Stress, Dyadic Coping, and Social Support: Moving toward Integration

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Stress, Dyadic Coping, and Social Support: Moving toward Integration

Abstract
Many events that cause distress in the lives of individuals who are part of a couple affect both individuals, because of their shared concerns, resources, goals, and social ties. Two approaches have been articulated for how couples respond when one or both members need assistance, encouragement, or comfort: the social support approach (e.g., Cutrona, 1996; Pasch & Bradbury, 1998; Sullivan & Davila, 2010) and the dyadic coping approach (e.g., Bodenmann, 1995; Coyne & Fiske, 1992; Delangis & O’Brien, 1990; Revenson, 1994). While these two approaches have considerable overlap, they originated in two different research traditions and evolved relatively independently. The social support approach emerged from research on the effects of stressful life events on health and how these effects were moderated by social resources (e.g., Kaplan, Cassel, & Gore, 1977). Although early studies focused on all sources of support within individuals’ social network, over time, interest developed in the special importance of support from an intimate partner (e.g., Acitelli, 1996; Brown & Harris, 1978; Cutrona, 1996). The dyadic coping approach built on the literature that addressed how individuals cope with daily hassles and stressful life events (e.g., Lazarus & Folkman, 1984) and expanded the coping model to include both members of the couple. An entire chapter of the current volume is devoted to a description of new developments in social support research (Feeney & Collins, Chapter 21, this volume). The current chapter focuses primarily on new research in dyadic coping and ideas about how the social support and dyadic coping approaches to stress in couples can be usefully integrated.

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Comments
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In this chapter, an overview is provided of the most important tenets of the dyadic coping approach, followed by a more detailed description of the most widely used dyadic coping model, Bodenmann’s systematic transactional model (STM; Bodenmann, 1995, 1997b, 2005). Two contributions of the STM are highlighted: dyadic construals of stressors and common dyadic coping, a symmetrical process of coping in which both members of the couple participate as equal partners.

**DYADIC COPING**

Multiple approaches are encompassed under the rubric of dyadic coping (see review by Bodenmann, Meuwly, & Kayser, 2011). Contributions highlighted in the current chapter were derived primarily from Bodenmann’s model (STM) of dyadic coping (Bodenmann, 1995, 1997b, 2005; Falconier, Randall, & Bodenmann, 2016), which emphasizes how partners evaluate stressors and cope together as a unit. The STM views the process of stress and coping as a series of dyadic actions and transactions, all of which affect and modify the system in which the individuals are embedded.

The STM describes the interpersonal events that transpire in the wake of a stressful event, including communication of the stressor to one’s partner, the partner’s reactions to the disclosure, the appraisal of the stressor that involves an assessment of individual and couple resources, and a range of options for acting to deal with the stressor, individually or together. This entire process—dyadic coping—considers the dyad as the unit of coping. Bodenmann’s model extends the stress appraisal process (Lazarus & Folkman, 1984) from an individual process to a dyadic process that includes both individual and joint appraisals of the stressor by both members of the couple. An important dimension of this appraisal process is the extent to which each member of the couple “owns” the stressor. When both members of the couple acknowledge the impact of the stressor on them and take responsibility for dealing with it, they have appraised it as a common stressor, termed a “dyadic stressor,” or a “we-stress” rather than an “I-stress.” Important psychological consequences are associated with appraisal as a dyadic stressor. From a dyadic appraisal (“we-stress”), common dyadic goals may result, which guide a team approach to dealing with problems.

Bodenmann’s STM broadens the range of behavioral options that couples may use when confronted with a stressor. In addition to prosocial acts that correspond closely to traditional dimensions of social support and various types of negative responses (i.e., hostile, ambivalent, or superficial dyadic coping), the STM introduces
“common dyadic coping,” which occurs when both members of the couple work as a team to deal with adversity (Bodenmann, 1995, 1997a). This is in contrast to scenarios in which one member of the couple is the provider of support and the other member of the couple is the recipient. The two partners take on more or less symmetric roles. This kind of dyadic coping builds on the previously described “we” approach and is a natural next step in the coping process (Badr & Acitelli, 2005). Couples work together to solve problems; they are a problem-solving team rather than a provider and a recipient. Common dyadic coping may take on all of the forms of traditional social support (i.e., emotional, esteem, information, appraisal, and tangible). Selected recent research in the areas of communal responsibility for stressors and common dyadic coping are summarized briefly next. Following these selective summaries, ideas are presented for how the dyadic coping and social support approaches to dealing with adversity and challenge may be integrated, resulting in a model that benefits from innovations in both literatures.

COMMUNAL RESPONSIBILITY FOR STRESSORS

Impressive evidence supports the positive relationship and health outcomes that are associated with couples adopting shared or dyadic “ownership” of serious stressors that threaten one or both members of the couple. Researchers have found a positive association between communal orientation toward stressors (e.g., "we-stress" or "we-disease") and highly valued outcomes using a wide range of research methods and techniques for operationalizing communal orientation toward stressors. These techniques include linguistic analyses of couples’ conversations, coding qualitative data derived from in-depth interviews with couples, administering questionnaires that directly or indirectly ask about communal orientation toward stressors, and controlled experimentation that manipulated whether a stressor was experienced individually or communally.

