

## Chapter 2

# Why Work with Couples?

*“We share decisions, we share the research. One of us isn’t running off saying ‘this is what I’m doing. I don’t care—it’s my disease.’ It’s shared—it’s a we-disease.”*

*“I saw it [the cancer] in some way as guaranteed to be relationship building, we were bound to learn a lot, and have to deal with a lot and that’s another kind of gift in this—that to deal with crisis and build through it—is good for the relationship we want.”*

The stress of a patient’s cancer can easily be felt by her partner so that the cancer becomes a shared stress or a “we-disease.” In this chapter, we look at how couples experience the cancer diagnosis and treatment and the ways they cope together with the illness. As practitioners, we are particularly interested in understanding the process of dyadic coping and the characteristics associated with a couple’s coping that lead to a positive adjustment to cancer.

### The Interdependence of Partners’ Responses to Cancer

A series of studies have found what most clinicians have already observed among couples coping with cancer: many times the mood of one partner can affect the mood of the other partner, producing a strong correlation between their levels of adjustment. Feelings of hopelessness and emotional distress are easily transferred from one partner to the other. Husbands and wives report similar levels of stress in trying to carry out their usual roles at home and work. This similarity in adjustment to the cancer not only occurs at diagnosis, but also continues over time. For example, when measuring their adjustment at three times (time of diagnosis, 60 days later, and 1 year later) moderately high correlations between patients and husbands were found on each of the adjustment measures (Northouse, Templin, & Mood, 2001). How well husbands adjusted after 1 year had a direct effect on how well their wives adjusted 1 year after the diagnosis. Furthermore, 2–3 years after diagnosis and treatment, wives and their husbands were still showing similar levels of emotional adjustment (Carter & Carter, 1993).

The downside of the strong correlation between partners’ adjustment is that when both partners experience similar high levels of distress, they are most at risk for long-term adjustment difficulties. What is the mechanism by which partners’ moods

and adjustment influence each other? A simple explanation may be that the listening and empathizing with a partner's plight and mood may lead to a transfer of mood and emotions to the other partner. Even without empathizing with the person's feelings, just observing a spouse's negative mood can alter the partner's mood. While this spillover of mood may occur, we view the process as more complicated.

### ***The Connection Between Partners' Coping Strategies and Adjustment to Cancer***

Just as there is a reciprocal effect of mood between partners, the ways in which each individual manages stress also affect the other. Indeed, studies find that the coping strategies used by one partner affect the other partner's adjustment to the stress of the illness. There is a reciprocal influence between individuals in how they react to stress. They shape each other's coping, and their coping responses, in turn, shape the quality of the support they provide each other. Here are some examples from research. Wives' positive adjustment to breast cancer has been associated with:

- Husbands' use of more problem-focused coping (Ptacek, Ptacek, & Dodge, 1994)
- Husbands' use of external control-resignation coping (Hannum, Giese-Davis, Harding, & Hatfield, 1991)
- Husbands' use of active engagement coping strategies (Kuijer et al., 2000)

Women with cancer are more likely to feel distressed when:

- Husbands use wishful thinking to cope (Ptacek et al., 1994)
- Husbands use denial or optimism (Hannum et al., 1991)
- Husbands are overprotective toward them (Kuijer et al., 2000)

In a similar vein, breast cancer patients' coping strategies also impact their husbands' adjustment. Husbands adjust better when:

- Wives use optimism as a way to cope (Hannum et al., 1991)
- Wives use more problem-focused coping and less avoidance (Ptacek et al., 1994)
- Wives do not use wishful thinking (Ptacek et al., 1994)

These findings illustrate the significant relationship between the coping of one spouse and the adjustment of the other spouse. But we also know from research that how a couple copes together influences an individual partner's well-being. Partners engaged together in coping tend to be communal in their approach to coping; that is, each partner sees that it is in his/her self-interest to approach and manage the stress together. Their communication of support is sophisticated in that they not only acknowledge and validate each others' feelings, but also tend to view a stressful situation as "our" problem, and share the burden and responsibility for managing the problem in a way that balances both individual and relationship needs.

