A cancer diagnosis, regardless of type or site, raises feelings of fear and loss of control in patients and their partners. Being married is associated with lower mortality from a wide range of illnesses, including cancer. However, the quality of marital interactions is a stronger predictor of health outcomes than marital status alone. When people face great life challenges, they attach importance to their intimate partner’s behaviors. Trust, a key component of relationship quality, can lend stability as well as emotional and practical support during treatment. This article will examine the results of research focused on patients with cancer and their partners and discuss the effects of a cancer diagnosis on couples. Recommendations for clinical practice include couple behaviors, communication patterns, and coping strategies. In addition, partners should be included in assessment and interventions to improve the quality of care for patients with cancer.

**At a Glance**

- A cancer diagnosis affects the lifestyles of patients as well as partners.
- Relationship quality has a strong influence on couples' coping ability.
- Nurses should encourage patients and partners to use active engagement and open communication for optimal outcomes.

A cancer diagnosis threatens the health of patients and the existence of partner relationships. The reactions and coping styles of partners and patients are important in cancer care (Cutrona, Russell, & Gardner, 2005; Manne & Schnoll, 2001; Pistrang & Barker, 2005). Issues of partner trust and support are vital to patients throughout the cancer diagnosis and treatment process (Cutrona et al.). The relationship between partners and patients with cancer is a complex dyad that differs from the general social support structure of family and friends (Bodenmann, 2005; Gale et al., 2001; Manne, Taylor, Dougherty, & Kemeny, 1997). A dyad is couples in a committed or marital relationship composed of heterosexual or same sex partners. Most of the literature on patients with cancer and their partners involves heterosexuals and homogenous, disease-specific populations (e.g., patients with breast or prostate cancer). Many cultures have been represented in international studies, including the Dutch (Hagedoorn et al., 2000), Israelis (Baider, Walach, Perry, & Kaplan De-Nour, 1998; Ben-Zur, Gilbar, & Lev, 2001), Canadians (Bultz, Speca, Brasher, Geggie, & Page, 2000), Swiss (Bodenmann, Pihet, & Kayser, 2006), and British (Gale et al.). Although many studies accepted same-sex couples, few participated. As a result, this article will review literature that encompasses heterosexual couples in intimate, marital, or committed relationships.

The study of coping strategies, which developed from Lazarus and Folkman’s (1984) research on stress response, addresses three processes: perceiving a threat, forming a response to the threat, and coping (the process of executing the response). The model implies that coping is a process, not an event. Many studies assess coping as two strategies: problem focused (managing or eliminating the stress) and emotion focused (managing the emotional distress that arises from stress appraisals) (Revenson, Abraido-Lanza, Majerovitz, & Jordan, 2005).

The construct of dyadic coping, which involves both partners (usually in a marital or committed relationship), is the interplay between the stress signals of one partner and the coping reactions of the other partner. Dyadic coping can include daily communication, interpersonal conflict, joint problem solving, giving and receiving emotional support, and dealing with life stressors as a couple rather than as individuals (Bodenmann et al., 2006). The dyadic strategies are defined as active engagement and protective buffering (see Figure 1). This article will enhance nursing care of emotional distress that arises from stress appraisals (Revenson, Abraido-Lanza, Majerovitz, & Jordan, 2005).

Mary Ann Morgan, PhD, ARNP-BC, is an advanced registered nurse practitioner in the survivorship clinic at the Moffitt Cancer Center in Tampa, FL. Morgan received an American Cancer Society Nursing Doctoral Scholarship (DSCN-08-209-01) for dissertation work related to this article. (Submitted May 2008. Accepted for publication August 3, 2008.)

Digital Object Identifier: 10.1188/09.CJON.65-72
the patient-partner dyad by illustrating the importance of including partners in cancer assessment, treatment, ongoing support, and follow-up care.

Dyadic Coping in Patients and Partners

Dyadic coping has positive and negative natures. A partner’s adjustment to the patient’s cancer diagnosis is critical to the patient’s adjustment to the disease (Manne et al., 1997; Northouse, Mood, Templin, Mellon, & George, 2000). Psychological distress is predicted by dyadic adjustment and coping styles for patients and partners following cancer diagnosis (Banthia et al., 2003). Partner distress correlates with patient distress (Ko et al., 2005); if one partner becomes distressed, the other likely will (Gilbar & Zusman, 2007).