Linguistic Analysis

One set of studies that is especially impressive because of the simplicity of the measurement approach and low potential for self-presentational bias uses automated linguistic analyses to infer communal orientation. In these studies, couples are asked to discuss problems they are facing and the transcripts of their conversations are analyzed with respect to the proportion of plural (we, us, our) versus singular first-person pronouns (I, me, my) used by each participant (Robbins, Mehl, Smith, & Weiks, 2013; Rohrbaugh, Mehl, Shoham, Reilly, & Ewy, 2008; Rohrbaugh, Shoham, Skoyen, Jensen, & Mehl, 2012). The use of plural first-person pronouns is conceptualized as an indicator of a communal approach to coping (Rohrbaugh et al., 2008). In one study, researchers analyzed pronoun use among couples in which one member suffered from congestive heart failure, as they discussed their approach to coping with the disease (Rohrbaugh et al., 2008). The ratio of plural to singular first-person pronouns (we, us, our/I, me, my) spoken by the healthy spouse significantly predicted positive change in the patients’ condition and general health over the next six months, and did so better than questionnaire measures of marital quality or self-evaluated communal coping. Interestingly, only spouses’, but not patients’, use of plural first-person pronouns was associated with patient health outcomes. The spouses’ active engagement in the patients’ recovery appears to have particularly beneficial effects on health outcomes. It should be noted, however, that both partners’ use of plural first-person pronouns was associated with both one’s own and the spouse’s self-reported marital satisfaction.

Similar results were found in a study of couples in which all one individual had smoking-related health problems and was enrolled in a smoking-cessation program designed to increase collaborative coping (Rohrbaugh et al., 2012). The proportion of first-person plural pronoun use by the spouse during a pretreatment discussion significantly predicted whether the patient remained abstinent twelve months after the conclusion of treatment. An increase in plural pronoun “we-talk” by both partners over the course of the intervention predicted abstinence-related outcomes as well. Entire families in which the mothers had been diagnosed with breast cancer were interviewed regarding how they were coping with the illness and transcripts of their conversations were subjected to pronoun analysis similar to that described earlier (Robbins et al., 2013). Results showed that the spouses’, but not the patients’ or children’s proportion of plural possessive “we-talk” was associated with better patient adjustment, as indexed by lower depressive mood and higher couple marital quality.

One issue that arises when evaluating the association between communal construal of problems (“we-stress” or “we-disease”) and positive health outcomes is the extent to which a third variable, such as relationship quality, accounts for the apparent association. It may be that good quality relationships are characterized by both a communal orientation to problems and good health (Kiecolt-Glaser & Newton, 2001). Indirect evidence for the causal influence of construing stressors communally comes from an experimental study. Couples were randomly assigned to one of three groups: woman stressed, man stressed, or both partners stressed. In the latter condition, although both partners were stressed, the stressor was administered to them individually. Both men and women in the condition that placed both partners under stress showed lower levels of physiological stress reactivity compared to those who knew that only one of them was experiencing the stressor. One interpretation of these results is that individuals who perceive a stressor as occurring to “us” rather than to “me” derive comfort from knowing that the stressor is a shared experience that will be understood and processed from
a perspective of empathy with the partner after it is over. The experimental nature of the study adds additional credence to the assertion that perceiving a stressor as “belonging” to both partners has positive consequences, apart from the tendency of couples in high-quality relationships to view stressors communally.

Qualitative Studies of Collaborative Coping

A series of qualitative studies has investigated the relational characteristics and coping behaviors of couples who cope well versus poorly with serious illness in one partner (e.g., Gamaré, Comfort, Wood, Neilands, & Johnson, 2015; Kayser, Watson, & Andrade, 2007; Mireskandari et al., 2006). Several of these studies have independently identified a communal perspective on the illness as a characteristic of couples who are coping well. Of particular interest in the current context is the additional information these studies provide on the relationship qualities and behaviors that accompany a communal versus a highly individual orientation toward stressors.

In an in-depth interview study of couples in which the woman had recently been diagnosed with non-metastatic breast cancer, researchers sought to understand patterns of behavior and relationship qualities that were associated with adaptive coping (Kayser et al., 2007). Those who suffered the least severe mental health problems and could avoid deterioration of their relationships engaged in what the researchers termed “mutual responsiveness.” These couples appraised the wives’ cancer as a joint stressor that affected both individuals and was the responsibility of both individuals to address (“we-disease”). A set of relationship qualities present in these couples was identified as crucial to their ability to successfully cope together. These included relationship awareness, a view that the cancer affected both members of the couple and that the relationship needed to be protected against the stress imposed by the illness; authenticity, a willingness by both partners to honestly disclose the emotions that they experienced as a result of the cancer; and mutuality, the ability to empathize with and provide emotional support to each other.