## *How Is Coping Related to Partner Support?*

There is an interaction between individual coping and mutual support processes among couples. For example, healthy partners' appraisals of both their own coping and the coping of the diagnosed partner influences the types of support they report offering to their partner (Kuijer et al., 2000). The type of support partners provide, in turn, affects the coping behaviors employed by patients (Manne & Glassman, 2000). Moreover, patients' coping behaviors may signal the type of support they need and serve to mobilize or discourage support from partners. In fact, individual coping and support processes appear so intertwined that some coping researchers have concluded that the ability to mobilize the desired type and amount of support from significant others is a coping skill in itself (Bodenmann, 2005; Kennedy-Moore & Watson, 2001; Stanton et al., 2000). As an illustration, a partner interprets the other partner's not talking about the cancer as coping well and therefore, offers little support to the other. In contrast, a partner who openly expresses fears about the cancer may be offered a lot of support from the partner, who interprets the concerns as not coping well with the cancer. Thus, couples who are satisfied with the support they give and receive may be skilled in communicating their support needs to each other (Duck, 2002). They mutually shape the nature of their support processes in a way that positively enhances both partners' adjustment to cancer.

Support, then, should be viewed as a mutual activity rather than an individual one. When a partner has cancer, she not only is the recipient of support but provides support to her partner. Typically the value of support is assessed from the perspective of only the recipient and not the provider. Many patients show concern about the effects of their cancer on loved ones and attempt to support those loved ones, while also seeking support from them (D'Errico, Galassi, Schanberg, & Ware, 1999). There is much evidence to suggest that, for a person in a committed relationship who is coping with a severe illness, a major influence on their adjustment is mutual support between partners. It is widely accepted that partner interaction is so crucial in coping with a major crisis that, for the best outcome, the couple should conjointly cope with the stress. Thus, the two partners should interact in ways that positively influence each other's mood and methods of coping.

To illustrate the importance of this couple or dyadic focus, consider the following two studies of couples coping with breast cancer. First, Skerrett (1998) interviewed 20 couples about their coping, focusing on their communication, beliefs regarding illness and health, problem-solving techniques, feelings of loss and disfigurement, and other topics. Based on the interview data, the couples were categorized as either resilient or problematic. Most of the 20 couples were viewed as resilient: They had a philosophy of coping that was mutual and served as a basis for dealing with the ongoing demands of the illness. They strongly believed that they were "in it together" and served as each other's confidante, advisor, and sounding board. Most talked openly about cancer but did not allow the talk of the illness to dominate their daily living.

In contrast, there was a small cluster of "problematic" couples for whom breast cancer had a devastating impact on their lives. The illness seemed to color every

aspect of their interaction. The “problematic” couples were unable to formulate a common coping philosophy. Their communication took the form of one of the two patterns: individual retreat into withdrawal and silence or, conversely, reactive, anxiety-driven, tell-all communication. They struggled to find ways to understand and make meaning of the experience.

In the second qualitative study, Zunkel (2002) identified four relational or dyadic processes in which each partner contributed to coping with breast cancer. These were: (1) sharing in the patient’s recovery, (2) helping her, (3) normalizing the household, and (4) moderating or minimizing the intrusion of the cancer. Zunkel (2002) concluded that there were two distinct types of processes: an acknowledging type and a moderating or minimizing type. The acknowledging process attempted to incorporate the illness into family life; couples openly expressed their feelings about its presence and acknowledged their partners’ responses to the cancer and recovery. In contrast, the moderating or minimizing process attempted to limit the cancer’s impact on the family.

## **A Model for Understanding the Process of Dyadic Coping**

Dr. Guy Bodenmann, a Swiss psychologist, has extensively studied and observed how hundreds of couples cope with various types of stresses. He defines dyadic coping as a stress management process where partners either ignore or react to each other’s stress signals in order to maintain or return to a pre-illness level of well-being as individuals, as a couple, and with other people outside the dyad (Bodenmann, 2005). His concept of dyadic coping is an extension of the coping model originally proposed by Lazarus & Folkman (1984) in which coping involves (1) cognitive appraisal, (2) emotional reaction, (3) coping behavior, and (4) adjustment. In Bodenmann’s theory (1995, 1997, 2000), a communication of stress triggers both partners’ coping responses. One partner’s stress signals are sent to the other partner, who perceives, interprets, and decodes them, and then responds with some form of coping (which might involve ignoring these stress signals). Stress can be communicated verbally or non-verbally (e.g., voice tone, sighs, or facial expression). Several cognitive processes are involved in communicating stress: the appraisal of who is troubled by the stress (partner A, partner B, both partners), the appraisal of the causes for the stress event (the partner, others, external causes), and the appraisal of controllability (by partner A, partner B, both). Depending on the stressor under consideration and what is at stake for the individual and the dyad, both partners make efforts to maintain or restore the well-being of the relationship.