Positive supportive coping occurs when one partner assists or helps the other by providing counseling, communicating beliefs in the other’s capabilities, and expressing solidarity (Bodenmann, 2005). Support also may include self-sacrifice (e.g., one partner assumes tasks or household duties that normally are shared) (Cutrona et al., 2005).

Empathy or an emotional connection is particularly important for patients with cancer (Carlson, Ottenbreit, St. Pierre, & Bultz, 2001). Positive coping results in a feeling of mutual trust, reliability, and commitment as well as a perception between partners that support is promised despite difficult circumstances. Efforts that support one partner also help to reduce the supporting partner’s stress and sustain the relationship (Bodenmann, 2005).

Negative forms of dyadic coping, including hostile, ambivalent, and superficial coping, can affect the process of cancer diagnosis and treatment (Schmaling & Goldman Sher, 2000). Support provided in negative dyadic coping is perceived as sarcastic, unwilling, or insincere (Bodenmann, 2005). Characteristics of negative or lacking support include physical avoidance of the patient, avoidance of open communication with the patient, engaging in forced cheerfulness, or minimizing of the illness and its consequences. The disconnect can result in patients feeling rejected or abandoned (Hinnen, Hagedoorn, Sanderman, & Rancho, 2007; Manne et al., 1997) (see Table 1).

Patients who used avoidance coping techniques tended to report greater distress and poorer adjustment to cancer diagnosis and treatment (Ben-Zur et al., 2001; Couper et al., 2006). Partners, particularly those who use avoidance coping styles, have equal or higher risk for distress as patients because they also are forced into new and unpredictable situations (Baider, Koch, Esacson, & De-Nour, 1998; Hinnen et al., 2007). Partners’ patterns of coping affect their own level of distress as well as patients’ (Couper et al.). However, Banthia et al. (2003) reported that dyadic strength (high-quality marital satisfaction or adjustment) moderated the effects of maladaptive avoidance coping on mood disturbance. Members of stronger dyads reported less distress compared to couples in low-quality marital relationships, regardless of their use of maladaptive coping behaviors.

Active engagement is a discussion held by the patient dyad that explores thoughts, emotions, and the initiation of positive efforts at problem solving; active engagement is considered supportive coping (Bodenmann, 2005; Hinnen et al., 2007). Protective buffering, which involves hiding one’s concerns, denying worries, and yielding to the partner to avoid disagreements, is intended to reinforce or strengthen the efforts and psychological, physical, and social functioning of the other partner or increase marital satisfaction (Bodenmann); however, protective buffering also can increase the user’s own distress. Some authors consider protective buffering a strength (Bodenmann; Revenson et al., 2005), whereas others consider it generally unsupportive or maladaptive (Hinnen et al.). Protective buffering and active engagement are unrelated constructs and should be evaluated separately (Hinnen et al.). Hinnen et al. reported that older patient dyads (aged 34–77 years, X = 54 years, SD = 9.4) often used protective buffering, whereas younger or higher-educated (college education) patient dyads used active engagement. Distress also was strongly and positively associated with distress of the partner and its consequences. The disconnect can result in partners feeling rejected or abandoned (Hinnen, Hagedoorn, Sanderman, & Rancho, 2007; Manne et al., 1997) (see Table 1).

Patients who used avoidance coping techniques tended to report greater distress and poorer adjustment to cancer diagnosis and treatment (Ben-Zur et al., 2001; Couper et al., 2006). Partners, particularly those who use avoidance coping styles, have equal or higher risk for distress as patients because they also are forced into new and unpredictable situations (Baider, Koch, Esacson, & De-Nour, 1998; Hinnen et al., 2007). Partners’ patterns of coping affect their own level of distress as well as patients’ (Couper et al.). However, Banthia et al. (2003) reported that dyadic strength (high-quality marital satisfaction or adjustment) moderated the effects of maladaptive avoidance coping on mood disturbance. Members of stronger dyads reported less distress compared to couples in low-quality marital relationships, regardless of their use of maladaptive coping behaviors.

