

Couples Coping With Chronic Illness: What's Gender Got to Do With It?

*Tracey A. Revenson, Ana F. Abraído-Lanza,
S. Deborah Majerovitz, and Caren Jordan*

Over the past decade, the lion's share of research on coping has focused on individual coping efforts and adaptation outcomes. However, major life stressors are not experienced in a social vacuum. When one family member is experiencing ongoing, complex stressors or life strains, other family members are affected by both the stressor itself, its psychological impact on the affected individual, and its effect on the family's functioning. At this juncture in *stress and coping* research, it is important to move past a dominant focus on individual-level processes into a social ecological or family systems framework.

Marriage is a primary relationship often considered distinct from other family relationships because it is long-term, affords a central role identity, and provides a fundamental resource of social support and coping assistance (Revenson, 1994). Much research has demonstrated the beneficial effects of social support from family on patients' coping, across a number of chronic conditions (e.g., Cutrona, 1996; Lyons, Sullivan, Ritvo, & Coyne, 1996; Revenson, 2003). Far less research has focused on the effect of illness on the healthy spouse, children, the marriage, or the family (Pedersen & Revenson, in press).

Husbands and wives experience unique stresses as a result of living with a chronically ill person (see chap. 6, this volume; Hagedoorn, Kuijer, Buunk, DeJong, Wobbes, & Sanderman, 2000; Revenson & Gibofsky, 1995; Revenson & Majerovitz, 1990, 1991). Some stresses emanate directly from caregiving in which spouses are inextricably involved in decision making about treatment and day-to-day care if the patient is disabled. Other stresses emerge from the need to restructure family roles and responsibilities as the disease progresses

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or presents new challenges. Still other stresses are filtered through the lens of the patient's experience, as in the case of a healthy spouse feeling helpless at seeing her or his partner in pain. There are also societal or normative expectations that spouses care for their ill partner. In fact, the provision of support may be conceptualized as a stressor for the spouse in its own right, particularly when, as in the case of chronic illness, it is a lifelong task.

Spouses and others in committed relationships, such as domestic partnerships, are faced with dual challenges in the coping process: as the primary provider of support to the ill partner and as a family member who needs support in coping with the illness-related stresses she or he is experiencing. Individual coping choices not only affect both partners' health and well-being but also affect the marital relationship (see chap. 2, this volume).

In this chapter, we address several issues in the conceptualization and study of dyadic coping with specific illustrations from the literature on couples coping with illness. First we describe several nascent theoretical approaches to dyadic coping. We then explore the "missing" variable of gender from research on couples who are coping with illness by examining coping from two perspectives that are extremely gendered—one that has been studied before, social support, and one that has not been found under the rubric of coping, division of labor. We end with a blueprint for future research on couples' coping that incorporates gender.

Conceptual Models of Marital Coping

In the past decade, a number of studies have examined couples coping with illness at the dyadic level of analysis. This research has studied heart disease (Coyne et al., 2001; Coyne & Smith, 1991, 1994; Lyons, Mickelson, Sullivan, & Coyne, 1998; Michela, 1987; Rankin-Esquer, Deeter, & Taylor, 2000; Rohrbaugh et al., 2002; Rose, Suls, Green, Lounsbury, & Gordon, 1996; Suls, Green, Rose, Lounsbury, & Gordon, 1997), end-stage renal disease (Gray, Brogan, & Kutner, 1985), infertility (Berghuis & Stanton, 2002; Levin, Sher, & Theodos, 1997; Pasch & Christensen, 2000); rheumatoid arthritis (Bermas, Tucker, Winkelman, & Katz, 2000; Danoff-Burg & Revenson, 2000; Manne & Zautra, 1989, 1990; Revenson, 1994, 2003; Tucker, Winkelman, Katz, & Bermas, 1999) and cancer (Baider, Koch, Eascson, & Kaplan De-Nour, 1998; Baider, Perez, & Kaplan De-Nour, 1989; Hagedoorn, Kuijer, et al., 2000; Halford, Scott, & Smythe, 2000; Manne, Alfieri, Taylor, & Dougherty, 1999; Manne & Glassman, 2000; Northouse, Templin, & Mood, 2001; Northouse, Templin, Mood, & Oberst, 1995; Pistrang & Barker, 1995; Zunkel, 2002), as well as other health conditions (Schmaling & Sher, 2000). These studies can be characterized by three different, though somewhat overlapping, approaches to couples' coping: relationship-focused coping, mutual influence, and coping congruence (*fit*). All three approaches can be applied to couples confronting a health-related stressor; all integrate elements of family systems theory; and all require data from both husbands and wives in their research endeavors.

Relationship-Focused Coping

An exciting approach to couples' coping focuses on maintaining the quality of the marital relationship as part of the coping process (see chap. 3, this volume; Coyne & Fiske, 1992; DeLongis & O'Brien, 1990; Lyons et al., 1998; O'Brien & DeLongis, 1996, 1997). This approach expands the stress and coping paradigm developed by Richard Lazarus (Lazarus, 1981, 1999; Lazarus & Folkman, 1984; Lazarus & Launier, 1978) to dyadic-level coping and also considers coping within an interpersonal context.