Building on Bodenmann’s theory, we have developed a framework by which we can analyze the couple’s process of coping.<sup>1</sup> This process is depicted by a wheel

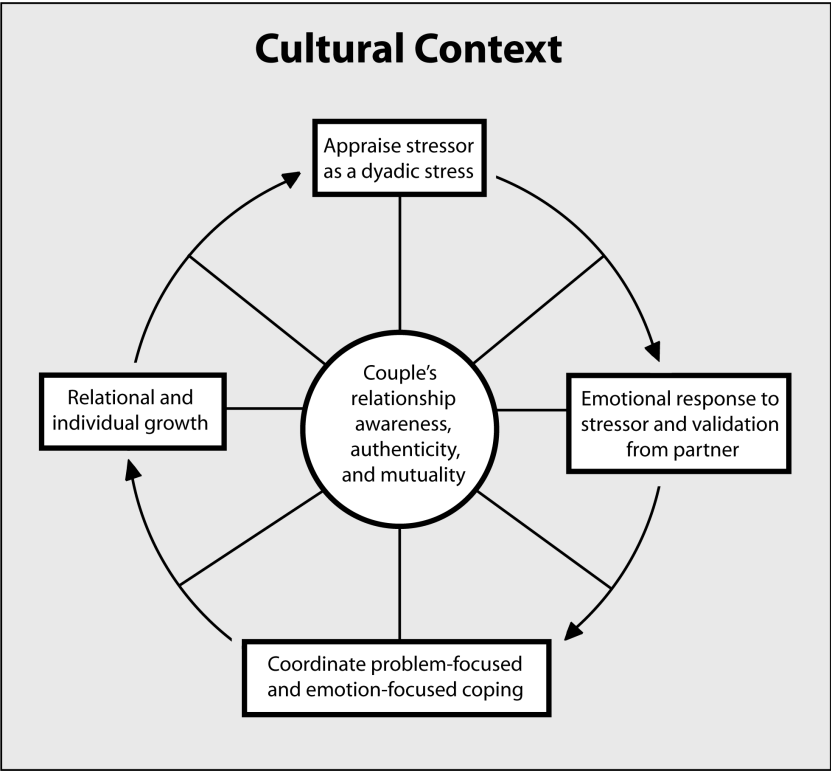
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<sup>1</sup> This model first appeared in Kayser, Watson, & Andrade (2007).

that illustrates the cycle of coping that occurs repeatedly as a couple is challenged by the series of stresses associated with each phase of the cancer experience (that is, diagnosis, treatment, and end of treatment) (see Fig. 2.1). In the hub of the wheel we have listed three relational qualities that facilitate the movement from one step to another. These included *relationship awareness* (understanding of stress as “our stress”), *authenticity* (honest self-disclosure of feelings and thoughts), and *mutuality* (the ability to empathize with each other). These characteristics of the relationship shape the pattern of coping that couples develop. We identify two distinct patterns among the couples going through this process: mutual responsiveness and disengaged avoidance.

*Mutually Responsive Couples*

*Appraisal.* Couples who are mutually responsive in their coping tend to appraise the cancer as a stressor that affects them both. They communicate in terms of a shared stress and experience the intensity of the stress at similar levels. Furthermore, they



**Fig. 2.1** Relational-cultural coping process (Copyright © 2007 by the American Psychological Association. Reprinted with permission from Kayser et al., (2007))

talk about the cancer changing their lives as a couple. The quote at the beginning of this chapter, referring to cancer as a “we-disease,” provides a good illustration of this type of appraisal.

*Emotional Response and Validation.* As mentioned earlier, when a partner expresses his or her stress to the other partner, it triggers a stress communication process. The partner receiving the stress signals perceives, interprets, and decodes them, and then responds (or does not respond). Certain emotions increase a partner’s potential probability of responding to cues, indicate their level of distress or adjustment, and alert a partner or other members of a support network to a person’s need for support (Keltner & Kring, 1998). In essence, negative affect is a stimulus to a partner to offer support. Positive support occurs when the distress is noticed and responded in a sensitive manner. With mutually responsive couples, each expression of feeling is met with genuine listening and validation from the other partner. The couples with whom we have worked would make comments such as, “He understands my needs and respects my moods,” “we are tuned into each other,” “we pick up on each other’s emotions,” or “we share our sadness.” Successful coping behaviors usually result from this process of emotional response and validation.