By contrast, couples who appeared to have the most difficulty dealing with the wives’ cancer engaged in what the researchers termed “disengaged avoidance.” They each discussed the cancer’s effects on themselves and described how they attempted to cope with it individually. One or both members of these couples tried to deal with the cancer through avoidance or denial. This avoidant approach precluded honest discussion of fears and other negative emotions. Their coping behaviors were focused toward concrete problem solution rather than seeking respite from painful emotions.

Similar patterns of successful and less successful coping were reported in a study of men whose wives were at high risk for genetic vulnerability to breast and/or ovarian cancer, and the couple faced the decision of whether the wife would submit to genetic testing (Mireskandari et al., 2006). Those men who coped well dealt with the medical issues as a team with their spouses and reported open communication about their emotions. The husbands in this group were well informed on medical issues and actively sought information from health professionals. They were involved in all aspects of dealing with the wives’ health threat. By contrast, partners who took an independent approach viewed the testing decision as belonging only to their wives. They saw their role as limited to providing support and were not actively involved in decision-making. They were poorly informed and felt inadequate as sources of support. They had difficulty communicating with their partners. Their denial and avoidance had a detrimental effect on their relationships.

A somewhat different conclusion regarding the benefits of joint ownership of health problems emerged in a study of gay male couples coping with HIV in one or both partners (Gamaré et al., 2015). Two basic orientations toward health were identified, which were very similar to those identified in prior research: relational and personal. Those with a relational orientation described their health as interconnected and prioritized being aware of one another’s health status and care needs. Those with a personal orientation consisted of couples in which one or both partners described their health and health care as independent and autonomous issues. However, participants indicated that this stance was flexible and dependent on their partners’ health status. The most striking difference between the studies reported previously and the current study was that the level of expressed caring, open communication, and supportiveness did not differ as a function of whether individuals adopted a relational or a personal orientation toward health. Viewing one’s health as one’s own responsibility could occur within a healthy intimate relationship and partners readily acknowledged that if the health of one partner deteriorated, the healthier partner would willingly step in and take on greater responsibility for the other’s health. Difficulties in adjustment were associated with differences in orientations, when one member of the couple wished to be more involved in his partner’s health issues, but was prevented from doing so. When one member of the couple adopted an avoidant stance toward his own or his partner’s illness, it was difficult for the partner who desired more intimacy and self-disclosure to adjust to the illness. This study emphasizes the importance of considering differences in the stances of partners regarding how illnesses are construed.

Taken together, the qualitative studies suggest that a dyadic view of illness is a natural outgrowth of a trusting, open relationship, in which partners are comfortable disclosing their emotions and working together to overcome challenges. The ability to forge such a relationship undoubtedly builds on the personality traits, prior relationship experiences, and interpersonal skills of both partners.
TAKING ACTION: DYADIC COPING

The STM describes the process through which couples deal with adversity, beginning with stress-related self-disclosure. After disclosure, the model lays out a set of possible responses to the initial verbal or nonverbal communication regarding the stressor. Common dyadic coping is not the only approach to stress management used by couples in the STM; however, it is highlighted in this chapter because the other components overlap with traditional social support and much less research has isolated the specific effects of common dyadic coping. After brief descriptions of these other components, the focus turns to recent research findings regarding common dyadic coping.

In the STM, coping components are categorized into positive and negative dyadic coping. Positive dyadic coping includes supportive, delegated, and common dyadic coping. Supportive and delegated coping consist of one individual providing assistance to another who is viewed as "under stress." Supportive dyadic coping (problem-oriented or emotion-oriented support provision) and delegated dyadic coping (taking over tasks that the partner usually does to reduce his/her stress) have both been described previously in the social support literature (e.g., Cassel, 1976; Cobb, 1976; House, 1981; Vaux, 1988). Common dyadic coping involves an equal partnership, in which both partners identify the stressor as a shared responsibility and work as a team to deal with it. In the STM, negative dyadic coping (Bodenmann, 1995) includes hostile dyadic coping (disregardment, distancing, mocking, sarcasm, open disinterest, or minimizing the seriousness of the partner's stress), ambivalent dyadic coping (support is provided unwillingly or with the attitude that one's contribution should be unnecessary) and superficial dyadic coping (insincere, cursory, or unmotivated support).

When couples engage in common dyadic coping, they confront stressors together that directly or indirectly concern both partners, plan together, and manage their emotions together as a team. For example, if a couple faced a financial crisis, they would discuss the fact that their financial problems are causing them to feel demoralized and depressed. They may formulate a plan for bolstering their spirits by scheduling enjoyable low-cost activities, such as long walks together. During these walks, they may exchange expressions of caring and concern for one another and help each other to refocus on potential positive aspects of the situation. They may brainstorm about ways to pay down their debts more quickly, while deliberately planning ways to maintain the quality of their relationship and their daily experiences together. In the case of severe illness (e.g., cancer, heart disease, diabetes), both members of the couple are full participants in every phase of medical decision-making. They may come up with a joint plan for conducting research on the illness and current treatment approaches. It is not necessary that both partners perform exactly the same coping activities; rather, the key is that both partners feel fully engaged in confronting the illness as a team (viewing it as a "we-disease"). Individuals may specialize in their contributions, according to their personality traits, experience, skills, and practical limitations.

