

## Coping with Early Breast Cancer: Couple Adjustment Processes and Couple-Based Intervention

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Early breast cancer affects one in every nine women along with their families. Advances in screening and biomedical interventions have changed the face of breast cancer from a terminal condition to a chronic disease with biopsychosocial features. The present review surveyed the nature and extent of psychological morbidity experienced by the breast cancer survivor and her spouse during the post-treatment phase, with particular focus on the impact of disease on the marital relationship. Interpersonal processes shown to unfold in couples facing breast cancer, as well as risk factors associated with greater psychological morbidity, were reviewed. Moreover, interpersonal processes central to coping with chronic illness and adjustment were reconceptualized from the point of view of attachment theory. Attachment theory was also used as the grounding framework for an empirically supported couples-based intervention, Emotionally Focused Therapy, which is advanced as a potentially useful treatment option for couples experiencing unremitting psychological and relational distress following diagnosis and treatment for breast cancer.

Breast cancer has become an important public health concern both in Canada and worldwide. Currently the most prevalent female malignancy across all age groups, breast carcinoma accounts for 30% of all new cancers. Within the Canadian population, 22,300 new cases of breast cancer are diagnosed annually, of which 5,300 lives are claimed (Canadian Cancer Statistics, 2007).

Trend analyses over a thirty-year period from 1969 to 1999 reveal a cumulative incidence increase of 30%, which appears to have stabilized (National Cancer Institute of Canada, 2007). At present one in nine Canadian women will be diagnosed with breast

cancer during their lifetime (National Cancer Institute of Canada, 2007). Notwithstanding the steady rise in incidence, breast cancer mortality rates have dropped from 33.1 per 100,000 women in 1990 to 23 per 100,000 in 2007 (Canadian Cancer Statistics, 2007). The considerable gap between incidence rates and mortality is largely due to a combination of factors: enhanced risk awareness in the general population, participation in screening programs, improved detection technologies, and development of more effective systemic treatments. Today, 162,600 Canadian women have survived invasive breast cancer diagnosed at some point within the last 15

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years (National Cancer Institute of Canada, 2007).

Increased survivorship has essentially transformed the disease from what was formerly accepted as a terminal condition to one of chronicity (Sherman & Hossfeld, 1990) with biopsychosocial sequelae (Cassileth, 1979; Engel, 1977). Since patients are now living longer, they are faced with multiple challenges beyond the acute phase of medical treatment. These include dealing with having been diagnosed with a potentially life-threatening illness, long-term effects of toxic treatments, the possibility of recurrence even after many years of apparently successful treatment, career interruptions, and financial strain. Adequate resolution of these concerns, however, cannot be removed from a pre-existing marital context, which affects and is affected by disease and treatment variables. The pivotal role of the marital relationship has been receiving gradual recognition by researchers within the psychosocial oncology literature. Northouse (1993), for example, redefines breast cancer as a “biopsychosocial problem that occurs in the context of an intense personal relationship that affects, and is affected by, the disease process in circular reciprocity.” Baider and Kaplan-De Nour (1988b), similarly, describe cancer as a “family affair.”

The aims of this article are to (1) review the nature and significance of psychological morbidity experienced by the breast cancer survivor and her spouse along the illness trajectory, with particular emphasis on the post-treatment phase, (2) discuss the impact of breast cancer on the marital relationship, and (3) review empirically established interpersonal processes shown to unfold in couples facing breast cancer, as well as identify risk factors associated with greater psychological morbidity. Interpersonal processes central to coping with chronic illness and adjustment are then reconceptualized from the point of view of attachment theory. Attachment theory also provides the grounding framework for an empirically supported couples-based intervention, Emotionally Fo-

cused Therapy (EFT), which is presented as a potentially useful treatment option for couples experiencing unremitting psychological and relational distress following diagnosis and treatment for breast cancer.

### ADJUSTMENT TO BREAST CANCER ALONG THE ILLNESS TRAJECTORY

Adjustment or psychosocial adaptation to cancer has been defined as an ongoing process in which the individual attempts to manage emotional distress, solve specific cancer-related problems, and gain mastery and control over cancer-related life events (Brennan, 2001, Folkman et al., 2000, Kornblith, 1998, Nicholas et al., 2000). The adjustment process, therefore, is not a single unitary concept, but rather a series of ongoing coping responses to multiple tasks associated with living with breast cancer. It is important to distinguish between normal adaptive responses versus problematic ones in patients with breast cancer, in order to intervene appropriately. Assessment of the appropriateness of an emotional response requires taking into account several factors, including the disease stage and where the patient falls in the cancer continuum from pre-diagnosis, confirmed diagnosis, treatment, remission, and recurrence (Simonton & Sherman, 1998). Such disease-related variables, while relevant, will invariably interact with a patient's inner resources, as well as those of her partner, to produce a distinct emotional response, which will vary in its adaptiveness.

Holland (2000) describes the “normal” or expected responses to receiving the diagnosis of a life-threatening illness, such as cancer, as consisting of three major phases; initial response, dysphoria, and longer-term adaptation. Initial reactions can be intense and typically involve feelings of shock, disbelief, and often denial of medical findings. Patients are often unable to clearly

process or remember any information as a result of the emotional upheaval, directly linked to enhanced long-term potentiation in the amygdale secondary to chronic stress (Amunts et al., 2005). Once the new "reality" is acknowledged, feelings of depression, anxiety, insomnia, anorexia, and poor concentration typically soar (Epping-Jordon et al., 1999; Jamison, Wellisch, & Pasnau, 1978). With more information regarding treatment options, adequate social support, and initiation of medical therapy, intrusive thoughts about the illness and the possibility of death may subside, although variation has been reported with respect to the temporal stability of PTSD (Andrykowski et al., 2000). Longer-term adaptation is marked by the emergence of more lasting and permanent coping styles. During the post-treatment phase, adjustment typically involves utilization of a variety of coping strategies, the most useful of which has been shown to be emotionally expressive coping (Stanton et al., 2000; Stanton, Danoff-Burg, Cameron, & Ellis, 1994; Stanton, Kirk, Cameron, & Danoff-Burg, 2000). Emotionally expressive coping is defined as strategies involving active processing and expression of negative emotional reactions to stressors. By one year following diagnosis, adjustment levels tend to plateau (Northouse, 2001), with minimal spontaneous change or improvement thereafter.

#### **PSYCHOLOGICAL MORBIDITY ASSOCIATED WITH BREAST CANCER**

Research generally converges on the finding that a cancer diagnosis generates greater distress levels compared to any other disease (Shapiro et al., 2001). While it is true that most women manage to survive the threat of diagnosis and the invasive treatments associated with breast carcinoma (Anderson et al., 1994; Baker, Marcellus, Zabora, Polland, & Jodrey, 1997), approximately one-third continue to experience un-

remitting psychological, relational, as well as health-related distress during the first two years following treatment (Dean, 1987; Morris, Greer, & White, 1977; Shields, Travis, & Rousseau, 2000). Depression appears to be the most prevalent psychological issue in breast cancer survivors (Lansky et al., 1985) followed by anxiety (Derogatis et al., 1983).