Lazarus' stress and coping paradigm has been the gold standard in the field for over 2 decades. In its most simplistic interpretation, coping strategies have been described as serving problem-focused and emotion-focused functions. Problem-focused coping efforts are aimed at managing or eliminating the source of stress; emotion-focused coping is directed toward managing the emotional distress that arises from stress appraisals. Supportive relationships are conceptualized primarily as available resources that can aid the individual's coping in a number of ways by providing (a) information about coping options; (b) feedback validating or criticizing the individual's coping choices; (c) instrumental assistance in carrying out the coping actions; or (d) emotional sustenance to help sustain coping efforts (e.g., Cutrona, 1996). As such, social support has been conceptualized as coping assistance (Thoits, 1986).

Relationship-focused coping involves a reformulation of the stress and coping paradigm to include a third coping function. When faced with a stressful situation, each partner may attend to the other's emotional needs in order to maintain the integrity of the relationship. Partners endeavor to manage their own distress without creating upset or problems for the other partner. Relationship-focused coping involves a balance between self and other, with the goal of maintaining the integrity of the marital relationship above either partner's needs. Modes of coping include negotiating or compromising with others, considering the other person's situation, and being empathic (DeLongis & O'Brien, 1990).

A few studies have examined relationship-focused coping among couples in which the husband had experienced a myocardial infarction (MI; Coyne & Smith, 1991, 1994; Suls et al., 1997).¹ These studies focused on a particular relationship-focused coping strategy, *protective buffering*, which involves "hiding concerns, denying worries, and yielding to the partner to avoid disagreements" (Coyne & Smith, 1991, p. 405). Although protective buffering is ostensibly used to avoid disagreements and "protect" the relationship, it appears to exact psychological costs for the person using it in terms of increased psychological distress. Thus, wives' coping efforts to shield husbands from stress in the post-MI period may contribute to their own distress (Coyne & Smith, 1991), as do husbands' efforts to protect their wives (Suls et al., 1997). Perhaps this happens because the partner using protective

¹Another excellent research example of relationship-focused coping can be found in chapter 3 of this volume, in which Preece and DeLongis study relationship-focused coping with the interpersonal stresses experienced by stepfamilies.

buffering feels constrained in expressing negative emotions or worries to the other person (cf. Lepore's, 1997, idea of social constraints). However, protective buffering does not appear to harm the spouse, that is, the person being "protected" (Suls et al., 1997). Thus, relationship-focused coping may require a trade-off between protecting one's own well-being and that of her or his partner.

Mutual Influence Models

Mutual influence models do not specify a particular function of coping but focus on the effects of one partner's coping on the other partner's coping and adjustment (e.g., Manne & Zautra, 1990). A study of adjustment to infertility conducted by Berghuis and Stanton (2002) provides a nice illustration in that it attempts to untangle three possible mechanisms through which each partner's coping influences her or his own adjustment as well as the other partner's. The first mechanism is essentially an additive, or separate influence, model: Each person's adjustment is independently affected by her or his own coping *and* the partner's coping. The two other mechanisms are interaction models in which the relation between coping and adjustment is moderated by what the other person is (or is not) doing. One version of this interactional model posits that if partners use similar coping strategies then adjustment will be greater. The other interaction model suggests that one partner's use of an effective strategy might predominate, either nudging the other partner's coping in the same direction or "canceling out" the effects of the partner's less effective strategies. Although slightly different, both interaction mechanisms involve one partner's coping moderating the other partner's coping.

These models were tested in a prospective study of couples seeking treatment for infertility (Berghuis & Stanton, 2002). Husbands and wives completed measures of coping, depression, and marital satisfaction twice: prior to artificial insemination by the husband and after receiving a negative pregnancy test result. The findings supported all three models to some extent, but the evidence was strongest for the third model, primarily with regard to *coping through emotional approach*, a coping mode that involves both emotional processing and emotional expression. The relationship between wives' use of emotional approach coping and depression was a function of their husbands' use of that same strategy. If wives coped primarily through emotional approach, their husbands' use of that strategy was less influential on (the wife's) level of depression. Conversely, if husbands engaged in emotional approach coping, although the wives did *not*, the wives had relatively low depression scores. In other words, if wives used very little emotional approach coping, their husbands' emotional approach coping was more strongly related to the wives' depression level. If both members of the couple coped very little through emotional approach, wives were more depressed after the failed insemination attempt. This pattern of findings suggests a *compensatory coping* model, in which one person in the family has to use an effective coping strategy (effective, i.e., relative to the target stressor).

Coping Congruence

A third approach emphasizes the congruence or fit between marital partners' coping responses as a predictor of adaptation (Revenson, 1994). Conceptualizing couples' coping in terms of congruence is drawn from person–environment fit theory (French, Rodgers, & Cobb, 1974) and family systems theories (e.g., Patterson & Garwick, 1994). Within family systems theories, stressors such as illness are seen as exerting a disorganizing influence on the family, which then requires a reorganization effort, a form of coping. Thus, the goal of couples' coping is to maximize the congruence or *fit* between the partners' coping styles in order to cope most effectively *as a couple*. Strategies that work in direct opposition or cancel each other out are incongruent and would lead to worse psychosocial outcomes.