Active engagement is a discussion held by the patient dyad that explores thoughts, emotions, and the initiation of positive efforts at problem solving; active engagement is considered supportive coping (Bodenmann, 2005; Hinnen et al., 2007). Protective buffering, which involves hiding one’s concerns, denying worries, and yielding to the partner to avoid disagreements, is intended to reinforce or strengthen the efforts and psychological, physical, and social functioning of the other partner or increase marital satisfaction (Bodenmann); however, protective buffering also can increase the user’s own distress. Some authors consider protective buffering a strength (Bodenmann; Revenson et al., 2005), whereas others consider it generally unsupportive or maladaptive (Hinnen et al.). Protective buffering and active engagement are unrelated constructs and should be evaluated separately (Hinnen et al.). Hinnen et al. reported that older patient dyads (aged 34–77 years, X = 54 years, SD = 9.4) often used protective buffering, whereas younger or higher-educated (college education) patient dyads used active engagement. Distress also was strongly and positively associated with distress of the partner and its consequences. The disconnect can result in partners feeling rejected or abandoned (Hinnen, Hagedoorn, Sanderman, & Rancho, 2007; Manne et al., 1997) (see Table 1).

Patients who used avoidance coping techniques tended to report greater distress and poorer adjustment to cancer diagnosis and treatment (Ben-Zur et al., 2001; Couper et al., 2006). Partners, particularly those who use avoidance coping styles, have equal or higher risk for distress as patients because they also are forced into new and unpredictable situations (Baider, Koch, Esacson, & De-Nour, 1998; Hinnen et al., 2007). Partners’ patterns of coping affect their own level of distress as well as patients’ (Couper et al.). However, Banthia et al. (2003) reported that dyadic strength (high-quality marital satisfaction or adjustment) moderated the effects of maladaptive avoidance coping on mood disturbance. Members of stronger dyads reported less distress compared to couples in low-quality marital relationships, regardless of their use of maladaptive coping behaviors.

Active engagement is a discussion held by the patient dyad that explores thoughts, emotions, and the initiation of positive efforts at problem solving; active engagement is considered supportive coping (Bodenmann, 2005; Hinnen et al., 2007). Protective buffering, which involves hiding one’s concerns, denying worries, and yielding to the partner to avoid disagreements, is intended to reinforce or strengthen the efforts and psychological, physical, and social functioning of the other partner or increase marital satisfaction (Bodenmann); however, protective buffering also can increase the user’s own distress. Some authors consider protective buffering a strength (Bodenmann; Revenson et al., 2005), whereas others consider it generally unsupportive or maladaptive (Hinnen et al.). Protective buffering and active engagement are unrelated constructs and should be evaluated separately (Hinnen et al.). Hinnen et al. reported that older patient dyads (aged 34–77 years, X = 54 years, SD = 9.4) often used protective buffering, whereas younger or higher-educated (college education) patient dyads used active engagement. Distress also was strongly and positively associated with distress of the partner and its consequences. The disconnect can result in partners feeling rejected or abandoned (Hinnen, Hagedoorn, Sanderman, & Rancho, 2007; Manne et al., 1997) (see Table 1).

Patients who used avoidance coping techniques tended to report greater distress and poorer adjustment to cancer diagnosis and treatment (Ben-Zur et al., 2001; Couper et al., 2006). Partners, particularly those who use avoidance coping styles, have equal or higher risk for distress as patients because they also are forced into new and unpredictable situations (Baider, Koch, Esacson, & De-Nour, 1998; Hinnen et al., 2007). Partners’ patterns of coping affect their own level of distress as well as patients’ (Couper et al.). However, Banthia et al. (2003) reported that dyadic strength (high-quality marital satisfaction or adjustment) moderated the effects of maladaptive avoidance coping on mood disturbance. Members of stronger dyads reported less distress compared to couples in low-quality marital relationships, regardless of their use of maladaptive coping behaviors.

Active engagement is a discussion held by the patient dyad that explores thoughts, emotions, and the initiation of positive efforts at problem solving; active engagement is considered supportive coping (Bodenmann, 2005; Hinnen et al., 2007). Protective buffering, which involves hiding one’s concerns, denying worries, and yielding to the partner to avoid disagreements, is intended to reinforce or strengthen the efforts and psychological, physical, and social functioning of the other partner or increase marital satisfaction (Bodenmann); however, protective buffering also can increase the user’s own distress. Some authors consider protective buffering a strength (Bodenmann; Revenson et al., 2005), whereas others consider it generally unsupportive or maladaptive (Hinnen et al.). Protective buffering and active engagement are unrelated constructs and should be evaluated separately (Hinnen et al.). Hinnen et al. reported that older patient dyads (aged 34–77 years, X = 54 years, SD = 9.4) often used protective buffering, whereas younger or higher-educated (college education) patient dyads used active engagement. Distress also was strongly and positively associated with distress of the partner and its consequences. The disconnect can result in partners feeling rejected or abandoned (Hinnen, Hagedoorn, Sanderman, & Rancho, 2007; Manne et al., 1997) (see Table 1).