Studies primarily assessing patients within the first year of diagnosis have reported rates of up to 42% experiencing psychiatric and/or psychological disturbance, in the form of depression, anxiety, or both, which, in turn, compromised quality of life (Derogatis, et al., 1983; Dean, 1987; Hughes, 1982; Kissane et al., 2004; Surtees, 1980; van't Spijker, Trijsurg, & Duivenvoorden, 1997). Within this proportion of psychologically distressed patients, an anxiety disorder and major depression were diagnosable in 8.6% and 9.6% of sampled patients, respectively. Similar findings have been reported in other studies (Maguire et al., 1985; Spiegel, 1996).

Life-threatening illness and its highly stressful medical procedures have also been associated with the development of post-traumatic stress disorder (PTSD) or PTSD-like symptoms in some women (e.g., Doerfler, Pbert, & DeCosimo, 1994). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000, p. 464), "being diagnosed with a life-threatening illness constitutes a traumatic event." The limited number of existing studies has reported cancer-related PTSD prevalence rates in the range of 5-10% (Alter et al., 1996; Cordova et al., 1995) that persisted up to one year post surgery in a sub-set of patients (Tjemsland, Soreide, & Malt, 1998). Indeed only a minority of breast cancer survivors do actually develop PTSD symptoms of sufficient magnitude to meet diagnostic criteria, Amir and Ramati (2002) point out that most patients develop partial or sub-syndromal levels of PTSD which, while not meeting established clinical criteria to warrant a clinical diagnosis, result in impaired quality of life that merits clinical attention nonetheless.

Aside from severe psychiatric disturbance, which is not as common among breast cancer survivors as once thought (Bloom et al., 1987; Glanz & Lerman, 1992; Gordon et al., 1980; Moyer & Salovey, 1996), women do report having to confront significant psychosocial concerns and emotional sequelae that may be equally distressing particularly close to or at completion of medical treatment and thereafter. For example, the most potent concern for patients with early stage breast disease is fear of recurrence and uncertainty regarding the future (Fertig, 1997; Gotay, 1984; Spencer et al., 1999). In fact 30% of women describe the time of chemotherapy completion as distressing (Ward, Viergutz, & Tormey, 1992), due to loss of frequent and reassuring doctor visits and no longer being in active treatment, both of which seem to be associated with a sense of safety. Other highly rated concerns include long-term effects of adjuvant treatments (e.g., fertility, feeling less feminine), financial strain, and "not being able to live out important relationships and having life with a partner cut short" (Spencer et al., 1999). Body image was moderately problematic, particularly for younger women, who also experienced stronger sexual and partner-related complications in relation to older women (Spencer et al., 1999).

While the nature and degree of psychological disturbance potentially triggered by the breast cancer experience can be far-reaching for the patient, the illness does represent a health concern that ultimately impacts spouses and children too. The salience of a woman's spousal relationship in particular during a potentially life-threatening illness has received increasing recognition from several researchers in the field, who contend that breast cancer is best understood as a "family problem" that affects spouses as much as patients (Baider, 1988; Lasry et al., 2003; Northouse, 1993).

### IMPACT OF BREAST CANCER ON THE MARITAL RELATIONSHIP

Following diagnosis of a life threatening illness, patients often cite their spouses as their primary sources of support (Lasry et al., 2003). The illness experience and associated treatment regimens are potent enough, however, to provoke various forms of emotional disturbance in patients' partners, including anxiety, depression, and fear of recurrence and losing one's partner to death (Iqbal et al., 2001). As many as 29% of sampled couples who had been receiving cancer treatment report clinically significant levels of emotional distress (Rodrigue & Hoffman, 1994).

Incidentally, there is evidence for concordance between the levels of emotional distress experienced by patients and their partners (Baider & Kaplan De-Nour, 1988, Northouse et al., 1995). Studies addressing the couple unit in particular found that in the face of a cancer diagnosis, spouses either experienced similar levels of distress as their affected partners or even more (Ferrell, Ervin, Smith, Marek, & Melancon, 2002; Northouse, Mood, Templin, Mellon & George, 2000; Omne-Ponten, Holmberg, Bergstrom, Sjoden, & Burns, 1993). Northouse and Swain (1987), for example, observed that both survivors and their husbands reported corresponding initial levels of distress that tended to improve slightly one month after surgery. In another follow-up study tracking couples 18 months post-surgery, Northouse (1989) observed that, again, despite a decrease in distress scores over time, both partners reported similar levels of psychological distress. More importantly from a coping perspective, Northouse and colleagues (2001) found that husbands' and wives' levels of adjustment to breast cancer, at 1 year post-diagnosis, had a significant and direct effect on each other's adjustment.

Difficulties in psychosocial adjustment are not solely confined to the early phase of illness but may persist over time for both wives and husbands in a consistent fashion

(Walker, 1997). Dyadic adjustment problems and elevated emotional distress occurring well into the post-treatment phase have been reported in several studies (Baider, Kaplan De-Noor, 1988; Ell, Nishimoto, & Mantell, 1988; Hagedoorn, Bruunk, Kuijer, Wobbes, & Sanderman, 2000; Northouse, Mood, Templin, Mellon, & George, 2000; Oberst, & Scott, 1988). Goldberg and colleagues (1984), for example, found that for some couples depression tended to worsen over time for both partners. In a longitudinal study of 143 newly diagnosed breast cancer patients, undertaken by Keitel and colleagues (1990), it was found that spouses' distress levels tended to decline over time and that those who continued to experience adjustment difficulties were more likely to be married to women with relatively higher levels of physical symptoms. In another study by Omne-Ponten and colleagues (1993), comparing the levels of adjustment among husbands of women who had undergone either breast-conserving surgery or mastectomy, 48% were found to experience continued emotional distress up to 13 months post-surgical treatment. This rate was similar to that reported in patients themselves, adding validity to the reciprocal effect coupled partners have on each other found in previous studies.

Taken together, studies appear to converge on the following patterns: 1) dyads report similar levels of distress, suggesting some degree of congruence in their adjustment processes; 2) distress levels in couples appears to decline over time; and 3) for a sizeable proportion of couples there continues to be elevated levels of unremitting distress even after the immediate shock and crisis of diagnosis and treatment (Baider et al., 1984; Sabo et al., 1986; Wellisch et al., 1978; Zahlis et al., 1993). While the rates of dissatisfaction and divorce in couples facing breast cancer are not any higher than in couples in the general population, there is evidence of more strain and conflict (Carter, Carter, & Siliunas, 1993; Northouse, Templin, Mood, & Oberst, 1998; Wai Ming, 2002). Not sur-

prisingly, couples who were at high risk for marital breakdown were those who faced the breast cancer experience with pre-existing marital problems, where the illness added further demands and strain on their relationship (Carter, Carter, & Siliunas, 1993; Lewis & Hammond, 1992; Lichtman, Taylor, & Wood, 1987; Morris, Greer, White, 1977; Northouse, 1989).