Common dyadic coping has most frequently been tested as a correlate or predictor of relationship quality (Falconer, Jackson, Hilpert, & Bodenmann, 2015). The selection of relationship quality as the dependent variable is consistent with the importance placed in this approach on protecting relationships against the deleterious effects of stressful life events (O'Brien & DeLongis, 1997; Randall & Bodenmann, 2009). Findings from selected studies that tested the association between common dyadic coping and relationship outcomes are summarized below. Some of these studies also tested for associations between common dyadic coping and individual health outcomes. These findings are presented as well. Notably, such findings are often more complex than those for relationship outcomes. A small number of studies are described that have examined moderators of the association between common dyadic coping and relationship or individual outcomes.

Empirical Findings

Common dyadic coping was tested as a predictor of relationship quality in a longitudinal study of 538 Danish couples in which the wives had been diagnosed with breast cancer (Rottmann et al., 2015). Patient reports of how frequently the couples engaged in common dyadic coping were a significant predictor of increased relationship quality for both patients and spouses over a five-month period. Patient reports of common dyadic coping notably predicted decreases in depression in both partners over time as well. Another longitudinal study of breast cancer patients and their partners followed 191 couples for six months, in which the wives' cancer had metastasized, making their prognosis particularly grave (Badr-Carmack, Kashy, Cristofanilli, & Revenson, 2010). Frequency of common dyadic coping, reported by both the patients and spouses, was significantly associated with higher relationship quality for both partners. A cross-sectional study of couples in which the husbands had been diagnosed with prostate cancer showed that frequency of common dyadic coping, reported by both patients and spouses, was associated with higher relationship quality for both partners (Regan et al., 2014). In a fourteen-day daily diary study of older couples, in which the men were undergoing treatment for prostate cancer, each member of the couple was asked to record the most troublesome event of the day, what they thought or did to deal with it, and whether their spouses were not involved, supportive, worked together with him or her, or took charge of dealing
with the stressor (Berg et al., 2008). For both patients and their wives, working together, collaborative (common) coping was associated with greater positive mood, and for wives only, with lower negative mood the same day. For both patients and their wives, greater collaborative coping was associated with the perception that they had coped more effectively with the stressor.

The extent to which dyadic planning was associated with successful self-management in carrying out a prescribed set of exercises was tested prospectively in a sample of couples in which the men had undergone radical prostatectomy as a treatment for prostate cancer (Burkert, Knoll, Luszczynska, & Gralla, 2012). Dyadic planning was defined as specifying with a partner when, where, and how the patient would engage in prescribed pelvic floor exercises as an aid in combatting urinary incontinence. Individual planning was monitored as well. Over a twelve-month follow-up period, neither dyadic nor individual planning directly predicted frequency of carrying out the prescribed exercises. However, partner reports of dyadic planning significantly predicted partner-reported social support toward the patients, which in turn, predicted exercise compliance. This study illustrates that common dyadic coping (joint planning) and social support may be closely related and both contribute to positive outcomes, a point made later in this chapter when integration of the two research approaches is discussed.

Moderation of the Effects of Common Dyadic Coping

The effects of common dyadic coping on relationship and health outcomes are sometimes moderated by such variables as the severity of the stressor, gender, or other factors, such as personal initiative toward problem solving. Turning first to moderation by stressor severity, among couples facing metastatic breast cancer, where the prognosis is grave and treatment effects are often highly depleting (Badr et al., 2010), patient reports of their own common dyadic coping use were positively associated with cancer-related distress, whereas among non-ill spouses, use of common dyadic coping was negatively associated with distress. The patients may have felt that it was too difficult to confront issues of daily medical decisions and mortality with their partners while they were feeling very ill. Participation in common dyadic coping requires emotional labor by patients, which may extract a cost. They may have wished for their partners to simply take care of them. By contrast, the non-ill partners, who were less physically depleted, may have benefited from their partners’ emotional engagement and also felt that they were making a useful contribution by working with their partners to solve problems. Similarly, in a study of community-dwelling couples in Switzerland, common dyadic coping was tested as a buffer against the effect of daily stressors on anger and verbal aggression (Bodenmann, Meuwly, Bradbury, Gmelch, & Lerermann, 2010). At low levels of life stress, common dyadic coping was a significant buffer against the effects of stressors on both anger and verbal aggression; this was not true when the level of stress was high.