Congruence, however, can involve either similarity or complementarity of coping styles. If spouses use similar coping strategies, it might be easier to contend with stress: Coping efforts are coordinated and mutually reinforcing—that is, one partner's efforts do not impede the other's efforts. At the same time, complementary coping styles can be congruent when they work in concert to reach a desired goal, either enhancing the other person's strategy or filling a coping "gap." In fact, complementary strategies may be more effective than when husband and wife use identical strategies because the couple, as a unit, will have a broader coping repertoire. Dissimilar strategies would be seen as noncongruent if one partner's coping efforts were undermined by the other's coping efforts.

An Empirical Investigation of the Coping Congruence Model

In this investigation, we used the congruence approach to study marital coping among 113 middle-aged and older married couples who were coping with one partner's rheumatic disease (the wife in three quarters of the couples, the husband in the remaining one quarter). We refer to the person with rheumatic disease as the *patient* and the partner without rheumatic disease as *the spouse*. The measures, all self-report multi-item scales with good reliability and validity, included coping (Revised Ways of Coping Scale; WOC-revised; Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986), depressive symptoms (Center for Epidemiological Studies Depression Scale; CES-D; Radloff, 1977), marital functioning (Dyadic Adjustment Scale; DAS; Spanier, 1976), and mental health (Mental Health Inventory; MHI; Veit & Ware, 1983). Patients and their spouses completed all measures independently, and data were linked *within* the couple for statistical analyses, yielding a couple-level analysis.

The primary measure of coping was the Revised Ways of Coping Scale (Folkman et al., 1986), a 66-item self-report measure that contains a broad range of cognitive and behavioral strategies. We made the scale situation specific by eliciting coping responses in response to *your illness* (for the patient) or *your partner's illness* (for the spouse). Although most studies have adopted the factor structures found with samples of healthy, young-adult

married couples and older couples (Folkman et al., 1986), we found these structures did not fit our data. Our own factor analysis produced a seven-factor solution that included a broad range of strategies.² We used cluster analysis (Aldenderfer & Blashfeld, 1984) to analyze and describe how husbands and wives coped *as a unit* with rheumatic disease. The statistical procedures leading to the final four-cluster solution are described in Revenson (2003). On the whole, the use of a single strategy or set of strategies did not characterize couples' coping profiles; instead, individuals in all four profiles used a wide range of strategies, suggesting flexible coping.

The first cluster, composed of 14 couples, was characterized as *effortful partnerships*, because of the fairly high level of congruence in husbands' and wives' coping and the tendency to use more problem-focused strategies. These couples favored a number of coping strategies, particularly positive problem solving and rational thinking, although patients used slightly more of each strategy than their spouses did. The second cluster, with 36 couples, had a moderate degree of congruence—that is, patients and spouses were similar in their use of some strategies and not others. Both spouses and patients engaged in fairly high levels of positive problem solving. Spouses used more escape into fantasy, rational thinking, acceptance, and finding blame than did patients. Thus, although the couple solved problems together, spouses used more emotion-focused coping strategies than patients. We called this cluster *problem solvers with emotion-coping spouses*.

The third cluster, with 33 couples, although characterized by congruence, could be described as *minimalist copers*. Coping efforts by both husbands and wives were low on all strategies, and no single strategy predominated. Note that Clusters 1 and 3 are both congruent, but the intensity of their coping efforts differs.

The fourth cluster, with 30 couples, included couples whose coping styles were not congruent. Patients used a combination of distancing, rational thinking, and passive acceptance and tended *not* to use the strategies of escape or finding blame. In contrast, their healthy spouses exerted few coping efforts across the board. If any strategy predominated among spouses, it was rational thinking. We called this cluster *and the patient copes alone*.

There were no differences among the four coping clusters on any of the measures of social support: support received from the partner, support provided to the partner, and satisfaction with support. Nor were there differ-

²The seven strategies are explained as follows: *Positive problem solving* is an instrumental coping strategy with an optimistic tone. It includes items involving forward-looking, problem-focused cognitions and behaviors, such as planning for action, and reappraising the illness as a time of personal growth. *Escape into fantasy*, a cognitive avoidance strategy, describes a more passive coping style of wishing that things had happened differently and imagining a better life situation. *Distancing* describes efforts to minimize or avoid the threat and detach oneself from the emotional distress caused by the illness. *Rational thinking* reflects a calm, collected approach to managing the stressful situation. *Seeking support* involves actions to mobilize social resources for reassurance and confirmation. *Passive acceptance* includes a number of nonactions that may not make things better but prevent the situation from becoming worse. This strategy reflects the coping mode of "inhibition of action" that Lazarus (1981) described in his original paradigm but which has seldom been included in coping measures. *Finding blame* describes expressions of anger toward a person or circumstances responsible for the stresses of illness.

ences among coping clusters on any medical variables: self-reports of pain and disability, physicians' ratings of disease severity, disease activity, and disability. There was, however, a consistent and meaningful pattern of cluster differences in the couples' *subjective* experience of the illness. Couples in Cluster 1, the *effortful partnerships*, stood apart from couples in the other three clusters in a number of meaningful ways. Patients in this cluster had greater levels of depressive symptoms than patients in any of the other three clusters, with half having CES-D scores indicative of clinical depression (> 16 ; Radloff, 1977). Similarly, spouses perceived a much greater degree of stress in their lives than did spouses in the other clusters, particularly interpersonal stress with family and friends, illness intrusions (ways in which the partner's illness intruded into their daily lives), and caregiver burden.