Table 1. Positive and Negative Aspects of Dyadic Coping

<table>
<thead>
<tr>
<th>ORIENTATION AND COPING BEHAVIOR</th>
<th>OUTCOME FOR COUPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>POSITIVE</td>
<td></td>
</tr>
<tr>
<td>Providing counsel</td>
<td>Feeling of mutual trust</td>
</tr>
<tr>
<td>Communicating belief in the other partner’s capabilities</td>
<td>Reliability</td>
</tr>
<tr>
<td>Expressing solidarity</td>
<td>Commitment</td>
</tr>
<tr>
<td>Assuming tasks or household duties that normally are shared</td>
<td>Promise that despite difficult circumstances, support is provided</td>
</tr>
<tr>
<td>NEGATIVE</td>
<td></td>
</tr>
<tr>
<td>Hostility</td>
<td>Physical avoidance</td>
</tr>
<tr>
<td>Ambivalence</td>
<td>Avoidance of open communication</td>
</tr>
<tr>
<td>Superficiality</td>
<td>Forced cheerfulness</td>
</tr>
<tr>
<td>Perceiving help as sarcastic, unwilling, or insincere</td>
<td>Patient feels rejected or abandoned.</td>
</tr>
</tbody>
</table>

*Note.* Based on information from Bodenmann, 2005.
related to protective buffering; less distress was associated with more active engagement.

**Relationship Characteristics**

Patient-partner relationships that demonstrate high marital quality frequently attribute negative behaviors to stress and frustration, thus counteracting any destructive impact. However, when trust is low, undesirable behaviors are attributed to enduring characteristics of the partner and negative interactions may occur at high frequency and intensity (Cutrona et al., 2005; Manne et al., 1997).

A cancer diagnosis, regardless of type or site, elicits fear and loss of control in patients and partners (Maliski, Heilemann, & McCorkle, 2002; Morse & Fife, 1998). Most studies examining couples that have been impacted by cancer include patients with breast and prostate cancer (Banthia et al., 2003; Ben-Zur et al., 2001; Bultz et al., 2000); some studies observed patients with gastrointestinal, colon, and lung cancer (Badr & Taylor, 2006; Northouse et al., 2000; Porter, Keefe, Hurwitz, & Faber, 2005). However, studies of couple communication and dyadic coping at end of life have not incorporated any measures that examine the impact of marital relationships on the dying process (McLean & Jones, 2007).

Being married is associated with lower mortality from a wide range of illnesses, including cancer; however, the quality of marital interactions and relationships is a stronger predictor of health outcomes than marital status (Halkoff, Scott, & Smythe, 2000; Ren, 1997; Schmaling & Goldman Sher, 2000). Mutual support experienced by partners predicts well-being for patients and partners (Halkoff et al.). Demonstrations of partners’ support are most critical during times of stress when people feel vulnerable (Cutrona et al., 2005; Hininen et al., 2007; Manne, Sherman, et al., 2004); in a study of patients with breast cancer, those with higher marital satisfaction had lower hopelessness and fewer adjustment issues (Northouse, Templin, & Mood, 2001).

Northouse, Templin, Mood, & Oberst (1998) conducted a longitudinal study of women who underwent breast biopsy and their partners. The groups were formed based on women with diagnoses of benign versus malignant masses. Both groups reported high levels of marital satisfaction and family functioning at diagnosis, but the malignant group had more negative moods and poorer quality of marital relationships over time. The poorer marital quality was attributed to increased illness-related demands experienced by patients with breast cancer and their husbands. However, couples in the malignant group with high scores on marital satisfaction at the beginning of the study maintained the scores at each assessment.

**Communication**

Although couples’ communication about cancer-related issues and concerns plays a valuable role in both partners’ adaptation to the disease, communication has received little empirical attention (Manne et al., 2006). Northouse and Peter-Golden (1995) identified three universal concerns of partners of patients with cancer: dealing with fear and threats associated with a cancer diagnosis, helping their partners cope with the emotional consequences of cancer, and managing adjustments in daily life caused by the disease. Partners often feel lost and confused about how to respond to each other’s distress (Pistrang & Barker, 2005). Hilton (1994) found two basic communication patterns for emotional issues in patients with early-stage breast cancer: couples who believed that talking was important talked openly, whereas couples who did not had increased difficulty with communication.