*Coping Behaviors.* After couples appraise their stress and respond emotionally, they use various coping strategies to deal with it. A useful way of categorizing coping behaviors is by distinguishing between problem-focused coping and emotion-focused coping. Problem-focused coping involves strategies intended to change some aspect of the stressor, for example, browsing the Internet to look up information about the effectiveness of various treatment options for breast cancer. Emotion-focused coping may not mean intervening directly to change the stressor, but it does involve thoughts and actions that are intended to manage the distressing emotions (Lazarus & Folkman, 1984). Mutually responsive couples tend to use both problem-focused and emotion-focused coping behaviors. They attend to their own and each other’s emotional and physical needs in a cooperative manner. If they were not using both kinds of coping strategies, they tended to delegate tasks so that one would manage stress by use of problem-focused efforts while the other used emotion-focused strategies. An example of a couple using the same coping strategies simultaneously was the couple who defined their illness as “we-disease.” When trying to make a decision on treatment, they both read about the doctors, they gathered information on the treatment protocols, and they attended religious services together. However, some couples use different types of coping strategies—one uses problem-focused and the other uses emotion-focused—but they coordinate their efforts so that the behaviors complement each other. For one lesbian couple, the partner took on the task of researching medical information about breast cancer by buying books and searching the Internet for resources (problem-focused coping), while the patient made sure they spent time processing their feelings about the cancer (emotion-focused coping). In the patient’s words, “I try to carve out time for us to talk and take time to be sad.”

What is notable about these couples is their relational capacity to accept and support each other’s coping efforts even if they are different. Without the partner’s

support for the patient's more emotion-focused coping behavior, for example, validation of her feelings, the patient may stifle her feelings or perhaps seek support for her emotional issues or concerns outside their relationship.

Many couples do not enter the cancer experience knowing how to cope in a mutually responsive way. It takes time to learn what a partner needs in terms of support and how to respond to those needs. It also takes time to move from an individualistic coping style to an interdependent one. Some couples learn during the course of the disease how to transform their individualistic behaviors into cooperative ones. Note how the following couple describes one of their conflicts and how they successfully resolved it:

*Patient:* I think in the beginning we had a hard time. And what he says is true: I am a strong person but when we first came here to the oncologist, he owns his own business and his cell phone was ringing. I was going to kill him. I was going to throw the phone out the window . . . he said he wanted to be here but he's here in body, not mind. I told him, "If your phone calls are that important, don't come. I'll do it myself or I'll bring someone who wants to be here. . ."

*Partner:* She's right. I wanted to be there, I blocked the day and that's it. Going through it together has helped me. I hope it has helped you.

Through the wife's expression of her needs to her husband and his ability to respond to them, this husband was able to support her efforts to manage the demands of her treatment. Through her authenticity and her husband's responsiveness, the stressful situation was transformed from one of loneliness and isolation to one in which the husband was present *both* physically and emotionally. Again, the point here is that learning to cope together is a process that takes time and may involve errors along the way.

It appears that the particular coping strategies of a couple are less critical than their specific relational abilities, namely, relationship awareness, mutuality, and authenticity. These relational qualities facilitate an acceptance and support of each partner's coping efforts—regardless of whether these efforts were problem-focused or emotion-focused. By relationship awareness, we mean the ability of partners to appraise the cancer as a shared stress in contrast to only perceiving the consequences of the disease on each individual. Mutuality is a concept similar to emotional support. It involves mutual, empathic listening, validation of and response to each other's feelings and communications of stress. Finally, by authenticity, we mean the expression of thoughts and feelings that show a sincere desire to facilitate relational coping, enabling a supportive response from one partner to the other's needs.

*Outcome.* Through the process of mutual responsive coping there is growth—individually and as a couple. When we ask couples if there is anything positive that comes from the illness, the mutually responsive couples often report a strengthening of the relationship, an increased closeness, or a change in their priorities that allows more focus on the relationship. A result of effective relational coping is an enhancement of the relationship and the individuals involved in the coping.

Often researchers look at individual outcomes such as depression, anxiety, physical symptoms, etc., as indicators of poor or ineffective coping. We take the perspective that dyadic coping can lead to a positive adjustment to cancer.

### ***Case Illustration of Mutual Responsiveness: Alan and Beth***

Alan (58) and Beth (56) had been married 26 years when Beth was diagnosed with invasive breast cancer. They had two children—a son and daughter in their early twenties. The couple had many work and family responsibilities—both of them had demanding jobs, they were in the process of remodeling their house, and Beth had an elderly mother to care for. However, they both put the issues of cancer at the front of their list of responsibilities. They had no experience dealing with cancer in their families, nor did anyone else who was close to them.