#### INTERPERSONAL PROCESSES IN COUPLES FACING BREAST CANCER: EMPIRICAL FINDINGS

The emotional support provided by an intimate partner can have a profound buffering effect on the stress levels experienced by the breast cancer patient as she contends with both the psychological and physiological sequelae of her illness (Krant & Johnson, 1978; Lewis & Deal, 1995; Northouse, 1984). Emotional support is conceptualized in the literature as communication of care, concern, empathy, comfort, and reassurance both verbally and nonverbally, such as through facial expressions and gestures (Helgeson & Cohen, 1996; House, 1981). Specifically, provision of emotional support by husbands has been linked to lower emotional distress, fewer depressive symptoms (Roberts, 1994; Tatelman, 1999) and better role adjustment in their wives who were experiencing breast cancer (Northouse, 1995). In fact, emotional support, as opposed to informational or instrumental support (i.e., problem-solving), emerged as the most preferred type of support cited by women facing breast cancer, particularly if they experienced greater impairment from their illness and treatment course (Manne, Alfieri, Taylor, & Dougherty, 1990a, ref). This is consistent with a study by Pistrang & Barker (1995) who observed that increasing feelings of vulnerability in the breast cancer patient were assuaged by intimate exchanges that were characterized by high empathy and low withdrawal from the spouse.



A woman's intimate relationship seems to provide a unique type of support that if absent or experienced aversively in this particularly stressful period will predictably lead to a greater likelihood of mood disturbance, according to a number of studies (Burg & Seeman, 1994; Carter & Carter, 1994; Kerner, Prince, & Jacobson, 1994; Paykel, 1979, Prince & Jacobson, 1995). Facing breast cancer and its associated stressors, however, can unwittingly propel couples to interact with each other in unsupportive ways, as each spouse attempts to cope and regulate perceived partner distress (Gurowka & Lightman, 1995; Lyons, Sullivan, Ritvo & Coyne, 1995). Spousal interactional patterns in the context of early breast cancer and their association with overall adjustment has been examined by a number of researchers yielding three general patterns observed in relationships; open engagement, mutual avoidance (also known as protective buffering), and pursue-withdraw (Manne, Ostroff, Norton, Fox, Goldstein, 2006; Northouse et al., 1995; Zunckel, 2002).

Couples who openly engaged were characterized by a high degree of emotional expressivity. The ability of couples to openly engage in communication of their feelings about the illness has been linked to positive adjustment, enhanced cohesiveness, and decreased destructive conflict (e.g., Northouse, 1984; Spiegel et al., 1983; Vess, Moreland, & Schwebel, 1985). Although these studies studied primarily women with metastatic breast cancer, others have led to complementary findings (e.g., Stanton et al., 2000). Specifically, in a study of 92 women diagnosed with Stage 1 and 2 breast carcinoma, those found to cope using emotional expression around their diagnosis had fewer cancer-related morbidities, decreased distress, and enhanced health and vigor three months post-assessment. (Stanton et al., 2000).

The second pattern, mutual avoidance, was examined in one study addressing coping processes of couples facing breast cancer where some partners, in an effort not to upset each other, withheld sharing their

feelings of distress and worries (Northouse et al., 1995), which, in turn, undermined adjustment in both partners. In a longitudinal study, Manne, Dougherty, Veach and Kless (1999) observed a similar pattern of "protective buffering" (p. 235), which was associated with higher distress in wives three months later. The phenomenon of protective buffering observed in some couples was compared to open communication and active engagement in a study by Hagedoorn, Kuijer, Buunk, DeJong, Wobbles, and Sanderman (2000). Predictably, the latter pattern of communication predicted higher marital satisfaction and better adjustment in the face of illness. Similarly, breast cancer survivors who confided in their partners during times of crises enjoyed better prognoses, as measured by survival (Weihs, Enright, & Simmens, 2002). These findings are particularly relevant in view of the positive relationship between quality of the marital relationship and adjustment responses in both partners (Rodrigue & Park, 1996), as well as disease recovery in patients (Burman & Margolin, 1992).

Other studies have also examined the impact of unilateral avoidance, specifically husbands' avoidance in reaction to their partners' illness, where wives desired more closeness. Sabo and colleagues (1986), for example, found that while their wives were undergoing mastectomies, some men tended to adopt a "protector's role" while simultaneously avoiding any open expression of feeling. This was, in turn, experienced aversively by spouses, in addition to being perceived as insensitive and rejecting. Avoidance of open discussion about the cancer experience and its association with greater distress is a recurring finding in the cancer literature (Spiegel, Bloom, & Gottheil, 1983; Vess, Moreland, Schwebel, & Kraut, 1988). This also parallels findings from the non-cancer literature linking husbands' withdrawal behavior to aversive states of emotion in their respective wives (Christensen & Heavey, 1990; Christensen & Malmuth, 1995; Christensen & Shenk, 1991; Gottman, 1993; Gottman,

1994; Gottman & Levenson, 1992; Noller & Feeney, Bonnell, & Callan, 1994), thus creating higher levels of marital dissatisfaction and conflict.

In the context of breast cancer, husband's avoidance is arguably the most deleterious interactional pattern to marital functioning and adjustment. In the face of crisis, patterns of relating to one another become particularly intensified. Avoiding discussion of the cancer has been shown to lead to communication problems, even among those couples who initially reported high levels of marital satisfaction (Lichtman et al., 1987). For other couples, long-standing negative patterns of communication escalate during the illness trajectory, directly impacting the extent of destructive conflict and strain on each partner's experiences (Cohen & Wellisch, 1978; Vess et al., 1985).

The third interactional pattern observed in some couples facing breast cancer, initially noted by Manne and colleagues (1997), entails a cycle of pursue and withdrawal from the wife and husband, respectively. Where emotional support and open engagement were unavailable, some breast cancer survivors tended to engage in criticism, which was favorably experienced as a sign of engagement (Pistrang & Barker, 1995). In such transactions, the distress associated with dispensing marital criticism is conjectured to be more tolerable than complete withdrawal on the husband's part. Unfortunately, the pursuing wife's behavior propels further distancing and withdrawal from her husband, leading to lower marital satisfaction (Manne et al., 1997).

Examination of withdrawing or distancing behavior of some husbands in reaction to their wives' illness has been examined in some studies. Specifically, some partners report feeling burnt out, secondary to chronic exposure to their wives' negative affective responses (Revenson, 1994; Wellisch, 1985) and also experience as complaints their wives disclosures about their emotional and physical reactions to their illness (Revenson, 1994). Since husbands, as previously men-

tioned, respond to their wives' diagnoses with their own increased mood disturbance (Baider, Perez, & Kaplan de-Nour, 1988; Carter & Carter, 1994), withdrawal from engagement is argued to be one form of affect regulation, albeit a maladaptive one. Withdrawal, as previously mentioned, is related to an enhanced risk for mood disturbance in the ill spouse (Grandstaff, 1976; Primomo et al., 1990).

In summary, unsupportive patterns of relating predictably lead to greater marital distress, especially in the context of a life-threatening illness, which can further exacerbate depressive symptoms in women (Bloom, 1982; Ptacek, Ptacek & Dodge, 1994). The distress experienced in the context of marital strife can, moreover, undermine one's ability to cope with an imminent stressor and also limit one's ability to obtain support in other relationships (Coyne, 1986). In fact, the spousal relationship has been found to be of significant emotional potency such that, if troubled, ensuing distress cannot be simply overcome by additional social support (Pistrang & Barker, 1995). Taken together, empirical studies examining interpersonal processes in the context of a potentially life-threatening illness converge on the centrality of the marital relationship in mediating coping, and overall adjustment of both partners.

