Dyadic coping with illness

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27 Dyadic Coping With Illness

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Introduction

Living with a chronic illness affects not only the individuals who have been diagnosed, but also the people close to them, in particular the spouse or partner (Berg & Upchurch, 2007). Illness places the couple between a rock and a hard place – both partners experience the stressors of making treatment decisions, disruption to normal routines and searching for meaning (Revenson *et al.*, 2016). At the same time, the partner is expected to serve as the main supporter for the patient.

The Concept of Dyadic Coping

Broadly viewed, dyadic coping recognizes mutuality and interdependence in coping responses to a specific shared stressor, indicating that couples respond to stressors as interpersonal units rather than as individuals in isolation. The construct of dyadic coping goes beyond the exchange of social support, although that is a central component. The concept of dyadic coping emerged in the mid-1990s (Bodenmann, 1997). Simultaneously, researchers in health psychology and relationship science were developing theories of couples' coping. Since publication of

the first book on dyadic coping (Revenson *et al.*, 2005), the field has grown exponentially; a recent volume by Randall *et al.* (2016) presents research across 14 cultural groups. This may be attributed to a core of researchers focusing on this topic at the same time that new statistical methods were introduced that allowed researchers to study the interdependence within couples (Kenny *et al.*, 2006).

Chronic Illness as a Dyadic Stressor

Maintaining healthy intimate relationships requires effort throughout the lifespan. Stressful contexts may create additional problems within the relationship by diverting time and attention away from activities that promote intimacy. Stress can also challenge partners who are already ill-equipped to cope with their partner's illness by draining them of the resources necessary for coping (Neff & Karney, 2017).

Serious illness may have a profound impact on couples' intimate relationships. Patients and partners have to deal with their emotions, as well as with possible consequences such as fatigue, sexual distress, infertility, job loss and the possibility of death (Mosher *et al.*, 2016). Societal expectations are that spouses care for each other 'in sickness and in health'. The types and severity of stressors ebb and flow as patients progress through the stages of the illness trajectory (Hoyt & Stanton, 2012). Illness stressors may be acute, continuous or intermittent, and one stressor may create a cascade of smaller stressors. Although early studies found that the caregiving partner experienced more distress than the partner with the illness, a meta-analysis (Hodges *et al.*, 2005) found a tendency for caregivers to report more distress during the treatment phase when physical and emotional caregiving demands were high.

Northouse *et al.* (2012) suggests that couples react to cancer as an 'emotional system' and that the patient–caregiver dyad must be viewed as the unit of care. Many couples report that the illness brought them closer together, but at the same time report illness-related changes in their relationship (e.g. Dorval *et al.*, 2005). Dyadic coping processes are key to successful adaptation, including psychological and relational well-being (Traa *et al.*, 2015).

Approaches to Dyadic Coping

Relational Coping

Relational (DeLongis & O'Brien, 1990) or relationship-focused coping (Coyne & Fiske, 1992) involves efforts to attend to the other partner's emotional needs while maintaining the integrity of the relationship, and includes efforts to manage one's own stress without creating upset for others. Relationship-focused coping modes include negotiating or compromising with others, considering the other person's situation, and being empathic (O'Brien & DeLongis, 1997; O'Brien *et al.*, 2009). Relationship-focused coping rests on the assumption that maintaining relatedness with others is a fundamental human need.

The two relationship-focused coping strategies that have dominated the literature are active engagement and protective buffering. *Active engagement* strategies involve the partner in discussions about practical matters and feelings, and are characterized by joint problem-solving. In general, dyadic coping strategies that are characterized by active engagement, mutual constructive communication and collaborative coping (i.e. combining resources to solve problems) have been associated with lower levels of distress and better marital adjustment among couples with cancer (e.g. Badr *et al.*, 2010; Hagedoorn *et al.*, 2000; Kraemer *et al.*, 2011; Traa *et al.*, 2015) and myocardial infarction (Coyne & Smith, 1991). Active engagement may allow couples to regain control over their lives; it may signify that the partner sees the illness as a shared stressor.

Protective buffering involves hiding concerns from the partner to minimize upset and conflict. Dyadic coping strategies such as protective buffering and overprotection (underestimating the partner's ability to cope) have been associated with higher levels of distress and worse marital adjustment among couples with cancer (e.g. Badr *et al.*, 2010; Traa *et al.*, 2015). In a longitudinal study of 139 couples in which the wife had recently completed treatment for breast cancer, husbands' approach-oriented coping predicted an increase in women's perceived cancer-related benefits ten months later, while coping through avoidance with their wives' breast cancer predicted a decline in women's marital satisfaction (Kraemer *et al.*, 2011).