The effectiveness of common dyadic coping may also be influenced by the extent to which the ill partner is perceived as behaving responsibly by the non-ill spouse. In the study of prostate cancer surgery patients who were advised to engage in pelvic floor exercises to aid recovery (Burkert et al., 2012), dyadic planning was not only associated with partner support, but also with partner attempts at controlling the patients’ behavior, especially when the patients’ individual planning was low. Partner control was associated with worse exercise compliance, both concurrently and prospectively. Thus, in some circumstances, involvement of the partners in joint problem-solving increases the probability that the partners will try to control the patients’ behavior, an undesirable outcome. This appears to be especially likely when the patients are not actively managing their own behavior to the satisfaction of their partners.

There is some evidence of moderation by gender in the association between common dyadic coping and various outcomes. A cross-sectional study of immigration stress among Latin American immigrant couples in the Washington, DC, area examined the extent to which common dyadic coping buffered couples’ relationships against the deleterious effects of stressors associated with immigration (Falconier, Nussbeck, & Bodenmann, 2013). For women, common dyadic coping buffered the effects of immigration stress on women’s relationship satisfaction. For men, common dyadic coping did not buffer the effect of immigration stress. In fact, for men, common dyadic coping exacerbated the negative effects of immigration stress on their relationship satisfaction. Ideals of independent, self-sufficient manhood in Latino culture may have prevented men from benefiting from open discussions of their problems and how to overcome them with their wives.

IS IT MEANINGFUL TO COMPARE THE IMPACTS OF COMMON DYADIC COPING AND SOCIAL SUPPORT?

Common dyadic coping was not introduced as a replacement for social support, but as an additional approach that couples may use to deal with stressors in their individual or shared lives (Bodenmann, 1995, 2005). The key difference between social support and common dyadic coping is that social support explicitly implies a provider and a recipient of assistance. By contrast, common dyadic coping involves coequal partners confronting difficulties as a team. The same kinds of coping and assistance are utilized in both social support and common dyadic coping transactions (e.g., emotional, informational, tangible, esteem, and appraisal). They are both part of most stress-related transactions. Furthermore,
according to Bodenmann, common dyadic coping and social support often occur simultaneously, in response to the same stressor (Bodenmann, 2005).

Nevertheless, it is of interest to ask whether there is evidence that common dyadic coping is associated more strongly with social support with positive outcomes, given that the equal status of both partners may eliminate problems of implied incompetence and shame that sometimes accompany the provision of social support from one partner to another (Bolger & Amarel, 2007; Bolger, Zuckerman, & Kessler, 2000). Of even greater importance is the question of whether it is possible to identify circumstances in which common dyadic coping versus social support is most helpful.

A recent meta-analysis examined the strength of association between a range of dyadic coping strategies (including social support) and relationship quality in couples (Falconier et al., 2015). Studies were included that were published before 2014, so very recent work is not included. A total of seventy-two independent samples from fifty-seven reports (most cross-sectional) met inclusion criteria. The Dyadic Coping Inventory (DCI; Bodenmann, 2008), a self-report inventory based on Bodenmann’s STM, was used in most of the studies. The DCI asks respondents to report on their own and their partners’ use of each component of dyadic coping. Across studies, the mean correlation between common dyadic coping and relationship quality was 0.53. The mean correlation for supportive dyadic coping was 0.47. Supportive dyadic coping (emotional or problem-focused) can be considered social support, as it is provided by one partner to the other. The mean correlation for delegated coping was 0.31. Delegated coping involves one partner taking over the responsibilities of the other to ease the other’s burden and is comparable to tangible or instrumental support. The mean correlations with relationship quality for common dyadic coping and supportive coping were not significantly different from each other in magnitude; however, they were both significantly stronger than delegated coping or any other types of assistance that have been examined in the dyadic coping literature. No significant gender differences were found in the associations between dyadic coping behaviors and relationship quality.

Of course, it is possible that under some circumstances, common dyadic coping or a particular type of social support predicts the best outcomes. The predictive powers of supportive dyadic coping and common dyadic coping were compared in a longitudinal study of 360 Swiss couples (Bodenmann, July 10, 2015). Both one and two years later, relationship satisfaction was significantly more strongly predicted by initial common dyadic coping than supportive coping, for both men and women, although the effect was more pronounced for women.

To summarize, there is not sufficient evidence at this time that common dyadic coping is consistently more effective than more traditional forms of emotional and practical social support within couples. In most stress situations, a variety of forms of dyadic coping are used, making it difficult to disentangle the influence of each form. The question that should take precedence is under what circumstances common dyadic coping versus social support is most effective, for what type of couple, in what stage of the life cycle. The next goal of this chapter is to consider ways in which the dyadic coping and social support approaches can be integrated, drawing the best from each into an overall framework for understanding how people in interdependent relationships communicate their needs, exhibit kindness, gather information, and garner their personal and material resources to overcome difficult situations.