For Beth, the biggest change since her diagnosis was re-prioritizing her activities and viewing her life from a shorter-term perspective. As she described it, “We’re on a different timetable.” For the husband, the issues of not having control and the fear of losing his wife were most prominent. For both of them, the hardest part of the cancer diagnosis was dealing with ambiguity and uncertainty. The couple admitted that they could deal better with “black and white,” clear-cut decisions. They kept looking for the “right” decision. Hence, for both of them, the unpredictability, uncertainty, and loss of control that accompany cancer were the greatest challenge.

Alan had thoughts about the possibility of Beth dying and was willing to talk about it. He expressed his worries and anxieties. In his own words, “we talk about all of this—we’ve talked about death, we’ve talked about all the things in between. . . . I can’t bear to see her suffer. And that is most troublesome.” Beth is a planner, but has learned to live with the cancer one day at time, without thinking too far into the future.

When we first met Alan and Beth, they were still in the process of making decisions about treatment. Chemotherapy had been recommended to them but they were undecided about the regimen and where Beth should receive it. They delegated the tasks of researching possible cancer treatments and doctors to Alan but both agreed that Beth would make the final decision about her treatment. Beth arranged her appointments and transportation. In reprioritizing her activities, Beth decided to take a paid leave of absence from her job and focus on taking care of her health needs while still caring for her mother. Alan supported her in this decision. Alan and Beth have an extensive support network—neighbors and friends sent flowers, called and emailed, brought food over, and offered to drive her to her appointments. The couple joked about the number of dishes of lasagna they stored in their freezer.

The coordination of tasks and coping efforts were not always clear-cut and easy for them. Although Alan was able to take time off work to attend Beth’s office visits, he was still working long hours at the office. He often would not come home until eight or nine in the evening. Beth told him that she did not need him to take her to



her clinic appointments and would prefer that he be home in the evening. Alan considered a leave of absence from work until Beth has completed her chemotherapy.

Alan and Beth anticipated changes in their life due to the cancer. Beth scheduled an appointment for a family photo before she began her chemotherapy, in case she lost her hair. She bought a wig even though she did not think she would wear it. Alan looked on the lighter side of the situation and told his wife that she will save time getting ready to go out because she would not need to shampoo and dry her hair.

Alan and Beth identified multiple benefits that have come from their experience with cancer. They have become more spiritual—even their children are attending church after a long hiatus. They feel that they have become closer to their children. Beth states, “I think I’ve found that there are some really caring people who have reached out and have taught me that perhaps I should have been reaching out to others along the way too.” They were touched by the overwhelming support that they received from their friends and neighbors.

When talking about the illness, this couple often used “we” language. They appraised the stress in similar ways and with a similar level of seriousness. Their empathy and mutuality permeated their conversations. Alan acknowledged that he could not “bear to see her suffer.” Beth stated, “it’s easier to be the patient than the partner.” The couple was always looking at the “silver lining” of their experience such as gaining a new perspective on what is important.

Communication was very important to this couple. Beth was aware that her husband loved her, but his expressing it verbally was especially reassuring to her. Their manner of communicating demonstrated a respect for each other. During their sessions with the social worker, they regularly waited until the other person had finished before voicing their own opinions. They validated each other’s responses by acknowledging the other’s feelings, even when they may have disagreed with their partner’s perceptions.

## ***Disengaged Avoidance***

*Appraisal.* Couples whose coping styles were disengaged and avoidant tended to appraise the cancer as an individual stressor. When asked to talk about their stress as a couple, disengaged partners tended frequently to refer only to their individual experience, excluding any reference to the partner’s experience. “I” was used more frequently than “we.”

When asked what was the most important change that cancer brought into their life *as a couple*, one husband responded that it was the difference in his wife’s physical appearance. He missed the way his wife looked in the past when they first met. He avoided his wife and wished that she could look like the person she was before her treatments. Although he expressed his own feelings about the cancer, he seemed oblivious to the impact on his wife—despite the phrasing of the question to respond “as a couple.”

Some couples who appeared disengaged in their coping with cancer did not appraise the cancer as the most stressful event in their lives. Typically, these couples

were dealing with other stressors that overshadow the experience of cancer. This was especially the case for younger couples who cared for young children, were under financial stress, or worked in new careers. These stressors demanded more of their time and resources on a daily basis.