While many couples clearly possess the emotional resources required to weather the crisis of a cancer diagnosis and its psychosocial implications, there is evidently variation in the manner in which couples effectively cope with this difficult experience. Understanding normative processes as well as individual variation in emotional regulation, coping and adjustment is important in relation to being able to identify couples at risk for developing unremitting distress and adjustment difficulties, in addition to offering suitable remediation. Clinical intervention, however, requires a theoretically informed framework to guide clinicians in working with such couples and the multitude of issues they face. Attachment theory arguably pro-

vides the most cohesive and well-articulated framework, which unifies both intrapersonal and interpersonal processes that emerge in the face of challenge. Adult attachment theory provides the theoretical anchor for Emotionally Focused Therapy, a couples-based intervention offered to couples experiencing adjustment difficulties following breast cancer illness.

### ATTACHMENT THEORY

Attachment theory is primarily concerned with the salience of interpersonal relationships, which serve to maintain adaptation (Bowlby, 1973, 1988). Bowlby argued that humans are endowed with a biological propensity to seek and maintain proximity to attachment figures. These close relational ties serve to buffer anxiety as well as offer physical protection, particularly during times of stress (Bowlby, 1982, 1969, 1973). Within the attachment system, Bowlby outlined several universal aspects. First, attachment figures confer a safe physical and emotional space, or safe haven. The secure base afforded through proximity to attachment figures allows the organism to explore the world in a non-defensive manner and thrive. Second, proximity-seeking tendencies are behavioral manifestations of in-born affect regulation strategies aimed at protecting the individual from real or imagined threat and ensuing distress. And third, due to its survival value, the attachment behavioral system is manifested throughout the human life span or from the "cradle to the grave" (Bowlby, 1979). Bowlby's theory also accounts for interpersonal differences observed in behavioral attachment systems.

Attachment theory has undergone extensive integration with research on adult relationships (Hazan & Shaver, 1987; 1994). The attachment model of adult intimacy views a relationship between couples in terms of a bond with an irreplaceable other. This psychological tie is a function of four

interrelated elements, emotional, cognitive, behavioral, and physiological processes that interact to optimize survival. An individual's response to any real or perceived separation from or loss of an attachment figure, particularly in the face of threat, has been shown to instigate a predictable series of responses designed to re-instill the bond and to facilitate an adaptive response to environmental demands (Bowlby, 1969, 1988). For example, research in adults has shown that departure of one partner of a dyad is associated with a heightened overt display of proximity-seeking behaviors in the other partner (Fraley & Shaver, 1998). Similarly, adults demonstrate a behavioral tendency to seek others for support while, or immediately following, encountering stressful events (Kobak & Duemmelr, 1994; Lazarus & Folkman, 1984). Proximity-seeking behavior in the face of physical/psychological stress or threat has clear survival value in that comfort and security are obtained from an attachment figure thereby restoring any psychological/physical homeostatic deviations to optimal states, which in turn enhance adaptation to or coping with the presenting stressor.

Central to attachment theory is the concept of internal working models, which accounts for the interpersonal differences observed in attachment behavioral systems (Bartholomew & Horowitz, 1991; Collins & Read, 1990; Main, Kaplan, & Cassidy, 1985). These constitute organized internal representations of the self in relation to significant others. Beliefs and feelings of oneself are partially dependent on perceived accessibility and responsiveness of an attachment figure to one's needs for security and comfort (Cassidy, 1988). Internal working models provide a cohesive framework from which attachment-related events are interpreted and revised (Bowlby, 1973).

In the context of close relationships, working models tend to give rise to attachment strategies, which are essentially habitual forms of engagement that become salient in times of fear or uncertainty, such as receiving a breast cancer diagnosis or having to



undergo invasive treatments. Secure attachment is based on the perception that attachment figures are accessible and responsive to a vulnerable-feeling self facing an uncertain future. The unsure self is soothed through exchanges from a responsive and attuned attachment figure. Exchanges that are marked by emotional engagement ultimately constitute the building blocks of secure bonding, and the relationship becomes defined as a safe haven.

In contrast, unresponsiveness of an attachment figure will instigate less than secure patterned responses or attachment strategies by the individual in an attempt to re-instill some connection with an irreplaceable other. Insecure forms of engagement are limited in number and can be organized along a two-dimensional model: anxiety (self) and avoidance (other) (Brennan, Clark, & Shaver, 1998). Adults endorsing elevations on attachment anxiety, along with low attachment avoidance, typically engage in emotionally intense pursuits of loved ones, marked by clinging and even aggressive behaviors, in their attempt to re-engage their significant other when feeling vulnerable. Adults who are low on anxiety and high on avoidance, on the other hand, cope with the aversiveness associated with an absent safe connection by suppressing attachment needs altogether. Such individuals employ distancing strategies to avoid distressing emotional engagement with attachment figures.

These habitual ways of engagement, also known as attachment styles in the literature (Sroufe, 1996), may be conceptualized as filters for construing attachment experiences, which affect how people cope in the face of adversity. Two characteristic features distinguish attachment strategies from fixed cognitive schema. First is the interpersonal and reciprocally reinforcing nature of attachment strategies that becomes particularly salient in close relationships. Second, is their emotional nature, as stressed by Bowlby (1969). Specifically, it is the emotional quality of attachment strategies which ultimately organizes dyadic interactions, but also makes

them open for revision following corrective emotional experiences (Johnson, 2002).

### A THEORY OF AFFECT REGULATION AND COPING

Attachment theory is primarily a theory of affect regulation. Attachment strategies or habitual ways of engaging one's significant other in times of threat are manifestations of a biobehavioral control system that becomes activated in the face of danger. Its activation serves to promote emotional and physical proximity towards the goal of achieving a felt sense of security. Close relational bonding has a protective impact on emotional and physical health, including restoration of immune competence, as well as mediating optimal coping with adversity, including chronic illness (Kiecolt-Glaser et al., 1993). It is the secure emotional aspect of connectedness that promotes effective self-regulation, openness to experience and new learning, and integration of information (McFarlane & van der Kolk, 1996).

In contrast, emotional connection that is desperately needed from an attachment figure, but not forthcoming for a variety of reasons, culminates in relational distress (Simpson & Rholes, 1994) and is associated with symptoms of post-traumatic stress and depression (Whissman, 1999). In the context of such relationships, couples find it difficult to weather a potentially traumatic experience, such as a life-threatening diagnosis and its often taxing medical treatments. Specifically, the absence of secure attachment will likely result in feelings of being flooded with fear and helplessness, an inability to cope adequately, and to adapt to new situations (Bowlby, 1973, 1969; Cassidy & Shaver, 1999). The relationship becomes defined as insecure, and couples become readily consumed by absorbing and compelling states of negative affect that entrap them in dysfunctional cycles of interacting with one another.