**DYADIC COPING AND SOCIAL SUPPORT**

**Insights from the Dyadic Coping Literature**

A major theoretical insight from the dyadic coping literature is that the exchange of comfort and assistance is not always unidirectional, from a person playing the role of helper to a person playing the role of recipient. Couples sometimes define a stressor as a common challenge, take equal responsibility for dealing with it, and work as a team to minimize the harm inflicted on them. This interdependent process is not reflected in the social support approach and is a very important contribution to our understanding of how couples deal with adversity. Full participation in the evaluation of the stressor and planning stages may eliminate the implied status differential when one person is viewed as victim and the other as helper.

Another contribution of the dyadic coping literature is the insight that stressors threaten not only the health and well-being of individuals, but also the health and well-being of relationships. Thus, dealing with all aspects of a stressor must include actions that protect the quality of people’s interactions: minimizing withdrawal, irritability, and blame and maximizing constructive communication, kindness, and empathy. Mutual emotional and esteem support, which have been construed primarily as aids in coping with stressors, may also be used to protect the relationship. A subtle shift of emphasis that comes from the dyadic coping literature is using emotional and esteem support to sustain the quality of the relationship. Expressions of caring and respect in the service of relationship maintenance can be a crucial part of coping with adversity.

It may be that the most important component of common dyadic coping is communication about the stressor: sharing each partner’s perspective on the nature of the situation, emotional reactions, and how each partner thinks they should deal with the situation. Discussions have the potential to reveal the needs and preferences of both partners, for themselves, and for the relationship. Each person has the opportunity to comment on the other’s proposed approach to the problem, and to
communicate how the other’s proposed behavior will affect himself or herself. There is the opportunity to educate one another about differences in preferred approaches to coping and to take into account each person’s skills and vulnerabilities in plotting a course of action. ("I can’t figure out the right questions to ask the doctors, and I get upset when they come into the room. You’re better at coming up with good questions and they listen to you better.") On the emotional level, couples communicate about the meaning of the situation and how they feel and what they need from the other to overcome stress-related emotions. Most often emotional common dyadic coping (sharing one’s emotions and sharing a common definition of the problem) is a crucial basis for problem-oriented common dyadic coping.

In sum, the dyadic coping approach highlights elements of the process of coping with stress in couples that the social support literature overlooks. The most important insight is that it is possible to avoid the roles of provider and recipient, and approach solving problems as coequal partners. A second important insight is that in coping with adversity, it is important not only to solve the external problem, but to protect the relationship from the deleterious effects of the stress it imposes on the family system. Finally, the process of developing a joint plan for coping together may contain the most important benefit of common dyadic coping: the opportunity to listen to one another and to oneself and gain better understanding of the partner and oneself through discussion of perspectives, emotions, and strategies for solving the problem.

**Insights from the Social Support Literature**

The social support literature also has insights to contribute. One contribution is the concept of optimal matching between stressors and the type of assistance that is maximally useful (e.g., Cutrona & Russell, 1990; Cutrona, Shaffer, Wesner, & Gardner, 2007). Much less emphasis has been placed on the question of optimal matches between circumstances and choice of dyadic coping strategy, so such an integration has potential to strengthen our understanding of when specific types of dyadic coping will yield maximal benefits to relationships and individual well-being. Not only type, but amount of social support provided may either fall short of or exceed the amount of support desired (Brock & Lawrence, 2008). For example, one partner might desire more common dyadic coping while the other desires less involvement by the other. Measuring the extent to which there is a match between desired and received levels of support has improved our accuracy in predicting the extent to which support has its intended positive effects (Brock & Lawrence, 2008). It would be useful to conduct studies on the match between desired and experienced common dyadic coping and how such matches affect outcomes, especially when mismatches occur in desired levels within couples.

A more fully elaborated model of factors that influence the success of social support behaviors is the social support effectiveness model (Rini & Dunkel Schetter, 2010; Rini, Dunkel Schetter, Glynn, Hobel, & Sandman, 2006). Drawing on multiple social psychological theories, the model contends that support needs are highly subjective and individualistic. A given stressor may engender very different needs in different individuals and in the context of different relationships (Rini & Dunkel Schetter, 2010). The authors have built a predictive model that identifies characteristics of individuals and relationships that are associated with the receipt of effective support. Note that studies of dyadic coping have addressed the effects of a range of individual difference variables, including personality traits, empathy, spirituality, emotional intelligence, and motives as well as relationship characteristics, including relationship satisfaction and commitment (Bodenmann, 2000; Falconer et al., 2016; Meuwly et al., 2012). However, these variables have not often been examined as predictors of the use or success of common dyadic coping specifically. As more research is conducted on common dyadic coping among partners who are dealing with a range of stressors, it would be helpful to consider the effects of the kinds of contextual, individual difference, and relationship variables that are considered in models of adequate and effective social support (Brock & Lawrence, 2008; Rini & Dunkel Schetter, 2010).