These differences suggest the subtle influence of the social context on couples' coping. Patients in Cluster 1 were more distressed than patients in any other cluster, and their spouses reported a greater degree of stress. Adopting a traditional stress and coping model, we might conclude that the problem-focused efforts of these couples may have been insufficient to manage the ongoing burdens of pain and increasing disability and that the efforts by these couples to improve their situation may have left them feeling worse. Perceiving the ineffectiveness of their coping efforts, they may have tried many different types of coping strategies, also without success (Aldwin & Revenson, 1987). Either the indiscriminate use of every strategy within their repertoire led to poorer adaptive outcomes or emotional distress led these couples to try every coping strategy they could think of in an attempt to manage that distress. Although the base rate of seeking counseling was low in the full sample (approximately 23% of patients and 19% of spouses), the majority of these individuals tended to be in Cluster 1. Couples in this cluster may have been at the stage of confronting the meaning of the illness for their lives, and this may have (temporarily) heightened their emotional distress. Or, these couples may have been struggling to use active coping strategies to control a situation that was beyond their control, contributing to their emotional distress.

One other finding suggests yet another interpretation of the data. Patients and spouses in Cluster 1 had higher scores on a measure of personal growth developed to assess the positive outcomes of illness (Felton & Revenson, 1984). Thus, despite their distress, these actively coping couples were able to reappraise their illness in a more positive light and could see benefits from their struggle. Thus, contextual coping analyses may reveal a resilience that may not be apparent from approaches that examine the effect of individual-level coping strategies on individual-level outcome measures.

The less vigorous coping efforts of the three less distressed clusters may have reflected a coping response that was appropriate to the appraisal level of illness-related stress. This is consistent with Lazarus' stress and coping paradigm, emphasizing the importance of psychological appraisal processes and the situation specificity of coping (Lazarus, 1999; Lazarus & Folkman, 1984). With long-term, non-life-threatening illness and effective treatment, perceptions of illness stress may lessen or stabilize over time or couples may learn to accommodate to the vicissitudes of the illness.

Thus, dissimilar coping styles within a couple do not necessarily signal a greater level of psychological or marital problems. It is likely that the partners' different modes of coping did not cancel each other out but complemented each other, producing a wider repertoire of coping options. The question of whether the fit between husbands' and wives' coping is a greater predictor of adjustment than simply knowing which strategies were used remains unanswered; couples in one cluster characterized by high similarity were highly distressed, whereas in another cluster they were not.

These data emphasize the importance of understanding couples' life context and *their perceptions of it* as they cope with a serious illness. Coping seems less dependent on the objective circumstances of the illness and more on the couple's integration of those circumstances into their life. For example, although features of the medical context did not differentiate couples' coping patterns, the experience of pain or disability spilled over to the distress experienced by the healthy spouse.

Expanding These Approaches

All three approaches to couple-level coping provide evidence that couples' coping may be substantially different from the "sum" of the individuals' coping. Putting these three approaches together leads to a transactional process model of couples' adaptation similar to those proposed in several chapters of this book, with regard to dyadic coping (see chap. 2, this volume) and interpersonal conflict and interpersonal communication (see chap. 4, this volume). These process models revolve around the dynamic interplay of each partner's reactions. The "starting point" for this interaction is arbitrary; that is, either partner may create an emotional situation to which the other responds or a particular aspect of the illness or its treatment may elicit coordinated coping efforts by husband and wife (see chap. 2, this volume, for specific examples). Appraising the degree to which some feature of the illness is stressful, each partner tries a variety of coping strategies to minimize distress and maintain family functioning. The other partner's reaction to this coping creates, over time, a set of conditions to which the "first" partner responds. The "second" partner then tries to (re)act in a way that will minimize her or his partner's distress but may instead exacerbate it. Thus, the couple's adaptation to illness can be described as a spiral or cascade whereby the patient's distress affects the spouse's coping and support provision, which affects the patient's distress and coping, which affects the spouse, and so on (see chap. 2, this volume).

Although our study provided a rich description of couples' coping patterns, it cannot answer questions about long-term coping processes. With cross-sectional data, we can see the resulting patterns of congruence or incongruence of couples' coping but not the evolution of those patterns over time. Did one spouse's choice of coping strategy change how the other spouse coped? Do partners knowingly coordinate coping efforts, whether capitalizing on similarity or complementarity, to achieve desired outcomes? Does the couple's coping become more congruent over time as ineffective strategies or strategies that

impeded a partner's coping efforts are discarded and successful ones are adopted or recycled? These are the questions for the next generation of couples' coping research.