Habitual ways of engaging one another in the context of close relationships, which determine the extent of secure connection created, seems to be one of the determining factors as to whether a couple can pull through in the face of trauma or not. Specifically, a large body of research clearly associates attachment strategies with variation in emotional expression, emotional regulation, and goal-directed behavior in adults, such as seeking social support (Kobak & Sceery, 1988). A general model proposed by Collins and Read (1994) specifies that the various attachment strategies give rise to distinct emotional response patterns that vary both in nature (positive or negative) and intensity. This model has gained wide acceptance and is consistent with a substantial body of research from various studies examining the differential effects of attachment strategies on management of attentional resources, appraisal styles, emotional reactivity, proclivity for moving towards significant others in times of need, and eliciting their support (e.g., Bartholomew, 1990; Feeney & Kirkpatrick, 1996; Mikulincer & Nachson, 1991; Mikulincer & Orbach, 1995; Zuroff & Fitzpatrick, 1995).

Indeed several studies have substantiated systematic differences in ways of coping with stress, which appear to be guided by different attachment strategies that are pulled for in the context of close relationships, and overall adjustment (e.g., Collins & Feeney, 2000; Mikulincer & Florian, 1997; Simpson, Rholes, & Nelligan, 1992). In a study of dating couples, Simpson and colleagues (1992) observed that, in reaction to experienced anxiety, secure women showed a tendency to seek partner support, whereas avoidant women showed the opposite pattern. Similar findings were reported by Mikulincer, Florian, & Weller (1993), where securely attached adults evidenced higher support-seeking behavior in relation to their anxious or avoidant counterparts. Anxious individuals were more prone to engage in emotion-focused coping that emphasized negative emotions, whereas avoidants were more likely to

adopt repressive or emotion-distancing tactics. Another study by Ognibene and Collins (1998) reached consistent findings. Securely attached individuals readily perceived available social support and were more likely to make use of it, especially in times of stress. Anxious individuals, though employing social support strategies to some extent, also engaged in escape-avoidance maneuvers, such as smoking, drinking, eating, and drug use (Brennan & Shaver, 1995). Avoidants, consistent with their negative view of others, were the least likely to reach for interpersonal support, and they most prone to engage in escape-avoidance strategies (Mikulincer & Nachson, 1991; Ognibene & Collins, 1998; Simpson, 1990).

Taken altogether, empirical research clearly supports the use of attachment theory as a framework of affect regulation that becomes activated in the face of danger, giving rise to reciprocally determined attachment strategies in dealing with stress or trauma. By filtering perceptual information, shaping emotional regulation, and guiding coping strategies, predominant ways of relating are argued to hold important implications for adjustment and personal well-being, particularly in the face of chronic illness. Therefore, to the extent that distress is experienced and handled behaviorally, the individual will successfully adapt to changing environmental demands. A large body of research concurs that secure attachment or connectedness, which has been likened to an "inner resource" (Mikulincer & Florian, 1998, p. 144), effectively enables the individual to cope more adaptively in the face of stress, thereby optimizing adaptation. Interpersonally, individuals with secure attachment styles are able to seek and utilize support provided by significant others who through past experience have demonstrated their accessibility and responsiveness, particularly in times of distress. Attachment security will, therefore, confer psychological benefits, where stressful events are managed in a manner proportionate to their gravity thereby facilitating adjustment.

### UNDERSTANDING COPING WITH BREAST CANCER FROM AN ATTACHMENT THEORY PERSPECTIVE

Bowlby (1969) maintained that attachment behavior is most likely activated in the face of three main types of conditions: dangerous external events (e.g., a terrorist attack), physical or emotional withdrawal of an attachment figure, and departures from homeostasis with respect to physical health, such as during pain, fatigue, or sickness. Breast cancer poses a substantial threat to a woman's existence and to the attachment bond existing between her and her respective partner that will result in activation of the attachment behavioral system of both individuals. Attachment theory further posits that in the face of a potentially "existential plight" (Weiss, 1991, p. 5), couples will be physically and emotionally propelled towards one another. Several studies addressing couples' reactions to a cancer threat within a marriage reported findings consistent with this normative pattern of proximity-seeking behavior in both partners (Friedman, Baer, Nelson, & Lane, 1988; Leiber, Plumb, Gerstenzang, & Holland, 1976).

The attachment relationship has been found to be of such potency to the adjustment of breast cancer survivors that if troubled, ensuing distress cannot be simply overcome by additional social support (Pistrang & Barker, 1995). The social support inherent to a marital context, however, is explicitly differentiated by attachment theory as a shared dyadic process consisting of two distinct systems: a caregiver system and a care-seeker or attachment system (Bowlby, 1982). Kunce and Shaver (1994) point out that despite the disproportionate research accorded to the attachment or care-seeker system relative to the caregiver system, the latter is in fact a key component of the dyadic bond. It follows, therefore, that efforts at emotional regulation, coping, and overall adjustment to breast cancer will, predictably, vary through

the interaction of two partners' predominant ways of relating or attachment styles. Indeed, the effect of one's partner's preferred mode of affect regulation and coping on one's ability to regulate stress has been empirically addressed by several researchers (e.g., Simpson et al., 1992; Simpson et al., 2002).

In an attachment-based study examining adult interpersonal processes in the dyadic system, Collins and Feeney (2000) found evidence for normative patterns consistent with previous studies (e.g., Friedman et al., 1988; Leiber et al., 1976), as well as individual variation in the quality of support exchanges. Normatively, higher levels of experienced stress predicted more emotional support sought from respective partners, who in turn mobilized behavioral efforts and provided coordinated emotional and instrumental support. Caregivers demonstrated sensitivity as to the type of support elicited by their partners (emotional versus instrumental), demonstrating a pattern of attunement to partners' needs, which was, in turn, related to improved mood and felt security reported by care seekers. Partners' respective attachment styles also interacted to produce variation in the nature and quality of support exchanges.

Consistent with previous research and theoretical predictions, secure care-giver attachment was associated with higher flexibility and better coordinated efforts at caregiving (Simpson, Rholes, Orina, & Grich, 2002), more synchronized interactions and less dominance (Bouthillier, Julien, Dube, Belanger, & Hamelin, 2002; Pietromonaco, Greenwood, & Feldman Barrett, 2004). Withdrawal behavior, shown to be associated with high mood disturbance in an ill spouse (Grandstaff, 1976; Primomo et al., 1990), was also less problematic when both partners are securely attached (Senchak & Leonard, 1992).

Highly avoidant support seekers, while showing a lower likelihood of seeking help (Collins & Feeney, 2000; Mikulincer & Florian, 1995; Ognibene & Collins, 1998) when stressed, yielded a mixed pattern relative to

care giving that appears to be a function of internal working models of self (anxiety dimension). For example, higher avoidance was associated with a lower likelihood of providing support to partners experiencing emotional distress (Fraley & Shaver, 1998; Simpson et al., 1992), which is consistent with Kunce and Shaver's (1994) finding of lack of caring associated with dismissing avoidant caregivers. In contrast, fearful avoidant caregivers, who are higher in anxiety, showed excessive care-giving in relation to support sought (Kunce & Shaver, 1994).