Manne et al. (2006) adapted the communication patterns questionnaire to be cancer-specific. The questionnaire consisted of three subscales that classified communication strategies: constructive communication, mutual avoidance communication, and demand-withdrawal communication. Constructive communication was associated with higher relationship satisfaction and lower distress for patients and partners; mutual avoidance communication was associated with greater distress for patients and partners, although marital relationship satisfaction remained high. Demand-withdrawal communication, which is considered maladaptive and occurs when one partner pressures the other to talk about issues, was consistent with higher distress and lower marital satisfaction for patients and partners. In addition, Kornblith et al. (2006) found that the greatest issues with adjustment occurred when one partner in a couple wanted to talk about cancer and the other did not. Preexisting spousal communication issues did not disappear when facing a life-threatening illness and may have been exacerbated by the crisis (Hawes et al., 2006) (see Table 2).

Partners often are the communication conduit between patients and health professionals during diagnosis and treatment (Harden et al., 2002). In a study of issues of sexual function and psychological distress in patients with prostate cancer and their partners, partners had higher levels of psychological distress than patients (Soloway, Soloway, Kim, & Kava, 2005). The wives did not address sexual issues because they believed they were decreasing their husbands’ anxiety about prostate cancer by not openly communicating their distress; the wives’ reticence demonstrates protective buffering. Researchers and clinicians should advise couples to communicate during diagnosis, treatment, and the recovery process to improve outcomes (Bultz et al., 2000; Maliski et al., 2002; Soloway et al.).

### Table 2. Communication Strategies

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>DEFINITION</th>
<th>RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constructive</td>
<td>Both partners discuss issues, express feelings, understand each other, and feel that issues are resolved.</td>
<td>Best outcomes, least distress, highest marital satisfaction</td>
</tr>
<tr>
<td>Mutual avoidance</td>
<td>Both partners avoid discussing issues.</td>
<td>Greater distress for patient and partner; marital satisfaction remains high.</td>
</tr>
<tr>
<td>Demand withdrawal</td>
<td>One partner wants to discuss and pushes the other partner, who then withdraws.</td>
<td>Considered maladaptive; highest distress for patient and partner; lowest marital satisfaction</td>
</tr>
</tbody>
</table>

*Note. Based on information from Manne et al., 2006.*
Treatment-related side effects that impact the physical and mental well-being of patients with prostate cancer include fatigue, incontinence, and sexual dysfunction (Hawes et al., 2006; Knoll, Burkert, Rosemeier, Roigas, & Gralla, 2007). Treatment side effects can lead patients to rely more heavily on their partners, which can challenge caregivers’ abilities to adapt to the unpredictable and complex illness experience (Hawes et al.). Erectile dysfunction, the most common long-term side effect of prostate cancer treatment, can have implications for the marital relationship (Soloway et al., 2005); erectile dysfunction can lead to emotional distancing and protective behaviors by both partners when attempting to protect each others’ dignity. Soloway et al. reported that spouses rated patients lower in sexual performance and ability to gain erections than patients rated themselves. However, despite difficulties with erectile dysfunction identified in the study, couples were able to adjust to the sexual function outcomes of treatment if they continued to communicate during diagnosis, treatment, and recovery on critical sexual issues. The differences in perceptions between partners have implications for healthcare providers trying to resolve treatment-related issues. By emphasizing the importance of communication between patients and spouses and including partners in healthcare visits, better medical treatment decisions can be made (Soloway et al.).

Bultz et al. (2000) examined a randomized, controlled trial of a psychoeducational support group for partners of patients with stage I and II breast cancer held once a week for six weeks. The men discussed coping strategies, challenges, feelings about their anxieties and fears, communication with partners about cancer and sexuality, how to provide emotional support, body image issues, genetic risks for daughters, and the dying process. In addition, the men were able to ask the physician questions they had not previously asked or had been afraid to ask in the presence of their partners. A deterioration in marital satisfaction and level of support existed in the control group, whereas the intervention group remained stable; therefore, the authors concluded that the partners in the intervention group may have managed some of the cancer stress-related challenges more effectively with open communication.

Functional Impairment

Cancer often is accompanied by multiple issues, including pain. Physical deterioration caused by cancer progression frequently leads to social restrictions for patients and their partners as well as higher distress than patients who are newly diagnosed or in first remission (Manne, Alfieri, Taylor, & Dougherty, 1999; Morse & Fife, 1998). Manne et al. (2005) found that a couple-focused intervention was beneficial to women with breast cancer who considered their partners unsupportive at baseline. The intervention focused on constructive and unconstructive communication and expression of support needs. Women with high physical impairment and active partner-engagement interactions or mutual constructive communication had higher relationship satisfaction, despite the additional physical burden.

