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Commentary

# Communal Coping with Heart Failure: Commentary on Marital Quality and Patient Survival

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## Abstract

Earlier *Am J Cardiol* papers reported that a composite measure of marital quality predicted heart failure (HF) survival over follow-up intervals of 3 and 8 years after adjusting for baseline illness severity (NYHA class). The strongest single predictor in the composite was reported frequency of the couple's useful discussions about the patient's HF, a finding reminiscent of *communal coping*, wherein partners come to construe a stressful health problem as "ours," rather than "yours" or "mine," and take collaborative actions to deal with it. Additional studies of partners' first-person plural pronoun use (*we*-talk) have bolstered the communal coping evidence base and prompted interest in helping patients and their partners achieve the health benefits communal coping appears to confer. In this commentary I note that routine clinical interactions can either reinforce an individualistic framing ("your disease, your responsibility") or foster communal coping by inviting shared appraisal and joint problem-solving. Specifically, simple shifts in clinical language (e.g., addressing both partners, externalizing the illness, asking how couples manage heart failure together) can help construct a sense of *we*-ness that reduces conflict, supports collaboration, and offers a plausible pathway linking relationship processes to survival. Communal coping thus offers a mechanism, a clinical target, and a practical bridge between cardiology and relational science that does not require asking physicians to become therapists.

## Commentary

Several decades ago, my colleagues and I undertook what turned out to be an important study of psychosocial contributions to the course of congestive heart failure [1,2]. After a comprehensive baseline assessment of 189 Michigan couples in which one partner (139 men, 50 women) had heart failure (HF), we examined the patient's all-cause mortality via survival analyses over follow-up intervals of 3 years [1] and 8 years [2]. In addition to LVEF and physician ratings of NYHA class, the baseline assessment included a range of established cardiac risk and protective factors such as psychological distress, hostility, neuroticism, self-efficacy, optimism, and breadth of perceived emotional support supplemented by interview and observational measures of marital quality involving both partners. Strikingly, a composite couple-level measure of marital quality strongly predicted patient survival at both follow-up intervals after adjusting for baseline illness severity (NYHA class). In fact, statistical effect sizes for marital quality and illness severity were roughly comparable, implying that a strong couple relationship might even compensate for a weak heart. We concluded that relationship factors may be especially relevant to managing a difficult chronic condition such as HF, which makes stringent and complex demands on patients and their families. Based on subsequent research and clinical observation this commentary proposes that these findings can be usefully understood through the lens of *communal coping* – a dyadic process through which couples construe HF as a shared problem and coordinate their responses accordingly [3,4].

Other notable findings from the Michigan project concern sex differences in the marital quality-to-survival association (favoring women) and a relatively poor showing of individual (patient-level) variables as predictors. The moderating role of gender is consistent with growing evidence that relationship quality is more important to the health of women than of men [5,6]. At the individual level, while statistical effects of psychological distress and other cardiac risk factors were unremarkable, confidence ratings of the patient's efficacy to manage HF by both the patient and spouse *did* predict survival, yet only the spouse's confidence remained significant when both were included in the same Cox regression model [7]. Moreover, including the broader marital quality composite eliminated the spouse confidence effect. In the risk factor framework articulated by Kraemer *et al.,* [8] the spouse confidence ratings thus appeared to function as a *proxy* for the broader protective factor of marital quality.

Importantly, the composite measure of marital quality in the Michigan study involved four intercorrelated components, some of which predicted patient survival better than others. The strongest predictor was reported frequency of the couple's *useful discussions* about the patient's HF. (Observer ratings of positive vs. negative affect during a videotaped marital interaction also predicted patient survival but self-reports of marital satisfaction and couple routines did not.) In any case, the useful discussion finding is reminiscent of what Lyons *et al*. [3] had earlier called "communal coping," which occurs when partners view a stressful health problem as "ours," rather than "yours" or "mine," and take collaborative actions to deal with it. Communal coping thus involves (a) shared appraisal of illness as "our problem" and (b) coordinated emotional, behavioral, and meaning-making responses organized at the level of the couple rather than the individual. Although related to the broader construct of relationship quality, communal coping is more specific and instrumental with respect to a particular health problem or stressful situation [9].