What's Gender Got to Do With It?

One key area that has been missing from research on couples' coping, as well as coping with illness, is a deliberate consideration of gender. Gender roles are a key component of intimate relationships, and our understanding of couples' coping is not complete without this dimension.

Because of funding priorities and constraints, most research on the impact of illness has focused on single diseases. However, because many diseases vary in their prevalence among men and women, many studies include respondents of only one sex, for example, women with breast cancer or arthritis, men with prostate cancer or heart disease, and if they are couples studies, they include the husbands or wives of these patients. Thus, if differences in the impact of illness on the spouse or in the efficacy of patients' coping efforts are detected across these studies, it is difficult to disentangle the influences of gender and the person's role as patient or partner. Similarly, because few studies have included both patients and their spouses and even fewer have analyzed the data taking into account the fact that these individuals are married to each other (using nonindependent statistical tests), we cannot discern whether the experience of coping with the "same" illness in the same family differs for women and men.

Existing research presents the strong impression that men and women cope with illness in extremely different ways and that women face a greater burden than men whether they are the person with the illness or the spouse caregiver. In an early study, Hafstrom and Schram (1984) compared couples in which the husband or wife had a chronic condition with couples in which neither spouse was ill. (Unfortunately, this study did not directly compare couples with ill husbands to couples with ill wives.) Compared to their counterparts in non-ill families, wives who were chronically ill did more housework (an average of 7 hours more a week!), although they spent 6 fewer hours in the labor force. There were no differences between the groups in global marital satisfaction, although women with chronic illness were less satisfied with their role performance as wives and mothers. In contrast, wives whose husbands had a chronic illness were less satisfied with their marriages than were wives in non-ill families. Compared to healthy families, wives in marriages in which the husband was ill were significantly less satisfied in many areas, including the husband's lack of understanding of their feelings, the amount of attention the husband provided, the husband's help around the house, the husband's role performance as a husband and father, the amount of time the couple spent together, and the way this time was spent. Wives of ill husbands also were less satisfied with their own role performance as mothers, but surprisingly, *not* with their performance as wives. These data suggested that women with ill husbands felt a responsibility to keep the family and home intact, but at great personal cost.

Studies of couples coping with myocardial infarction present a similar picture.³ After a heart attack, men tend to reduce their work activities and responsibilities and are nurtured by their wives. After hospitalization, women resume household responsibilities more quickly, including taking care of other family members, and report receiving a greater amount of help from adult daughters and neighbors than from their healthy husbands. Michela (1987), interpreting data collected from 40 couples in which the husband had suffered a first heart attack during the previous year, found substantial differences in husbands' and wives' experiences:

His experience is filtered through concerns about surviving and recovering from the MI with a minimum of danger or discomfort, while *her* experience is filtered through the meaning of the marital relationship to her—what the marriage has provided and, hence, what is threatened by the husband's potential death or what is lost by his disability. (p. 272)

Is this gender? Or is it as a result of being the patient versus the caregiver?

A few studies of couples coping with illness have addressed this question directly and yielded equivocal results. Baider et al. (1989) compared patients with healthy spouses for women and men separately. Female cancer patients were more distressed than wives of male cancer patients, and in separate analyses, husbands of cancer patients reported more distress than male cancer patients. Thus, couples of female cancer patients with healthy husbands showed greater distress than couples of male patients with healthy wives. Hagedoorn and her colleagues (Hagedoorn, Buunk, Kuijer, Wobbles, & Sanderman, 2000) used a similar methodology to study gender differences but found opposite results. Wives of (male) cancer patients experienced greater distress and lower quality of life than did husbands of (female) cancer patients. Yet there were no differences between male and female *patients* in distress or quality of life. They concluded that neither gender nor role status alone makes a difference, but the combination of gender and role does. Hagedoorn and her coauthors leave us with the question, "What is it about being the partner of a patient with cancer that causes more psychological distress among women than men?" (p. 240). Possible explanations include the idea that women perceive more distress than men because they spend more hours on caregiving tasks or because they are more open about sharing feelings, or that men derive more satisfaction and self-esteem from caregiving. Our research on couples with rheumatic disease, described next, attempts to understand more fully these *his* and *hers* experiences.

Gender Differences in Marital Coping Processes Among Couples With Rheumatic Disease

Most research on psychological adjustment to rheumatic disease has focused on the patient's experience, and the majority of patients are women. Rheumatic diseases have a higher prevalence among women (approximately

³It is important to note that the majority of studies sample male patients and female spouses.

75%), and research suggests that there are meaningful gender differences in the patterning of disease, the experience of symptoms, and how patients cognitively appraise their symptoms (Danoff-Burg & Revenson, 2000; DeVellis, Revenson, & Blalock, 1997; Majerovitz & Revenson, 1994; Revenson & Danoff-Burg, 2000).

We return to the study of 113 married couples with rheumatic disease described earlier in this chapter to explore questions of gender. In all analyses, the couple is the unit of analysis. In some analyses, couples in which the husband is ill are compared with couples in which the wife is ill; in other analyses these couples are compared with an age- and income-matched comparison sample of 37 "healthy" couples in which neither spouse was diagnosed with a chronic illness.