A theoretical perspective that has been influential in the social support literature, attachment theory (e.g., Collins & Feeney, 2010), might also enrich the literature on common dyadic coping. Attachment theorists have built upon developmental theories that posit basic needs for security and for exploration to posit two different types of social support: safe haven support (comfort to a partner in times of stress) and secure base support (support for a partner’s personal strivings and ambitions) (Collins & Feeney, 2000; Feeney, 2004). Although the dyadic coping literature focuses on how couples cope with adversity, significant stress can be associated with the challenges that come with striving for valued goals (e.g., a promotion at work, winning a sports competition), and common dyadic coping can play a role in coping with this kind of stress.

In sum, the research on dyadic coping may benefit from consideration of contextual factors that affect the quality of the match between circumstances and the type of individual or joint assistance that is maximally beneficial. Type and severity of stressor, amount of desired partner engagement, individual personalities, and relationship history all may affect the tendency of couples to assess stressors dyadically and to engage in individual versus dyadic coping. In addition, the dual goals of assistance during adversity and encouragement during exploration and achievement, derived from attachment theory, may be usefully integrated into perspectives on dyadic coping. Members of a couple may work together not only to cope during difficult times but also to maximize opportunities for growth that arise for each individual.
BRINGING IT ALL TOGETHER

Our first attempt to integrate the key constructs from the dyadic coping literature (especially the STM) and the literature on social support in couples is represented in Figure 25.1. The most salient feature of this model is that relationship quality encircles the processes of dealing with stressors. Relationship quality is of primary importance at the beginning of the coping cycle and the after-effects of coping feed back into relationship quality. Every aspect of the process is influenced by and influences the relationship. Determinants of relationship quality are shown in the lower left corner of the figure. As noted by both dyadic coping and social support theorists, the interpersonal characteristics of both members of the couple influence the nature of their interactions and the quality of their relationship (Brock & Lawrence, 2008; Collins & Feeney, 2010; Meuwly et al., 2012; Rini et al., 2006). Thus personal characteristics are included as a key predictor of the quality of the relationship constructed by the couple. Past experiences in the life of the relationship also affect its quality (Karney & Bradbury, 1995). A history of adversity, conflict, and low support for the relationship from family and friends are examples of experiences that may damage relationships (Donato, Iafriate, Bradbury, & Scabini, 2012). Note that relationship quality may be changed by the experience of coping with a stressor (Kayser et al., 2007). Thus, in the figure, changes in relationship quality that resulted from coping with a stressor are depicted as cycling back to influence current relationship quality. The large arrow in the upper left corner depicts a stressor or challenge. It may be a negative event, such as an illness, or a positive challenge, such as the opportunity to compete for a spot in art school or to earn a promotion at work. The inclusion of positive challenges reflects recent work in the social support and dyadic coping literature that posits a role for support in achieving positive goals (Feeney, 2004; Gable, Gonzaga, & Strachman, 2006; Hilpert, Kuhn, Anderegg, & Bodenmann, 2015). The introduction of a stressor or challenge enters the relationship system and leads to a process of appraisal. This appraisal of the degree of threat and available resources involves both members of the couple, as noted by the STM (Bodenmann, 1995, 2005). One important outcome of the appraisal process is whether the stressor/challenge is construed as an individual or a dyadic ("we") issue (Bodenmann, 1995, 2005). If the stressor/challenge is judged to be dyadic, the STM predicts that common dyadic coping has a high probability of occurring (Kayser et al., 2007; Robbins et al., 2013; Rohrbaugh et al., 2012), although in some circumstances (e.g., where one partner is very ill), social support, in which one partner plays a primary caregiving role, may be most appropriate (Badr et al., 2010). If a stressor/challenge is judged to be individual rather than dyadic, the noninvolved partner may still provide social support (Gamarel et al., 2015; Mireskandari et al., 2006). However, some studies found that individualistic appraisals of stressors were associated with disengagement and avoidance of the problem (Kayser et al., 2007; Mireskandari et al., 2006; Skerrett, 1998).

The right side of the figure depicts the predicted association of common dyadic coping, social support, and disengagement with relationship quality. The effects of common dyadic coping and social support are expected
to be primarily (but not always) positive and the effects of
disengagement are expected to be negative. Moving
further to the right, the figure includes effective behavior
and affect regulation as a possible outcome of common
dyadic coping and social support; disengagement is more
likely to have a negative association with these outcomes.
In the figure, the effects of common dyadic coping, social
support and disengagement may directly predict effective
behavior and affect regulation, or indirectly, through the
mediation of relationship quality. More research is needed
on these pathways to determine whether they are direct or
indirect.