Similar to their avoidantly attached counterparts, anxiously attached caregivers tend to provide less than optimal support in response to their distressed partners (Carnelley, Pietromonaco, & Jaffe, 1996; Kunce & Shaver, 1996). Collins and Feeney (2000) observed a curious pattern in anxiously attached caregivers relative to the quality of support-seeking efforts engaged in by their partners. Specifically, a partner who made indirect requests (e.g., hints) was less likely to receive support in comparison to one whose support-seeking efforts were more evident (e.g., making a direct request).

Taken together, these findings carry clinically important implications for adjustment and well-being of couples with different combinations of attachment strategies. This point becomes clearer when, for example, the adjustment of an avoidant survivor-anxious caregiver dyad is compared to that of a survivor-secure caregiver couple, the latter survivor of which is more likely to both make overt pleas for emotional support, as well as receive them, compared to the survivor of the former dyad.

Attachment theory, in summary, appears to provide the most comprehensive framework unifying both intrapersonal and interpersonal processes involved in coping and adjustment. Though its utility is thoroughly recognized in clinical, developmental, and personality research, application of attachment theory in the medical field, and particularly in chronic illness, has been relatively neglected (Schmidt, Nachtigall,

Wuethrich-martone, & Strauss, 2002). To date, a total of three separate studies have examined patient coping and adjustment to chronic illness, including cancer, using attachment-based processes.

The first cross-sectional study by Schmidt and colleagues (2002) investigated whether different attachment styles bore any relationship to flexible coping in three types of medical conditions: breast cancer, chronic leg ulcers, and alopecia. Findings indicated a moderate effect size between attachment style and coping, with insecure attachment associated with less flexible coping behavior. Specifically, secure attachment was related to stronger social support seeking, in keeping with patterns observed elsewhere in the literature (e.g., Feeney & Kirkpatrick, 1996). Anxious prototypes, in contrast, evidenced more negative emotional coping, whereas avoidant ones engaged in distancing or distracting strategies.

In a study of melanoma survivors, Hamama-Raz & Solomon (2006) examined the relative contribution of the concepts of attachment style, cognitive appraisal, and hardiness to psychological adjustment to illness. With the exception of marital status, attachment style emerged as the best predictor of adjustment in relation to all other sociodemographic (e.g., gender, employment status) as well as disease-specific variables (e.g., stage of illness, time since diagnosis). In view of the heterogeneity inherent in conceptualizing and measuring psychological adjustment, this study used a tool which tapped both well-being and feelings of distress, thereby adding better understanding of the differential impact of attachment styles on aspects of adjustment. Using a continuous self-report measure of attachment (Brennan et al., 1998), secure attachment predicted higher levels of subjective well-being and lower distress. Whereas both anxious and avoidant attachment styles were related to lower well-being, only anxious patients endorsed higher distress.

The third study using an attachment framework for understanding affective out-

come involved terminal cancer patients. Consistent with findings of the previous two studies, attachment style again predicted negative affect over and above other background variables, (time since diagnosis, physical condition, age, stressful life events). Path analyses revealed a direct impact of anxious attachment on negative affect, as well as an indirect effect through mediation of social support. Avoidant attachment, on the other hand, seemed to exacerbate negative affect only through curtailment of social support.

In summary, the few studies employing an attachment perspective to understanding coping with chronic illness converge on several key findings. First, attachment style, or habitual ways of engagement, accounts for the largest variation in psychological adjustment to illness, beyond that associated with both patient characteristics and disease-specific variables. Second, secure attachment serves as an important inner resource and is associated with flexible coping, a prerequisite to successful adaptation to changing circumstances. Third, although insecure attachment is inversely related to adjustment, anxious and avoidant attachment styles appear to exert this effect through different mechanisms.

### PSYCHOLOGICAL TRIALS

The reality of increased survivorship coupled with the extensive body of research describing both the nature and extent of psychological morbidity experienced by many breast cancer survivors has prompted much intervention research primarily aimed at enhancing psychological adjustment or aspects thereof. Addressing adjustment is a relevant clinical endeavor from psychological, physiological, and behavioral perspectives. For example, the relationship between difficult adjustment and compromised quality of life is both intuitive and empirically substantiated (Ganz et al., 2003). From a physiological point of view, chronic states of negative affect (particularly depression and anxiety),

associated with poor adjustment to illness, tend to compromise immune function, which is conjectured to affect disease course in the long run (Anisman & Merali, 2003). The importance of optimal functional immunity (i.e., natural killer cell activity) has, in fact, been underscored by independent researchers (Dagleish, 2003; Levy et al., 1990), in light of its reliable link to disease-free periods and the control of micrometastases (Levy et al., 1990). The relationship between emotional distress, immunity, and intervention research is reviewed more extensively elsewhere (Herbert & Cohen, 1993). Behaviorally, enduring affective disturbance, especially depression, can interfere with the degree to which patients accept adjuvant treatments as necessary. For instance, Colleoni and colleagues (2000) found that depressed patients are less likely to be proactive in seeking more aggressive treatments that may enhance their chances for survival. Furthermore, when depressed patients had agreed to undergo chemotherapy treatment, depression was shown to independently undermine the therapeutic effects of systemic treatment (Walker et al., 1999). The potentially far-reaching effects of maladjustment to cancer with respect to the psychological, behavioral, and physical realms have become widely recognized, which has provided impetus for the growing number of intervention studies that have spawned the field of psycho-oncology.

The paucity of couples-based interventions within the cancer literature is particularly conspicuous, especially in view of the mounting research converging on mutually elevated distress levels in the patient and her significant other as well as the inextricable involvement of the latter in the adjustment process. Manne, Winkel, Grana, Ross, Ostroff, Fox, Miller, and Frazier (2005) aptly point out that intervention research does “not take advantage of the family context of cancer and a key source of support for patient, namely the partner” (634). In response to this gap, Manne and colleagues (2005) developed and tested the efficacy of a couples-based group intervention targeting



women with early breast cancer. Consistent with prior research, higher distress levels at study entry were associated with stronger treatment gains, and women describing their spouses as unsupportive benefited more compared to women with less critical husbands. A relatively small but stable treatment effect was found only for depression and not anxiety, general well-being, or trauma symptoms surrounding the cancer (e.g., avoidance and intrusion). This study is the first to address a major gap in the psychosocial treatment literature by evaluating a short-term intervention which capitalizes on resources inherent to the dyadic unit and aims to recreate more supportive exchanges between partners. Notwithstanding, the trial was characterized by a high refusal and dropout rate, leading the study researchers to speculate about the "acceptability" of a group-based couples intervention among breast cancer dyads.

The final goal of this review is to present a theoretically driven intervention offered to breast cancer couples experiencing difficulties in adjustment. Emotionally Focused Therapy (EFT) is an evidenced-based time-limited therapeutic approach which bears directly on the literature reviewed thus far on dyadic coping processes during stress and is rooted in a firm theory--attachment theory.