GENDER DIFFERENCES IN COPING. Independent sample *t* tests were used to compare frequency of use of particular coping strategies among couples in which the wife had rheumatic disease and couples in which the husband had rheumatic disease. Few statistically significant differences were found. Female patients used escape into fantasy and seeking support to a greater extent than male patients; female spouses used more passive acceptance than male spouses.

We also determined the proportion of couples in each cluster in which the wife versus the husband was ill. Although the chi-square statistic was not significant, $\chi^2 = 3.158$ ($df = 3$), $p = .37$, the proportion of women patients in each cluster looked different: In Cluster 1, the effortful partnerships, there were six times as many couples in which the wife versus the husband had rheumatic disease. In contrast, this ratio was 2:1 in Cluster 2, 3:1 in Cluster 3, and 4:1 in Cluster 4. (The matching of the number with the cluster number is coincidental.) Thus, it seems that the pattern of couples coping that we found may be shaded by gender.

GENDER DIFFERENCES IN ADJUSTMENT. A second question involved the relative levels of psychosocial adjustment experienced by patients and their spouses and whether these outcomes varied by the patient's gender. We examined three measures of psychological adjustment (depression, psychological distress, and psychological well-being) and two measures of marital adjustment (marital satisfaction and sexual satisfaction) using a 2×2 mixed model analysis of variance with partner status (patient or spouse) as a within-couple source of variance and patient gender (male vs. female) as the between-couples factor. In this way, we could examine gender differences among patients and spouses and whether there was an interaction between patient status and gender.

Women had significantly higher scores than men on the depression, psychological distress, and sexual dissatisfaction scales (Majerovitz & Revenson, 1994). This suggests that gender has an influence on adjustment, regardless of whether one is the person with rheumatic disease or the partner of someone with rheumatic disease. However, there were a number of interesting interactions between gender and patient status. Comparing the four groups (female patients, male patients, female spouses, and male spouses), female patients had the highest levels of depression and male patients the lowest. In fact,

female patients were the only group to approach the cutoff score of 16 on the CES-D (Radloff, 1977), which denotes clinical depression. Mirroring this effect, female patients had the lowest well-being scores and male patients the highest. Although there was not a significant interaction effect for marital satisfaction, there was a main effect for patient status: Patients (male and female) reported greater marital satisfaction than their healthy spouses did.

We were intrigued by the fact that female patients seemed worse off (psychologically) than male patients.⁴ This mirrors the literature on sex differences in depression in the general population. We wondered if this difference might be attributed to the fact that women in this sample had more severe disease; however, there were no differences between female and male patients in physician-rated disease severity or activity or in patients' self-reports of functional ability. We then turned to other psychological explanatory variables.

GENDER DIFFERENCES IN SOCIAL SUPPORT. The provision of social support is an important aspect of couples' coping (see chaps. 4 & 7, this volume; Lyons et al., 1998). In a study of women with rheumatoid arthritis and their spouses (Revenson & Majerovitz, 1990), a number of wives of ill men confided that they had lessened their own requests for emotional support for fear of increasing their ill husbands' distress. This reflects the coping strategy of *protective buffering* described in Coyne and Smith's (1991, 1994) study of couples coping with the husband's myocardial infarction.

We hypothesized that gender differences in adjustment may reflect caregiver burden and the degree to which female and male patients feel supported by their partners. We asked about a number of dimensions of support: positive emotional support, problematic (negative) support, and satisfaction with the support received. We asked husbands and wives about the degree to which they received positive and problematic support from their partners, the degree to which they gave positive and negative support to their partners, and the degree to which they were satisfied with the instrumental and emotional support received from their partners.

Contrary to predictions, there were no differences between male and female patients' reports of the positive or problematic support they received. However, there were significant differences between male and female *spouses*: Husbands of ill women reported receiving more positive support than wives of ill men. In contrast to this finding, wives of ill men reported receiving more problematic support from their partners than did husbands of ill wives. There were no differences among men and women overall (well or ill) in the amount of positive or problematic support that they reported providing to their partner.

Although there were no gender differences in received support, these findings suggest that men and women with rheumatoid arthritis were *providing* very different levels of support to their spouse. Male spouses reported receiving higher levels of support from their ill wives than wives reported receiving from their ill husbands, indicating that the chronically ill wives in this sample were coping with their own illness while continuing to provide

⁴It is possible that male patients showed psychological deficits on dimensions of mental health that we did not measure, for example, alcohol or substance abuse.

social support to their husbands. In contrast, ill husbands were not providing comparable levels of support to their wives. Perhaps the chronically ill men in this sample reduced their own burden by focusing more on themselves and less on supporting their partner, whereas the women continued to care for husbands and other family members despite their illness. This is congruent with Michela's (1987) study of the experience of myocardial infarction, described earlier.

Ill wives and their husbands were equally satisfied with the instrumental and emotional support they received from each other. However, there was a large discrepancy between ill husbands and *their* wives: Ill husbands were extremely satisfied and their wives were extremely dissatisfied. In fact, wives of ill men were the least satisfied of all respondents with the instrumental and emotional support they received from their partner. If ill husbands were indeed providing less support to their wives as they focused on their own illness, as suggested above, this would explain the discrepancy in support satisfaction.