Women reported additional negative feelings when partner behavior was rated as overprotective (Hagedoorn et al., 2000). Patients with greater physical impairment in relationships with high satisfaction continued to have lower distress, which was attributed to communication. Manne et al. (2005) proposed that physical impairment possibly resulted in greater sensitivity to the reactions of others or increased the quality of communication between partners. However, increased caregiving demands may be perceived as burdensome for patients and partners with poorer quality relationships (Kim & Carver, 2007).

In a study of 111 men and 108 women with advanced-stage breast and gastrointestinal cancers, wives had higher levels of interference or restriction on their personal and social activities than husbands (Manne et al., 1999). For participants with high marital satisfaction, the quality of the marital relationship moderated the association between functional impairment, interference in spousal activities, and spousal negative mood; for participants with less satisfying relationships, interference was associated with spousal distress and patients’ perception of critical attitudes toward spouses.

Manne et al. (1997) examined positive and negative supportive behaviors in 158 married people with stage III or IV gastrointestinal or breast cancers and found that negative behaviors occurred less frequently for all participants. For women, an increase in supportive behaviors decreased the likelihood of perceptions of negativity, which were perceived as avoidance or withdrawal and correlated with lower well-being and higher distress; the relationship was not found for men. Negative responses or avoidance had close associations with psychological distress in patients with cancer and increased as functional impairment worsened; therefore, symptom burden should be considered for the couple as disease progresses.

Age, Stage of Disease, and Financial Relationships

The relationship between age and adjustment to cancer diagnosis remains unclear. Cancer may change the way partners communicate and can affect marital satisfaction and stability, with added stressors that include role adjustments and financial implications. Partner and patient dyadic studies have not shown definitive relationships among age, stage of disease, and adjustment to cancer diagnosis (Northouse et al., 2000, 2001). Most studies of couples have observed homogenous populations and have not considered those variables. Some researchers who assessed individual patients, not couples, found that older patients had compromised quality of life if they also had serious medical issues and physical impairments; younger patients had more financial hardships and role adaptations, particularly because of an illness-related loss of income (Mor, Allen, & Malin, 1994; Vinokur, Threet, Caplan, & Zimmerman, 1989). Schnoll, Harlow, Stolbach, and Brandt (1998) found that the relationships of age and stage of disease to patients’ psychological adjustment were mediated through styles of coping.

Wagner, Bigatti, and Stormiolo (2006) reported a study that compared quality of life for husbands of wives with breast cancer to husbands of healthy wives. Both the breast cancer husband group and the healthy wives group had similar age and education. Husbands of wives with breast cancer scored lower on general health, vitality, role-emotional, and mental health subscales of the
Post-Traumatic Growth

Post-traumatic growth, positive changes an individual may experience after a traumatic event, is common among adults with cancer, particularly younger patients ($X = 50.1$ years, $SD = 9.9$) (Manne, Ostroff, et al., 2004). Thornton and Perez (2006) found that men treated for prostate cancer ($X = 61.2$ years, $SD = 7.2$) and their partners ($X = 57.4$ years, $SD = 8.8$) reported modest levels of post-traumatic growth; Maliski et al. (2002) reported similar findings. The growth was accounted for by coping strategies that used information-seeking, positive reframing, and emotional support. Cognitive and emotional processes contributed to increases in patient psychological growth, and patients had more growth when their partners discussed their own feelings (Manne, Ostroff, et al.).

Gender

Associations between perceived spousal support and well-being differ across genders. Men's perceptions of supportive behaviors are not significantly associated with psychological distress; however, women's perceptions of support from their partners gave them a higher sense of well-being (Manne et al., 2006; Manne, Sherman, et al., 2004). Manne et al. (1997) examined gender and disease-related functional impairment and found that negative aspects of close relationships played a stronger role than positive aspects in psychological distress and well-being, regardless of gender.

Women in North American cultures focus more attention on relationships than men (Acitelli & Badr, 2005) and tend to be nurturers even when they are ill (Revenson et al., 2005). However, men are less likely to seek outside support and are more apt to rely on their spouses for support (Banthia et al., 2003; Knoll et al., 2007); therefore, women reported more distress and assumption of nurturing roles, regardless of whether they were the partner or the patient (Baidier, Koch, et al., 1998; Couper et al., 2006; Northouse et al., 2000; Soloway et al., 2005).