In studies of couples coping with a husband's myocardial infarction (MI) (Coyne & Smith, 1991; Suls *et al.*, 1997), wives' coping efforts to shield husbands from stress in the post-MI period contributed to their own distress, as did husbands' efforts to protect their wives. In a study of spouses of rheumatoid arthritis (RA) patients, the wives of ill men confided that they had lessened their own requests for emotional support, for fear of increasing their ill husbands' distress (Revenson & Majerovitz, 1991). In one study of people with various cancers (Kuijer *et al.*, 2000), protective buffering had no effect on patients' distress, but in a study of women with breast cancer and their partners (Manne *et al.*, 1999), greater use of protective buffering was associated with greater distress experienced by the person engaging in protective buffering. Perhaps this happens because the partner using protective buffering feels constrained to express negative emotions or worries to the other person (Lepore & Revenson, 2007).

Systematic-Transactional Model

The systematic-transactional model (STM) conceptualizes and measures dyadic coping as a dynamic, transactional stress management process (Bodenmann, 1997, 2005). The STM focuses on partners' mutual communication of stress, the negative and positive support that partners provide to each other and the strategies that partners use 'in common' to cope with shared stressors. Some believe that dyadic coping efforts are pulled into play when individual-level efforts have not been successful, but others suggest that both may happen simultaneously.

Within the STM, partners must first conceptualize the 'event' creating distress as a *shared stressor*. To do this, one partner must communicate his or her own stress to the other in hopes of receiving help, support and coping feedback. The other partner can respond in either a supportive or unsupportive fashion. S*upportive dyadic coping* includes providing advice and practical assistance, showing empathy and concern, expressing solidarity and helping one's partner to relax and engage in positive reframing. *Unsupportive dyadic coping* involves showing disinterest, providing support that is accompanied by criticism, distancing or sarcasm, and minimizing the severity of the stressor.

Dyadic coping, however, goes beyond support provision. Couples that engage in *common dyadic coping* strategies work together to manage aspects of the shared stressor. (The label of 'common dyadic coping' indicates that the coping strategies are done 'in common' by both

partners.) *Common positive dyadic coping* involves joint problem solving, coordinating everyday demands, relaxing together, as well as mutual calming, sharing and expressions of solidarity. Common negative dyadic coping involves strategies such as mutual avoidance and withdrawal.

In a number of studies of community-living couples or couples in marital therapy, or couples dealing with breast cancer, common dyadic coping was significantly associated with higher marital quality, lower stress experience, better psychological and physical wellbeing (e.g. Bodenmann *et al.*, 2006; Rottmann *et al.*, 2015) and a lower likelihood of divorce (Bodenmann & Cina, 2005). Dyadic coping may alleviate the negative impact of stress on marriage and strengthen feelings of intimacy and enhance the cognitive representation of the relationship as supportive (Bodenmann, 2005).

Dyadic Coping With Chronic Illness

Consistent with the findings from community samples, dyadic coping is associated with a higher level of marital and psychosocial adjustment among patients with chronic illness. Ideally, couples take a 'we' approach, whereby both persons maintain a couples identity and work together to maintain the quality of their relationship (Kayser *et al.*, 2007; Rottmann *et al.*, 2015).

Many studies illustrate this perspective. Using a diary methodology, Berg *et al.* (2008) found that collaborative coping was associated with more same-day positive emotions for both men with prostate cancer and their wives, and less same-day negative emotions for wives. Thus, both partners benefited. In a longitudinal study of couples facing metastatic breast cancer (Badr *et al.*, 2010), positive dyadic coping decreased cancer-related distress and increased marital adjustment, whereas negative dyadic coping was associated with greater cancer-related distress and poorer marital adjustment (controlling for support provision). In a longitudinal study of 538 women with breast cancer and their male partners, positive dyadic coping was related to higher relationship quality and fewer depressive symptoms for both partners, whereas negative dyadic coping was adversely associated with both patients' and partners' outcomes. The more support patients provided (e.g. empathic concern or help in reframing the stressor) and the less partners took over the patients' tasks, the more depressive symptoms partners experienced. This may reflect the partners' idea that they and not the patient should provide support. And in a meta-analysis of 33 studies of couples with colorectal cancer (Traa *et al.*, 2015), dyadic coping characterized by open communication, cooperation and joint problem solving improved relationship functioning, whereas dyadic coping characterized by buffering, avoidance and not being responsive to each other's needs impeded relationship functioning.

Social Support

A central aspect of dyadic coping involves the transaction of social support. Spousal support is an important predictor of adaptation to illnesses such as arthritis (Holtzman & DeLongis, 2007), cancer (Manne & Badr, 2010) and heart disease (Case *et al.*, 1992). Partners provide emotional and tangible support, validate coping choices, and help reappraise the meaning of the illness. Partners provide continuity and security in a life disrupted by the physical indications, treatment challenges and emotional meanings of illness.