An important feature of the model is the introduction of
moderators in the associations of common dyadic coping,
social support, and disengagement with both relationship
quality and effective behavior and affect control.
A significant amount of research has examined moder-
tors of the effects of social support on outcomes, including
(but not limited to) adult attachment style (Collins &
Feene, 2010), characteristics of stressors (Cutrona et al.,
2007) and the visibility of support (Bolger et al., 2000).
Less research has addressed moderation of the effects of
common dyadic coping, but as more studies are conducted
with a greater variety of stressors and participants, it is
likely that systematic consideration of a range of modera-
tors will advance knowledge of the conditions under which
different kinds of dyadic coping are most effective. Finally,
paths are hypothesized from effective behavior and affect
regulation to health and well-being and to relationship
quality. It is also possible that there are direct physiologi-
cally mediated links from common dyadic coping, social
support, and disengagement to health outcomes (Uchino,
Cacioppo, & Kiecolt-Glaser, 1996), but these links are not
depicted in the figure for the sake of simplicity.

REMAINING QUESTIONS
A large number of unanswered questions remain regard-
ing processes through which members of intimate dyads
assist each other in times of distress. A few of these are
raised in what follows, in hopes that this discussion will
stimulate future research.

In light of the strong and consistent association of
dyadic appraisal and common dyadic coping with rela-
tionship quality, how can we know which takes causal
precedence? Is good relationship quality required for
a couple to spontaneously view stressors as something
they should work together to solve? Rini and Dunkel
Schetter (2006) have demonstrated that relationship
quality is a strong predictor of effective social support.
Perhaps the same is true of common dyadic coping.
Thus it is important to further investigate whether the
use of common dyadic coping precedes or actually
causes an improvement in perceived relationship qual-
ity over time, as is suggested by at least one longitudi-
nal study (Rottmann et al., 2015). If so, do specific
components of relationship quality improve more than
others? For example, social support leads to improve-
ments in trust (Cutrona, Russell, & Gardner, 2005) and
intimacy over time (Gleason, Iida, Shrout, & Bolger,
2008). There may be components of relationship quality
that are especially responsive to common dyadic
coping.

Another question is whether common dyadic coping
and social support can really be separated in the interac-
tions of intimate couples. It would probably be difficult to
distinguish whether some behaviors should be classified
as common dyadic coping or social support. Several
dimensions could be considered in making that determi-
nation, including explicit coordination of coping efforts,
equality of influence on coping decisions, and relative
effort exerted toward problem solution. A number of
ambiguous scenarios can be imagined, where it is difficult
to determine whether social support or common dyadic
coping is the dominant transaction. For example, a couple
might discuss the stressor and assign specific tasks to each
partner, but then act independently. One member of the
couple might dominate the planning and “assign” equal
tasks to each partner. A couple might agree that one part-
tner will take on 75 percent of the tasks required to deal
with the problem, leaving a small proportion to the other.
Both members of the couple might plunge into solving the
problem without discussion and devote approximately
equal amounts of effort. By contrast, it may be that con-
struing the problem as a dyadic stressor that affects both
partners is the most important characteristic of common
dyadic coping, and that equality of effort or participation
in decision-making is less important. Future research that
examines the effect of different characteristics of common
dyadic coping on outcomes would be useful.

The hallmark of common dyadic coping is that partners
explicitly discuss the challenges they are confronting.
As noted previously, these discussions may serve
a crucial role in educating each other about their perspec-
tives, emotions, and preferences. In fact, these discussions
probably are just as important as a way for individuals to
clarify for themselves what they believe, feel, and prefer.
It would be very interesting to further investigate this
phase, in which individuals develop their own points of
view and listen to their partners', as both perspectives
evolve through conversation. Self-knowledge, ability to
communicate, propose, and revise one's perspective and
to understand, empathize, and contribute to a partner's
perspective are all critical components of such conversa-
tions. It would be interesting to investigate whether such
transactions are the most important component of com-
mon dyadic coping AND of social support.

An important question is the effect of disagreement
between intimate partners regarding the best way to
cope with a stressor or challenge. One study found
that both individual and dyadic coping were associated
with maintaining relationship quality, but only if the
two individuals agreed on the approach (Gamarel
et al., 2015). Interventions, such as the Couples Coping
Enhancement Training (Bodenmann & Shantinath, 2004) have been successful in increasing self-reported common dyadic coping (e.g., Widmer, Cina, Charvoz, Shantinath, & Bodenmann, 2005). It would be of great interest to determine whether interventions are more or less successful as a function of the personal characteristics of participants. For example, individuals with an avoidant attachment style or high neuroticism might find it quite difficult to adopt a dyadic perspective. If one member of the couple has a secure style and the other an avoidant style, it might be especially difficult for them to collaborate in a way that meets the needs of both partners. Further studies should highlight the implications for treatment when couples have very different attachment styles.

Both the dyadic coping and the social support literatures have yielded unique and important insights about the helping process. Well-functioning couples seem to gravitate naturally toward mutual ownership of stressors and coordinated efforts to solve problems as a team. Such couples also tend to provide sensitive social support that is well matched to the stressor, the partners, and the relationship. Significant healing occurs in both scenarios. We have yet to learn when joint efforts provide the best outcomes, and when individuals must simply help their partners. In the meantime, it seems wise to promote a high level of skill and sensitivity in both.

REFERENCES


coping within couples dealing with breast cancer: 