Although the women and men in this study differed on indices of psychological and marital adjustment, these differences were not a result of gender differences in coping strategies. Moreover, there was an interaction between gender and whether one is the person with rheumatic disease or the spouse of a person with rheumatic disease. The findings offer only a partial explanation for the gender differences found in psychosocial adjustment—that is, they do not explain the fact that women with rheumatic disease have higher depression scores than men with rheumatic disease—scores that approach the cutoff point for diagnosing clinical depression. It seems that male patients' low levels of depression, high levels of well-being, and high levels of sexual satisfaction may be a reflection of their high satisfaction with the support provided by their wives. The significant differences lie in perceptions of spousal support (e.g., satisfaction). Men with rheumatic disease may perceive a great deal of support and caregiving from their wives that women with rheumatic disease do not.

Reconceptualizing the Link Between Coping and Support With a Dyadic-Coping Framework: The Division of Household Labor

A number of sociological studies have documented a gender gap in the sharing of household responsibilities by women and men (Hochschild, 1989). Even with the growing proportion of women in the paid labor force, women spend an average of 15 hours more a week on household responsibilities than do men. This gender inequity was described as having important implications for the mental health of women juggling careers and family life.

The notion of a gender inequity in household responsibilities is relevant to coping processes among couples living with a chronic physical illness. If one conceives of the family as an open system, when one partner becomes ill or disabled there is a need for the family to adapt. Daily routines must be adjusted, roles restructured, and long-established patterns of family activities rearranged. As Pearlin and Turner (1987, p. 148) have written, "disruptive events acquire much of their stressful character not by their own direct impact but by disrupting and dislocating the more *structured* [italics added] elements of peoples' lives."

Coping with chronic illness requires a restructuring of household responsibilities, but we hypothesize that the nature of this restructuring differs when the wife or husband is ill: In marriages in which women are ill, we expect there will be a narrowing of the gender gap in the division of household labor; that is, men will pick up more of the ongoing household responsibilities. In contrast, in marriages in which the husband is ill, women will add even more responsibilities.

We tested these hypotheses in our sample of 113 married couples with rheumatic disease (described earlier in this chapter) that also included an age-matched comparison sample of 37 couples without a chronic illness. We asked husbands and wives (separately) about the division of household labor on 14 different household tasks. Some of these tasks were traditionally female (e.g., doing dishes), others were traditionally male (e.g., car maintenance), and yet others were ambiguous ("household finances"). For each task, respondents were asked to divide 100% into the proportion of the task that they did, that their spouse did, and that was done by other help (either family members or paid help). To examine whether the distribution of household labor differed among couples in which the wives are ill, couples in which the husbands are ill, and healthy comparison couples, we used a nonparametric statistic, the median test, which produces a chi-square statistic.

A Gender Gap in the Division of Household Labor

A gender gap in the division of household labor was apparent across the full sample of 150 couples. For most tasks, wives did over half of the work; in most cases, they did even more, and there was good agreement in these estimates between husbands and wives.⁵

Our first hypothesis addressed whether the division of household labor shifts when wives are ill and moves toward greater gender equity. There were significant differences among couples on most household tasks: For 10 of the 14 tasks, the median test was significant for the proportion of work done by the wife, and for 3 of those tasks, the median test also was significant for the proportion of work done by the husband. Wives with rheumatic disease did a significantly smaller proportion of tasks than healthy comparison wives or wives of ill husbands. Level of functional disability was inversely correlated with this decrease: that is, more disabled women did even less household work. Thus, women with rheumatic disease relinquished or were relieved of some of their household responsibilities, particularly when disability was more severe.

However, the nonsignificant median tests are informative with regard to gender. There were no significant differences among women across the three types of couples for the tasks of cooking, doing dishes, social planning, and domestic finances. Women with rheumatic disease did no less of the daily cooking or dishes as compared to healthy wives (either in couples in which the

⁵This finding is replicated whether we use the husband's or wife's responses about the division of labor or an average of the two. The greatest amount of disagreement was in the areas of child care and car maintenance.

husband is ill or in healthy couples); women did about two thirds of the social planning; and husband and wives in all three types of couples shared responsibility equally for domestic finances.

The second part of the hypothesis predicted not only a shift in the pattern of women's work among couples in which the wife has a chronic illness but a move toward greater gender equity. This part of the hypothesis was only partially supported and differed by type of task. For some tasks, such as *running errands* and *grocery shopping*, husbands picked up the slack, increasing their proportion of work done. For the tasks of *doing laundry and heavy cleaning*, the decrease in work by ill wives was filled by a combination of the husband doing more and using outside help (either paid help or unpaid family members).

In contrast, for the tasks of *child care* and *routine cleaning*, husbands did not increase their contribution. Instead, couples relied on other help (either paid or family help) to compensate for the ill wives' decrease. For example, ill wives did less child care than comparison wives, but the husbands of the ill women did the same amount of child care as comparison husbands. The gap was filled by other people more often for couples with ill wives than for couples with ill husbands or comparison couples.