### EMOTIONALLY FOCUSED THERAPY

Formulated in the early 1980s, Emotionally Focused Therapy (EFT) is a structured and short-term approach designed to treat relational distress (Greenberg & Johnson, 1988; Johnson, 2004). Having undergone scientific scrutiny over a span of 15 years, studies associate EFT with clinically relevant change in marital functioning (Alexander, Holzworth-Munroe, & Jameson, 1994; Dunn & Schwebel, 1995), as well as stable rates of recovery (Gordon-Walker & Manion, 1998). A systematic review of randomized clinical trials assessing the clinical

efficacy of EFT on marital adjustment reported a clinically robust treatment effect size of 1.3 (Johnson, Hunsley, Greenberg, & Schindler, 1999). EFT has also been successfully adapted to clinical populations where relational distress was either comorbid with or exacerbated by other stressful couple or family concerns, including parenting chronically ill children (Walker, Johnson, Manion, & Cloutier, 1996), facing post-partum depression (Whiffen & Johnson, 1998) or dealing with post-traumatic stress disorder (Johnson & Williams-Keeler, 1998). Today, EFT is recognized as one of the best articulated and evidenced-based approaches for treatment of relational distress (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Gurman & Frankael, 2002).

Dialectically, EFT arose from a theoretical synthesis of experiential, humanistic, and systemic approaches to psychotherapy. One of its major strengths is its firm grounding in an empirically supported understanding of adult attachment processes (Bartholomew & Perlman, 1994) and nature of marital distress (Gottman, 1994). This conceptual understanding, or guiding map, has served to integrate intrapersonal and interpersonal processes involved in partners' constructions of emotional experiences and dyadic interactions (Johnson, 1996). Informed by attachment theory, EFT views the marital relationship as a bond with an irreplaceable other (Cohen, 1992). One's significant other is considered to be the primary source of support, comfort, and the secure base from which the physical/emotional stress of illness can be faced. The attachment bond is, therefore, characterized by a high affective valence (Johnson, 1996), such that if threatened by unresponsiveness or inaccessibility will lead to a predictable series of events aimed to re-instill it (Bowlby, 1969).

EFT regards distressed relationships in terms of insecure bonds, where attachment needs for physical or emotional closeness, comfort, and security, particularly during adversity, are not being met. In response to attachment threat, individuals will behave

in different, but a finite number of ways to deal with the experienced distress (Hazan & Shaver, 1994). The overarching goal of EFT is to foster the creation of secure bonds between partners, which in turn facilitates emotional connection and resilience in the face of adversity.

The emotionally mediated relationship between attachment security and relational adjustment is supported by research (Bowlby, 1988; Kobak & Hazan, 1991). As such, EFT accords emotion a key role in shaping dyadic interactions (Johnson, 2004). Specifically, emotion is viewed as a healthy and adaptive mechanism that guides perceptions, communicates needs to oneself and others, and organizes social interactions. In the context of intimate relationships, attachment behaviors are primarily guided and shaped by emotion. Predominant emotional experiences of felt insecurity or separation distress will therefore organize current interactions, typically leading to problematic cycles of relating. This perspective fits with Gottman's (1994) research with respect to distressed relationships. Specifically, he found that strained relationships tend to be characterized by partners' propensity to become stuck in absorbing states of negative affect that give rise to rigid interactional patterns, which lead to further aversive states. Johnson (1996) maintains that distressed couples were readily identifiable both by their rigidly organized interactional cycles and intense negative affect.

EFT further posits that whether in the form of negative affective states or rigid interactions, distressed couple are essentially manifesting a struggle for attachment security (Bowlby 1969). Creation of secure emotional connections between partners is, therefore, achieved by eliciting and expanding the couples' core emotional experiences that give rise to their interactional positions and then effectuating a shift in these interactional positions. One of the core assumptions of EFT is that emotional responses and interactional positions are reciprocally determined (Johnson, 2004). They are, therefore, both equally

addressed in treatment. Empirical evidence for the impact of EFT in creating more secure bonds in initially distressed couples has been reported (Makinen & Johnson, 2006). Secure bonds, in turn, have been shown to be powerfully associated with physical and emotional health and well-being, with resilience in the face of stress and trauma, and with optimal personality development (Burman and Margolin, 1992; Schmalzing & Sher, 2000).

EFT is a structured therapeutic intervention that has been manualized (Johnson, 2004). It consists of three major stages encompassing nine steps (Table 1) which delineate specific therapeutic tasks that can be delivered in approximately 10 to 15 sessions (Johnson, 2004).

The first stage involves assessment and the delineation of problematic cycles between partners, such as pursue/withdraw and the absorbing states of emotion that are associated with them. At the end of this stage of therapy, the couple is able to dislodge from negative cycles and have stabilized their relationship. Partners start to view the cycle as the enemy rather than each other. Excerpts from treatment sessions of a couple in their fifties are provided to illustrate how EFT diffuses negative cycles that escalate secondary to breast cancer-related needs, leaving the patient alone, more vulnerable, and less able to deal with the aftermath of the illness. This is a couple who entered treatment displaying a classic pursue/attack-withdraw/stonewall cycle.

HUSBAND: Things are better now. She's not on my back like before ... you know it was like when I returned home from work or if I went out to see my friends, she would be waiting for me ready to pick up a fight ...

WIFE: Well, you don't hide with your friends every night like you used to ... you come home at a decent hour. Oh, yes, and sober [sounds sarcastic], and I know I can at least talk to you when I'm upset about something, like when the nurse called the other day telling me

TABLE 1

Stage 1: Assessment and De-escalation	
Step 1	Create therapeutic alliance and delineate conflict
Step 2	Identify negative interaction cycle (e.g., pursue/withdraw)
Step 3	Access unacknowledged emotions (e.g., fear, longing) underlying interactional positions
Step 4	Reframe the cycle as the “enemy” and partners as “victims of the cycle”
Stage 2: Changing Interactional Positions	
Step 5	Promote identification of disowned needs
Step 6	Promote acceptance of partner’s experience and create new cycle
Step 7	Facilitate expression of needs and wants
Stage 3: Consolidation of Change	
Step 8	Facilitate emergence of new solutions to old relational issues
Step 9	Consolidate new interactional positions/cycle

that the doctor wanted to see me for the mammogram findings. You came home late, but at least you weren’t drinking.

HUSBAND: [becomes quiet and looks away]

THERAPIST: So, what’s happening for you Jack? [still looking away] Marie just told you that she is finding you’re more available now and that she can talk to you. Then she sounded a little sarcastic when mentioning how you don’t drink as much as before.

HUSBAND: [Long pause. Then looks at therapist]. Well, it’s like things going back again to the old way ... I feel like she’s attacking again, nothing is good enough and no matter what I do ... [looks away]

THERAPIST: It’s very difficult for you to hear this. My sense is that you’re trying really hard, and there is some part of you that feels really scared; does that fit for you?

HUSBAND: Yes, like it doesn’t matter what I do, it’s never good enough.

THERAPIST: Hmm. That’s part of that cycle that you both get trapped in.

WIFE: Things have been getting better, I said. Last week was really tough, because I got the phone call from the clinic in the afternoon and didn’t know what time you would be home so I can talk to you.

HUSBAND: I did remember that you

would be getting that phone call following the mammogram. You just assumed that I forgot.