*Emotional Response and Validation.* The communication of the couples who are disengaged and avoidant in their coping style tend to lack expression of emotion. When feelings are expressed by one partner, the other does not typically validate them. This may occur when a cancer patient who is highly distressed triggers distress in her partner, leading him or her to become increasingly withdrawn or critical during discussions about the cancer. This response is most likely to occur if the partner attributes the patient's distress to unproductive behavior on her part, such as poor coping (Cutrona & Suhr, 1992). A negative cycle can ensue in which the partner's negative behaviors contribute to a worsening of the patient's mood. She reciprocates her partner's negativity by blaming or criticizing him, which then adds to his already bad mood and makes him more reluctant to talk about the cancer. Further, her deteriorating emotional state may impede her ability to interpret accurately the emotions of her partner, as negative mood has been shown to do (Kirchler, 1989). For example, if the patient is depressed, her gloomy, negative perspective on her situation can spill over to her marriage, leading her to view her husband's behavior less favorably.

This disengaged communication was demonstrated in an interview with a young couple in the Partners in Coping Program who were experiencing a number of stressors including caring for a newborn. During the assessment interview, the couple was not talking about the emotional issues around the cancer and seemed to show very little support for each other. The husband, at one point in the interview, described in detail the hard time he had coping with the diagnosis and the uncertainty related to it. At the end of his lengthy and emotional response, his wife turned to the social worker and said, "I forgot the original question." Clearly, she did not acknowledge or validate her husband's distress and his feelings about the cancer.

*Coping Behaviors.* With disengaged, avoidant couples, at least one of the partners copes by avoiding or denying the stress of the disease. This may be functional to some degree as a way to manage stress, but it does not allow the couple to cope together in an engaged or relational way. In fact, it is a barrier to developing mutuality because neither person is expressing an authentic self or responding empathically to the other. Again, sometimes this pattern of coping is a function of dealing with other stressors in their lives and may be adaptive in their particular situation. They live day-to-day and hope to get through the day using mostly problem-focused coping strategies. By restricting their conversations to practical things, they avoid discussion of existential issues and emotionally charged topics such as death. When one partner wants to talk about his or her feelings and the other partner wants to avoid them, often the unsupported partner will seek emotional support from someone outside their relationship—a family member or friend.

*Outcomes.* Disengaged, avoidant couples typically do not perceive anything positive resulting from the cancer experience. Unlike the mutually responsive couples,

the disengaged couples rarely mentioned how the cancer strengthened their relationship. If they felt close as a couple, they did attribute it to going through the cancer experience.

### ***Case Illustration of Avoidant Disengagement: Charlie and Debra***

Charlie and Debra were a couple in their early 30s with a 6-month-old son. Both husband and wife stated that they tried to keep everything normal in the household since the diagnosis. To them, having an infant produced more changes and stress in their lives than the cancer. This was their first experience with a serious illness in their marriage.

During the assessment interview, they described the cancer as something affecting them each individually—there were no references to its effects on them as a couple. Debra focused on the physical effects of cancer—the lethargy, not feeling well, hair loss—and feeling more dependent on her husband and others. She stated, “I don’t know how it is impacting us as couple.” Charlie felt that stress had piled up for him since he had to take care of both an infant and his wife while working at his full-time job. Debra stated that their child had been a blessing because their attention had been diverted from the cancer to their son.

They coped together by trying to avoid the stress of the cancer—they did not talk about it, they tried to keep everything normal, and they focused on other aspects of their lives. Charlie described a friend who talked a lot about his cancer and stated that he thought that this was an ineffective way of dealing with it.

There was very little humor or levity in their conversation. In fact, they sounded more sarcastic and cynical as they talked about the cancer. They defined good coping as the absence of bad interactions—“we’re not disagreeing, we don’t fight,” etc. The social worker perceived a lack of “we-ness” or connection. The closest thing that approached a sense of connection was when Debra described herself as being a strong person and Charlie agreed. Their conversation lacked empathy—Charlie shared some feelings but Debra did not validate or empathize with his feelings. Neither of them could think of any benefits that they had experienced from going through the cancer. The question seemed almost incomprehensible to them. “How can anything positive come from this experience?” questioned Debra.

## **The Contexts of Dyadic Coping**

### ***The Cultural Context***

What does culture have to do with the ways that couples cope? Our understanding of stress and coping is predominantly based on the abundance of research with people who live in highly industrialized, Western countries. However, the process

of stress and coping cannot be fully understood without taking into account the cultural context. The Western view of how individuals appraise stress, emotionally react to it, attempt to manage it, and then make some meaning of the experience has restricted our understanding of stress and dyadic coping.