When spouses report receiving helpful support, they engage in more adaptive coping. Among patients with RA, Holtzman *et al.* (2004) found that support influenced pain severity through encouraging the use of specific coping strategies, such as positive reappraisal, as well as by increasing the effectiveness with which these coping strategies were employed. Moreover, support from the spouse attenuated the impact of maladaptive responses to pain, disrupting a cycle of pain catastrophizing (Holtzman & DeLongis, 2007).

However, support does not always minimize distress. In a study of women with RA, Revenson *et al.* (1991) showed that spouses provided both positive and problematic support, and that the problematic support could cancel out the positive effects. Similarly, in another study of RA, day-to-day supportive and negative interactions made independent contributions to the wellbeing of each partner (DeLongis *et al.*, 2004). Those with low marital satisfaction were particularly vulnerable to mood disturbance on days when there was an absence of positive interactions with the spouse. In a study of parents of a child with disability, positive spouse response attenuated the effect of maladaptive coping responses (interpersonal withdrawal, escape avoidance and confrontive coping) on psychological distress (Marin *et al.*, 2007). Those high in marital satisfaction may be better able to weather the ups and downs of illness.

Communication, Disclosure, and Social Constraints

People with chronic illness need to disclose thoughts and feelings in order to make sense of their illness; not disclosing can lead to rumination and prolonged intrusive thoughts, which can be distressing. Yet, many couples avoid discussing how illness affects their emotions, intimacy and sexual relationship. Withdrawing from communication has been related to higher distress for both patients and their partners (Badr & Carmack Taylor, 2008), especially in the context of a poor marital relationship (Ey *et al.*, 1998).

Social constraints involve individuals' perceptions of obstacles that lead them to refrain from disclosure of stress-related thoughts, feelings or concerns (Lepore & Revenson, 2007). Social constraints on disclosure are not dependent on objective circumstances. For example, although a partner may not know how to respond effectively to a patient's fear of cancer recurrence, the patient may be able to shape the conversation and not feel constraints. Greater levels of social constraints on disclosure have been associated with heightened psychological distress and lower psychological adjustment across a number of illnesses, primarily cancer (Manne *et al.*, 2005; Porter *et al.*, 2009), but also RA (Danoff-Burg *et al.*, 2004), HIV (Ullrich *et al.*, 2002), injuries (Cordova *et al.*, 2005) and pain (Herbette & Rime, 2004).

Emotional disclosure is not always beneficial. Among 68 couples in which one partner had colorectal cancer, greater disclosure did not improve depressive symptoms over time (Hagedoorn *et al.*, 2011). The highest levels of depressive symptoms occurred when the patient made fewer disclosures during a cancer-related conversation, but their partner disclosed a lot. Patients who are reluctant to disclose may feel uncomfortable or burdened listening to the emotional disclosures of their partner. Partner responsiveness is especially important to individuals with a high need to disclose (Dagan *et al.*, 2014).

Gender

A meta-analysis of 38 studies of couples with cancer (Hagedoorn *et al.*, 2008) untangled the relative importance of role (patient vs. partner) and gender on distress: female cancer patients and caregivers reported more distress than male patients or caregivers. In a longitudinal study of couples facing colorectal cancer, Northouse *et al.* (2000) found that

female caregivers had the highest distress (Revenson (2003) presents similar findings for couples with RA). Female caregivers spend more time providing care, perceive less support from others and experience more stressors (Revenson *et al.*, 2016).

Zakowski *et al.* (2003) found that the association between perceived spousal constraints on disclosure and mood disturbances was stronger among men (with prostate cancer) than among women (with gynaecological cancer). Men's reliance on their spouse as a primary outlet for disclosing their concerns and feelings related to cancer may make them more vulnerable when they perceive spousal constraints. Quartana *et al.* (2005) suggested that men may have difficulty responding to negative emotions because it communicates neediness and interdependence, which challenges their sense of autonomy. Women typically report larger social networks than men, while men tend to rely primarily on their partner for support (Harrison *et al.*, 1995), so women have more potential outlets for disclosure.

Conclusion

The study of dyadic coping continues to expand. There have been many advances, including new methods to assess dyadic coping and a focus on more diverse populations. Patients and spouses typically face the challenges presented by an illness diagnosis together. The study of coping on a dyadic level represents a next step in understanding adjustment to illness as a process as well as outcome.

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28 Emotions and Health

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Introduction

Over the last 30–40 years, there has been a substantial increase in media coverage of stress and as a result this has led to increased research and public awareness. Indeed, stress is now the most common cause of long-term sick leave and is frequently shown to be a very important factor accounting for in excess of ten million working days lost per annum in the UK (HSE, 2013). In 2011/2012, stress accounted for 40 per cent of all