can deal with the stress of their chronically ill child together. Facing such stress then tends to pull the couple together and reinforce the bond between them, rather than pulling them apart. More secure levels of attachment have also been found to be associated with positive factors, such as flexible, open communication, the ability to process information effectively, such as dealing with ambiguity and being able to take multiple perspectives, and the ability to empathize with others (Johnson & Whiffen, 1999). Therefore, creating emotional engagement would be expected to provide increased comfort and support, as well as a buffer against the stress associated with parenting a chronically ill child, thus preventing further crises from undermining the relationship. Moreover, each crisis weathered together may make the couple more able to depend on and be confident about the relationship and its ability to help them to deal with their child's chronic illness.

The difference in separation rates between the treatment and control groups suggests the importance of intervention for these families. Our findings are consistent with previous studies (e.g., Martin, 1975; Tew, Payne, & Laurence, 1974) that indicate deterioration in marital functioning in families dealing with a chronically ill child that results in increased separation and divorce when no intervention is provided.

Given the positive treatment outcome suggested by the findings of this study, it is important that maritally distressed couples be referred for intervention in a timely fashion. The fact that 38% of control couples ultimately separated underscores the importance of providing couple therapy interventions for this population. Such separation can be harmful for any family. For families with chronically ill children, the effects on parents and children can be even more negative given the added challenges of dealing with the child's illness.

In Wesley and Waring's (1996) critical review of the couple therapy outcome literature, they underscore what they consider to be their most compelling observation, that wait-list control groups showed no tendency for remission of marital discord; in fact relationships often deteriorated without intervention. Consequently, they question the use of wait-list controls. In our study, only 19% (3 of 16) of the wait-list control couples elected to initiate therapy when it was offered approximately 5 to 6 months after their initial interest. Given that 38% (5 of 13) of control couples separated at the 2-year follow-up, we embrace Wesley and Waring's suggestion of attention placebo and also highlight the potential ethical dilemma of not offering treatment when there is such a risk of relationship deterioration.

Although promising, these results must be interpreted with an appreciation of the following limitations, which include a small sample size, the lack of a control comparison at 2-year follow-up, the reliance on the DAS as the sole measure of clinical treatment effects and the lack of an observational measure at follow-up. Future studies using attention control may be able to better evaluate group effects at a longer-term follow-up, as there might be less attrition from the control group. It would also be prudent that future research include process data in addition to outcome data. Process data is important to identify in therapy factors and events that are associated with positive outcomes and with impasses in therapy to refine interventions. Recent research in EFT, for example, has suggested that attachment injuries—abandonment and betrayal at a key moment of high need (such as when a child or spouse is in a medical crisis)—if not addressed and resolved, tend to undermine a couples' ability to reach recovery and may then render them more vulnerable to relapse (Johnson, Makinen, & Millikin, 2001). One last recommendation is that EFT should be replicated with other populations of family systems experiencing marital distress and long-term follow-up be planned a priori.

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