Husbands of women with cancer reported less distress than wives of men with cancer (Hagedoorn et al., 2000). Men are more reluctant to acknowledge threatening experiences and respond to distress with repression and distancing strategies (Lutsky & Knight, 1994). Denial has been recognized as a way husbands limit emotional exchanges with wives (Northouse & Peters-Golden, 1993). Baider and Bengel (2001) have questioned the meaning of findings that women have more distress than men and suggested the possibility of gender bias in that the results may be indicative of women's introspective and self-reflective nature, rather than emotional overreaction and instability.

Carlson et al. (2001) assessed the scores of patients with prostate and breast cancer on the Profile of Mood States, a distress measure completed by patients and then completed by spouses as if they were the patients. Men in the study were older and had been married much longer than the women. Wives showed more congruence with their husbands' answers than men did with their wives' breast cancer experience. Wives understood what their husbands were experiencing, whereas men were not as perceptive. The authors attributed the differences in perception to gender, but also suggested that the length of time the couples were together may have increased the wives' accuracy.

Implications for Clinical Practice

Patients with cancer identify emotional support as the most helpful type of support from their partners (Kayser, 2005); however, emotional support is among the most difficult tasks of the cancer experience for partners (Northouse & Peter-Golden, 1993). Health professionals can encourage and confirm emotional support as an aspect of coping with cancer, recognizing that the spouse also needs emotional support. Patients and spouses should be encouraged to discuss their feelings and accept help from family and friends. Assessment of partners' sense of coherence or togetherness can be a focus for nursing interventions (see Table 3).

Nurses should be aware that patients who use denial, ventilation, restraint, and behavioral disengagement or avoidance have poorer psychological adjustment (Ben-Zur et al., 2001). Northouse et al. (1998) found that patients with high distress and role issues at disease presentation continued to have high distress one year later. Early identification of spouses with dysfunctional problem-solving styles and communication issues may allow nurses to make referrals to social service or mental health specialists for support (Morse & Fife, 1998). Joint clinic visits or inpatient team conferences that include patients and partners may enhance communication. Clinicians should try to intervene early to improve outcomes for patients and partners (Ko et al., 2005; Hinmen et al., 2007).

Manne, Ostroff, et al. (2004) recommended that partners of patients with cancer can benefit from focusing on positive reappraisal and emphasized the importance of not suppressing
or avoiding intrusive thoughts. Intrusive thoughts (unpleasant remembrances, such as being diagnosed with cancer) may encourage growth, particularly in younger patients (Manne, Ostrom, et al., 2004). Ben-Zur et al. (2001) found that patients who use positive reinterpretation, planning, and humor demonstrated better adjustment. Nurses’ use and support of positive reframing and humor can encourage patients and their partners.

Research suggests that patients with higher levels of education may better understand their situation and use information more efficiently (Maliski et al., 2002). Informational support is identified as most helpful by health professionals (Kayser, 2005). Patients and partners should be instructed about the typical course of cancer, what symptoms to expect, and current treatments, including available clinical trials (Northouse & Peter-Golden, 1993). Davison, Goldenberg, Gleave, and Degner (2003) showed that individualized information with computer-generated software for patients and their partners at the time of diagnosis lowered couples’ levels of psychological distress. In addition, patients and partners who used computer software could participate more actively in medical decisions. Nurses can give couples written brochures and materials as well as Web sites that are specific to patients’ cancer diagnoses and treatments (see Figure 2).

Nurses should assess patients and partners individually and be aware that women may be more receptive to communicating distress. Patients who use emotion-focused coping and have lower levels of education may feel more vulnerable and need additional instructions. Those patients have poorer adjustment to their illness (Ben-Zur et al., 2001) and, therefore, may be more difficult for nurses to manage because their distress can increase emotional neediness and decrease energy to fight their disease.