Considering the influence of culture, we would like to expand our thinking beyond categories of ethnicity or race and consider some fundamental constructs that underlie cultures and shape the perceptions, beliefs, and behaviors of members who share a common culture. These constructs are organizing principles and the basic structures that influence all other aspects of a culture such as its norms, customs, rituals, and religions (Hardy & Laszloffy, 2003). Examples of these constructs include the independent versus interdependent self, mastery versus fatalism, hierarchical versus egalitarian gender roles, and external versus internal control. There are other cultural constructs having to do with interpersonal relationships, families, and gender expectations within intimate relationships that can also influence the dyadic coping process. Societal norms, customs, rituals, religions, etc., will support the expression of these dimensions of culture.

While discussing each of these constructs as they relate to dyadic coping is beyond the scope of this chapter and the research literature, we encourage clinicians to ask questions that will reveal information about the couple's beliefs, customs, rituals, expectations for families, and gender roles and how these factors will influence how they choose to cope with the cancer experience. Since there can be as many variations within a culture as between subcultures, it is more effective to engage the couple in discussion of their cultural experience rather than relying on stereotypes about a particular ethnic or racial group. This discussion can involve questions such as the following: What is the meaning of the disease to each partner? How are feelings expressed in their culture? How are stresses typically managed? Are they encouraged to seek help outside the family? Is professional help commonly sought for support or do they rely on informal helpers? In each of the following chapters, there is a special section on cultural/social considerations for each of the components of our program. This section is not an attempt to provide suggestions based on stereotypes of particular cultures, but to assist in asking questions and raising awareness of the cultural context of coping.

### ***The Quality of the Relationship as a Context for Coping***

Just being married or in a relationship does not guarantee a better psychosocial outcome for cancer patients. A study that compared partnered and non-partnered women with metastatic breast cancer found no significant differences in mood disturbance between these groups (Giese-Davis, Hermanson, Koopman, Weibel, & Spiegel, 2000). However, the women's moods were related to their partners' moods and the quality of their relationship. In particular, the cohesion of the relationship and the couple's feeling that they can express themselves were positively associated with a better mood. Higher conflict in the relationship was related to a lower

mood disturbance. While this seems counterintuitive, conflict was also positively correlated with marital satisfaction. These findings suggest that relationships in which spouses do not withdraw when there are differences, but confront them directly, can be productive. Another possible explanation is that when a woman has metastatic cancer, she may benefit from open expression of disagreements. Furthermore, alleviation of her distress may be better achieved by focusing on the relationship rather than her individual coping (Giese-Davis et al., 2000). Conflict, then, may be an indicator of engagement, rather than disengagement, between partners.

The quality of the marriage is important to consider, since marital distress can make it more difficult for the couple to cope with illness. Over time, marital satisfaction of the cancer patient is linked to changes in her level of distress (Weihs, Enright, Howe, & Simmens, 1999). When receiving the diagnosis of cancer, a woman needs partner support and intimacy the most. Pre-existing marital distress may exacerbate the woman's stress and lead to greater depressive symptoms (Bloom, 1982; Ptacek et al., 1994). In fact, marital satisfaction at the time of diagnosis is closely related to breast cancer patients' future distress.

The strength of the relationship influences the availability and quality of supportive behaviors (Duck, 2002). When couples are dissatisfied with their relationship the partners often misinterpret the affect and intentions of their partners (Guthrie & Noller, 1988; Noller & Ruzzene, 1991). In contrast, satisfied couples exhibit more positive behaviors, such as approval, caring, and empathy and their perceptions of their partners' affect and intentions are more positive (Birchler, Clopton, & Adams, 1984; Noller, 1982). Overall, distressed couples are less accurate than non-distressed couples in their interpretations of each other's affect, intentions, and behaviors.

Poor communication, inaccurate perceptions of the partner, a low sense of emotional connection, and lack of effective support predict deterioration in relationship satisfaction (Buehlman, Gottman, & Katz, 1992; Carrere, Buehlman, Coan, Gottman, & Ruckstuhl, 2000; Pasch & Bradbury, 1998). However, this does not mean that it is simply a matter of ineffective support eroding relationship satisfaction. It has also been found that deteriorating relationship satisfaction predicts deteriorating couple communication (Noller & Ruzzene, 1991). Thus, there seems to be a reciprocal influence between relationship satisfaction and ineffective communication and mutual support.