THERAPIST: You’re disappointed that Marie doubted you?

HUSBAND: Yeah. How can I forget something like that? But it’s rough, you know, I mean trying to be there all the time and making it all right. Sometimes it feels like I can never make it.

In the second stage, both partners are able to access and utilize their respective emotional experiences as a guide to their needs. They also begin to communicate these needs in a way that maximizes their partner’s responsiveness. Usually the more withdrawn partner is able to express the emotional experience that evoked the withdrawal in the first place (e.g., “I was afraid of losing you to cancer”) and is able to ask their partner for the responses that will make emotional engagement more possible. For example, a withdrawn husband states that he will not tolerate sarcasm and hostile criticism but needs his wife’s acceptance. The more hostile partner will then begin to explore the emotional realities that evoked the relationship dance. This usually involves expressing hurts, fears, and disappointments and taking new risks with one’s partner. It is at this point, as this partner is invited into a new dance, that

the particular incidents, such as attachment injuries, may surface (e.g., “you left me all alone when the pathology report came back positive”) and need to be processed. Embedded within the second stage of treatment are two discernable process shifts, also known as change events: withdrawer re-engagement and blamer softening. These change events are powerful as they have the ability “to heal past injuries and wounds in the relationship” and create powerful new bonding events and the construction of a new positive cycle (Johnson, 1999, p. 21).

Withdrawer re-engagement takes place when the withdrawn partner goes beyond risking occasional engagement with the pursuing partner, but takes an active and engaged stance in the relationship. Below is an excerpt capturing a change event consistent with withdrawer re-engagement.

HUSBAND: [looks at his spouse]. When the pathology report came back positive, it was like a bad dream I couldn't wake up from ... I didn't know what to do ... I was petrified for you, for the children ... This was one I couldn't fix and I felt like a total failure.

WIFE: I had no idea you were feeling this way. I mean you never showed it, and it seemed like everything else was more important. I felt all alone and scared to have to deal with this, you know the surgery, the chemo, it was awful ... It's like seeing a whole different side of you.

THERAPIST: Jack, you felt so overwhelmed and scared yourself in the face of this new reality and didn't know how to comfort Margie.

HUSBAND: Yes. I didn't want to share my fears with her. I didn't feel it was fair. ... this was about her, not me. I felt like I needed to take care of her, not the other way around.

Another critical change event known as blamer softening needs to take place, with the support of the therapist, if partners succeed in redefining their relationship. Blamer softening is when a “previously hostile/critical partner asks, from a position of vulnera-

bility and within a high level of experiencing, for reassurance, comfort, or for an attachment need to be met.” (Bradley & Furrow, 2004, p. 234). Likened to an antidote to insecurity in a relationship, blamer softening is considered to be a potent change event in EFT, because it promotes an increased sense of safety, trust, and emotional closeness. Studies have further linked it to recovery from relational distress (Johnson & Greenberg, 1988).

Blamer softening is a change event which typically follows withdrawer re-engagement. After the withdrawn partner responds to the previously critical partner in a caring and supportive manner, the therapist then supports the critical (now softened) partner to formulate her attachment needs and longings, and to share these with her partner. This, in turn, pulls for a different interactional cycle between partners. Blamer softening is illustrated below:

WIFE: I thought ... I mean ... It didn't seem like you cared about me, but you were busy trying to take care of everything else. I really had no idea you were feeling this way. It reminded me of when this happened to my own mother ... you know, I shared this many years ago, when we were still engaged ... [became quiet]

THERAPIST: Marie ... what is happening for you at this moment?

WIFE: My father left my mother after she had her mastectomy; he left us behind for another woman. Mother said it was because he couldn't take how she looked after the surgery. He kept withdrawing until he stopped living with us.

THERAPIST: [in a quiet voice]. So you got scared when Jack started withdrawing that the same thing would happen to you?

WIFE: [nods and bursts into tears]. He'd never done that before the cancer happened. But when it did, I was afraid I'll be all by myself and deal with this alone.

THERAPIST: Marie, can you tell Jack what you just told me? Can you tell him how afraid you've been feeling?

WIFE: I'm scared I'll be all by myself with the children. I'm petrified that you won't be able to handle how I look after the surgery and leave me for someone else.

THERAPIST: Jack, what is it like for you to hear Marie say these things?

HUSBAND: I wanted to make everything okay for you ... you know ... you were going through a lot during treatments. I didn't want you to do any work around the house, with the kids and all that ... I guess I took on more than I should and stopped spending time with you, like you kept saying. I didn't know me not spending time with you reminded you of that story and made you feel this way. I'm sorry ... this is really the last thing I want is to hurt you. [husband felt safe during this transaction and was able to reach out and hold his partner's hands reassuringly and both remain quiet for a few minutes].

THERAPIST: Marie, can you turn to Jack and tell him what you need from him?

WIFE: I want you to hold me, especially after we come back from my check-ups. I need you to spend time with me right after those hospital appointments and tell me that you still care about me.

Following this session, the initially critical wife softened and became more responsive in her interactions with her husband. Her greater responsiveness, in turn, facilitated him remaining open and accessible. New cycles of relating gradually emerged.

The final stage is concerned with integration and consolidation of the positive changes that occurred during therapy. By reflecting on the process of therapy and validating new emotions and new interaction patterns that have replaced the former negative interactional cycle, couples can construct clear models and narratives of their relationship. With this new ability to communicate clearly about crucial issues, they can solve ongoing problems in the relationship.

## CONCLUSIONS

Breast cancer is becoming increasingly recognized as a chronic illness which impacts the entire family. While many families seem to adjust adequately in the face of such medical adversity, others become unwittingly entrapped in unremitting cycles of relational distress, exacerbated by various forms of psychological morbidity, such as depression, and anxiety. Negatively charged interactions adversely impact mental and physical health (Salovey et al., 2000). The powers of secure attachment bonds to significant others, on the other hand, have been clearly linked to emotional/physical health and well-being as well as general resilience, particularly in the face of trauma. Notwithstanding, systematic reviews have consistently lamented the conspicuous absence of theoretically driven interventions which take advantage of the dyadic unit. EFT, a short-term and empirically validated approach, is presented here as an important treatment choice for couples facing adjustment difficulties following breast cancer. Grounded in attachment theory, EFT helps couples by alleviating relational distress and restoring healthier ways of relating in a marital and familial context. By focusing on the quality of attachment exchanges and promoting emotional engagement, EFT offers partners the ability to respond to each other in more supportive ways, thereby creating more secure connections. Secure connections, in turn, confer more resilience. Specifically, partners are able to step away from reactive cycles of compellingly negative emotion, express their needs more clearly, and use one another as a source of support in regulation of the fear, helplessness, anger, and uncertainty often associated with breast cancer and facing the future. The relationship becomes the safe haven from which comfort may be sought when attachment needs are primed. By the end of treatment, the relationship will essentially provide the



necessary antidote against feelings of vulnerability often experienced in the context of breast cancer. As the positive interactions consolidated in treatment become enacted over time, each partner's sense of felt security

in relation to the other deepens, increasing the couple's ability to both tolerate and cope with adversity.

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