Disruptions of daily life, including role changes, household schedules, child care plans, and domestic and social restrictions caused by the illness impact patients and their partners (Northouse & Peter-Golden, 1993). Encouraging patients and partners to elicit support from other family members and providing relevant information at critical moments may help

**Table 3. Patient-Partner Behaviors and Nursing Interventions**

<table>
<thead>
<tr>
<th>BEHAVIOR</th>
<th>NURSING ASSESSMENTS AND INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of information</td>
<td>Patients who use emotional coping may exhibit greater distress and require repetition and patience. Provide written educational materials and Web sites to patients and partners and review with them (Davison et al., 2003; Maliski et al., 2002).</td>
</tr>
<tr>
<td>Negative or lack of support</td>
<td>Questions for nurse to consider</td>
</tr>
<tr>
<td></td>
<td>Does the patient feel rejected or abandoned?</td>
</tr>
<tr>
<td></td>
<td>Is mutual-avoidance communication occurring?</td>
</tr>
<tr>
<td></td>
<td>Is demand-withdrawal communication occurring?</td>
</tr>
<tr>
<td></td>
<td>Do the patient and partner exhibit emotion-focused coping (e.g., ventilation, avoidance)?</td>
</tr>
<tr>
<td></td>
<td><strong>Suggested questions for patient and partner</strong></td>
</tr>
<tr>
<td></td>
<td>Do you have any concerns as a partner that I may be able to help you with?</td>
</tr>
<tr>
<td></td>
<td>How are you both managing the changes the disease has caused to your life?</td>
</tr>
<tr>
<td></td>
<td><strong>Actions or interventions</strong></td>
</tr>
<tr>
<td></td>
<td>Encourage the patient and partner to share their concerns and feelings.</td>
</tr>
<tr>
<td></td>
<td>Encourage the patient and partner to accept help from family and friends (Ezer et al., 2006; Maliski et al., 2002).</td>
</tr>
<tr>
<td></td>
<td>Arrange for the patient and partner to attend clinic visitations or discharge planning (if inpatient).</td>
</tr>
<tr>
<td>Protective buffering</td>
<td>Assess whether the partner or patient is attempting to buffer and whether the buffer is appropriate or if both would benefit from open communication.</td>
</tr>
<tr>
<td></td>
<td>Address the patient and partner’s concerns privately, then together if appropriate. Partners may be afraid to discuss issues when the other is present.</td>
</tr>
<tr>
<td></td>
<td>Consider social services or psychological counseling to provide support (Morse &amp; Fife, 1998).</td>
</tr>
<tr>
<td></td>
<td>Be aware that protective buffering can increase stress for individual partners who may benefit from open communication (Bodenmann, 2005).</td>
</tr>
<tr>
<td>Positive support</td>
<td>Consider whether the patient and partner use constructive communication, problem-solving coping strategies, active engagement, or protective buffering or explore thoughts, emotions, and experiences.</td>
</tr>
<tr>
<td></td>
<td>Initiate the conversation with “Partners who explore their thoughts and feelings often have less distress. Have you been able to do this as a couple?”</td>
</tr>
<tr>
<td>Active engagement</td>
<td>Encourage continued efforts and ensure that the patterns have shown maximal benefit with least distress (Manne et al., 2006).</td>
</tr>
<tr>
<td></td>
<td>Encourage couples to accept help from family and friends.</td>
</tr>
<tr>
<td></td>
<td>Model the use of humor when appropriate (Ben-Zur et al., 2001).</td>
</tr>
<tr>
<td></td>
<td>Listen as couples find meaning in the disease experience.</td>
</tr>
</tbody>
</table>

**Figure 2. Internet Resources for Couples**

- American Society of Clinical Oncologists: [www.cancer.net](http://www.cancer.net)
- Livestrong: [www.livestrong.org](http://www.livestrong.org)
- National Cancer Institute: [www.cancer.gov](http://www.cancer.gov)
them feel that the situation is manageable (Ezer et al., 2006; Maliski et al., 2002).

Conclusions

For quick screening in clinical practice, healthcare providers should ask patients and partners to rate their degrees of happiness within their relationship. Patients in low-quality marital relationships may have even greater distress and negative impacts on quality of life because of their partners’ influences. Nurses and healthcare professionals should teach patients and partners skills to manage the illness, treatments, and symptoms; encourage positive coping strategies and communication; and help them find meaning in their experience. Future studies should include dyadic relationships in particular when examining concepts pertinent to patients with cancer, such as love, uncertainty, meaning of life, body image, and changing role status. By considering both partners as their patient team, nurses can make a positive impact on patients and their partners at one of the most difficult times in their lives, thus improving outcomes.

Author Contact: Mary Ann Morgan, PhD, ARNP-BC, can be reached at mary.morgan@moffitt.org, with copy to editor at CJONEditor@ons.org.

References