## **Couple-Based Interventions to Enhance Coping**

Although both patients and their partners are affected by the stress of breast cancer, there has been little systematic study of the effectiveness of psychosocial interventions targeted at the couple. Neither has there been much study of psychological outcomes for both partners or for the marriage. Given the frequency and intensity of interaction that a patient has with her spouse or partner, psychosocial interventions designed for couples may be more effective than peer groups or cognitive behavioral

interventions (Radojevic, Nicassio, & Weisman, 1992). Furthermore, recent changes in medical care have transferred greater responsibility from health care professionals to the spouse and couple, making it all the more important to work with a couple as a unit and include the partner in treatment plans.

In reviewing outcome studies on psychosocial interventions for cancer patients, we could find only seven studies that evaluated interventions that included a spouse or family member (see Kayser, 2005). Most of the studies were of interventions using behavioral training, educational groups, individual counseling, and support groups for patients. While support groups appear to be the most common type of intervention offered to cancer patients, recent studies have questioned their efficacy (Bordeleau et al., 2003; Goodwin et al., 2001). Some researchers have found not just minimal psychosocial benefits of peer support groups for early-stage breast cancer patients, but even adverse effects of peer discussion for some subgroups of women (Helgeson, Cohen, Schulz, and Yasko, 2001). There have been three randomized controlled trials evaluating couple-based interventions. Christensen's (1983) intervention involved four counseling sessions with 20 postmastectomy couples and emphasized communication and problem-solving techniques. Patients who had received the treatment had significantly lower levels of depression than patients in the control group. Also, the husbands who received the treatment had significantly lower levels of discomfort than the husbands who did not receive the treatment. The author noted that with the small sample it was difficult to obtain statistically significant results, but these preliminary results provide some promising findings for couple-based interventions.

The couple-based intervention, CanCOPE, was evaluated in a randomized controlled trial with 94 married women who were recently diagnosed with early-stage breast or gynecological cancers (Scott, Halford, & Ward, 2004). Women in CanCOPE compared to the other two conditions experienced less psychological distress, less avoidance of intrusive negative cognitions, and improved sexual adjustment. There was also a large increase in observed couple-coping, and supportive communication, and a large reduction in couples' coping effort or burden (Scott et al., 2004).

Partners in Coping, a couple-based intervention for breast cancer patients and their partners, was evaluated in a randomized control trial with 50 couples (Kayser, 2005). Patients in the Partners in Coping intervention arm reported higher overall well-being and common dyadic coping than the patients in the standard services arm at Time 2 (6 months post-baseline). Partners in the intervention arm reported higher stress communication coping and lower avoidance and hostile coping than partners in the standard services at Time 2.

A recent meta-analysis of 70 randomized studies on people with chronic illnesses found positive benefits for both patients and family members when including a family member in psychosocial interventions (Martire, Lustig, Schulz, Miller, & Helgeson, 2004). The studies compared interventions using traditional methods to interventions targeting patients' closest family member or both patient and family member. For patients, interventions that involved spouses had positive effects on depression and, in some cases, on mortality. For family members, these

interventions had positive effects on caregiving burden, depression, and anxiety. Only 5 of the 70 studies had samples of cancer patients—the illnesses were most frequently cardiac, dementia or Alzheimer's, or chronic pain.

## Summary

- Partners' responses to the cancer experience are interdependent: the mood of one partner affects the mood of the other.
- How partners individually manage the stress related to the cancer will affect the adjustment and coping of the other partner.
- Each partner's individual coping efforts can mobilize or discourage support from the other partner.
- Support is a mutual activity with both the patient and the partner giving support to each other.
- The process of dyadic coping can be conceptualized as a cycle involving appraisal of the stressor, emotional response and validation, coordination of coping strategies, and relational and individual growth.
- Three basic relational ingredients facilitate dyadic coping: relational awareness, authenticity, and mutuality.
- There are two general patterns to couples' coping: mutual responsiveness and disengaged avoidance.
- The cultural context that shapes the perceptions, beliefs, and behaviors of a couple will influence how they appraise and respond to the cancer.
- Couples with high levels of pre-existing distress in their relationships will experience more difficulty in coping with the demands of the partner's cancer.
- The influence of emotional support from spouses on their partners' adjustment to cancer, the reportedly high distress levels among husbands of women with cancer, and the positive effects of interventions including family members for both patients and spouses collectively formed the basis for the development of our couple-based interventions.

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