A different picture emerges for traditionally male tasks, such as taking out the garbage, household repairs, outside chores (e.g., mowing the lawn), and car maintenance. We found few differences between couples in which the wife was ill and healthy comparison couples. Husbands of ill wives continued to do tasks that are traditionally male. Men with rheumatic disease, however, did less than either healthy husbands or husbands of ill wives. When it came to *taking out the garbage*, wives picked up that responsibility (no pun intended). With regard to *household repairs*, wives picked up some of the work and some was done by outside help. In contrast, neither *outside chores* nor *car maintenance* became the women's responsibility; these were done by outside help.

Most of the couples appeared to be resourceful in taking some of the burden off the ill partner and in getting household chores done. This may have been possible because this sample had the financial resources to do so. The picture may be different in families with fewer economic resources.

Although there was clearly a responsiveness of the couples in our study to adjust their distribution of household responsibilities when one partner has a chronic illness, women—even those who are ill—were still responsible for many of the around-the-clock maintenance tasks such as cooking, cleaning, and child care. In a qualitative study of breast cancer patients and their husbands, Zunkel (2002) reported that many husbands felt a responsibility to pitch in with child care, particularly when the woman was unable to do so because of chemotherapy or pain. Several of the husbands described this as "taking over things," which suggests that these tasks are still seen as the wife's responsibility. The manner in which household tasks are shared even in ill couples suggests that a gender-based typology persists despite illness and that certain tasks remain forever the province of husband or wife.

This finding replicates that of national studies of healthy couples (Hochschild, 1989): Women do more of the tasks that need either daily or immediate attention and fix women's lives into a more rigid routine, such as

feeding the family and attending to children's needs. This can become problematic when one has a rheumatic disease that involves severe pain, joint swelling, and symptom flares that are neither predictable, controllable, nor time limited.

These data suggest that a traditional gender-typed division of labor exists even when chronic illness affects a marriage and may reveal only the visible surface of deeper emotional issues: What should a husband and a wife contribute to a family when one person is ill or disabled? How appreciated does each feel? And how does each develop a gender strategy for coping with these issues at home? These are the underlying issues that deserve further research attention in order to increase our knowledge about the specific ways in which gender is part of couples' adaptation to illness.

Explanations for the Gender Gap

In sum, wives of ill husbands reported receiving less emotional support and more problematic spousal support and were dissatisfied with the emotional and tangible support they were receiving from their partners. Perhaps it was the feeling of never-ending responsibilities that led women caring for ill husbands to feel dissatisfied with the instrumental emotional support they were receiving from their spouses. Women who had a rheumatic disease enjoyed greater sharing of responsibilities with their husbands, but the couples also relied on outside help. In contrast, in couples in which men were ill, they did even less, and their wives added on some around-the-clock maintenance to their responsibilities, perhaps leading to feelings of burden and a lack of appreciation. It is interesting that whereas wives of ill men scored neither higher than husbands of ill women on a standardized measure of caregiver burden nor lower on a measure of marital satisfaction, the variance for the wives was extremely large on both measures, indicating extreme highs and lows.

In conclusion, couples' experience of coping with illness cannot be extricated from gender. Whether they are the patient or the caregiver, women assume a disproportionate share of the responsibilities for maintaining the family's organization and providing nurturance to family members. Gilligan (1982), among others, has noted that women tend to be socialized into caretaking roles in close relationships and are more responsive to the well-being of others. One national survey found that women were 10% to 40% more likely to support a loved one during a crisis, depending on the nature of the problem (Wethington, McLeod, & Kessler, 1987). This also points to a gross inadequacy in our current conceptions of coping: If we continue to focus only on the patient's coping efforts and the patient's relation to adjustment, we miss the critical aspects of gender. Coping with illness does not simply mean being the person diagnosed; it involves caring for family members with illness as well. With the exception of the Alzheimer's disease literature, which focuses on caregiver burden, coping has largely avoided issues of gender by avoiding issues of family-level coping.

Differing gender roles and their influence on family coping processes have implications for both family functioning and health behaviors. Whereas family

coping responsibilities may be natural extensions of women's roles, they create added stress for wife caregivers. When their husbands are ill, wives do not reap the same benefits of increased caregiving and support from their husbands.

We would like to end on an optimistic note, however. Gender roles have changed over the past quarter century. Cohort studies point to less differentiation in gender roles today (Deaux & LaFrance, 1998), suggesting there may be greater flexibility for families coping with stress in the future. Current studies of chronic illness, including our own, often involve individuals in middle and old age whose early gender role socialization is likely to be different than their respective cohorts of tomorrow. Only by studying couples over the life course, and at different stages of family life, will we be able to discern whether the gender differences are due to generational effects or cohort effects.

It is important to begin to assemble a literature examining the braiding of gender with couples' adaptation to illness rather than bemoan the inadequacy of past studies. The mandate of this research would be to learn the specific ways in which gender is part of couples' adaptation to illness in order to most effectively maximize family adaptation and provide guidance to practitioners.

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