To examine communal coping more specifically we conducted a follow-up study with another sample of HF couples in Arizona, incorporating an unobtrusive measure of the construct based on partners' use of first-person plural pronouns (*we, us, our*) when they discussed coping with the patient's illness [10]. Here analysis of raw pronoun counts and *we/I* ratios from both partners revealed that the prevalence of *we*-talk predicted improvements in the patient's symptoms and general health over the next 6 months. *We*-talk prediction coefficients in these analyses were higher for spouses than patients and higher than those for direct self-reports of communal coping and marital quality.

Although prior studies had linked *we*-talk to relationship quality in romantic couples [11–13], ours was among the first to document prognostic implications for couples coping with a chronic illness like HF. Additional investigations employing diverse measurement methods with different chronic illnesses have since bolstered the evidence base regarding adaptive consequences of communal coping [14]. Work by Helgeson and colleagues featuring *we*-talk, self-report, and observational measures in a large sample of couples coping with diabetes is perhaps most exemplary in this regard [9,15].

HF differs from diabetes and other chronic illnesses in ways that make communal coping especially consequential. For example, ambiguous symptoms like dyspnea, fatigue, and edema require interpretation, monitoring, and decisions about when to escalate care. These are often implicitly dyadic tasks, even when clinicians address only the patient. When couples *fail* to communalize appraisal, one partner may catastrophize while the other minimizes, or monitoring may become controlling rather than collaborative. In addition, HF can involve role renegotiation and identity threat, as it commonly forces early retirement, sexual and activity limitations, and caregiver–patient role asymmetries. Without a shared narrative, couples may slide into overprotection, resentment, or moralized nonadherence ("If you cared, you'd follow the diet"). Communal coping, on the other hand, reframes these disruptions as joint adaptations, not personal failures.

As noted above, communal coping with HF is not simply high-quality spousal support or good marital adjustment; it requires shared appraisal and teamwork in response to a specific problem or illness. This distinction matters in HF because the condition is chronic, unpredictable, behaviorally demanding (regarding diet, medication, symptom monitoring, etc.), and existentially threatening — all of which amplify dyadic interdependence. While our *Am J Cardiol* findings show that marital quality predicts survival, communal coping offers a mechanism explaining *how* relationship processes may "get under the skin." This could entail micro-processes such as improved symptom interpretation, coordinated self-care, reduced conflict around adherence, or more timely help-seeking.

But what do such findings imply about how cardiologists and other health professionals can improve management of a chronic condition like heart failure? How can clinicians actively promote *we*-ness and relational teamwork to help patients and their partners achieve the health benefits communal coping appears to confer? Not surprisingly, most of the limited intervention work in this area has involved direct attempts to teach couples better coping and communication skills—and some of these approaches clearly hold promise [16–18]. My own approach, however, has evolved in a decidedly different direction: Rather than proposing a new couples intervention for HF, I draw here on a line of consultation work illustrating how clinicians can foster communal coping indirectly, even in brief encounters. In a series of team-based "family consultation" (FAMCON) intervention projects I undertook with Israeli psychologist Varda Shoham and others, we focused on couples coping with a variety of chronic health problems including alcoholism, smoking despite heart or lung disease, neuropsychiatric disorders, and complications from diabetes [19–22]. Many of the consultation interventions in these projects aimed to construct *we*-ness (communal coping) indirectly, just by asking questions, with no direct suggestions or instruction about how patients, partners, or couples should change. The aim was simply to promote active reflection and a sense of partner agency that direct advice and instruction can easily (albeit inadvertently) undermine.

In manualizing consultation interventions related to communal coping we typically formulated modules that a clinician familiar with couples and a particular chronic illness could administer in stand-alone format or as part of a larger FAMCON intervention package [4]. For example, modules such as "Identifying coping challenges," "Illness as an external invader," "Overcoming past adversity," and "Obstacles to teamwork" each included general guidelines and rationale along with specific questions and follow-up questions for the interviewer to use with the patient and partner. More recently, to make these indirect interventions more tangible, I combined 8 such modules into a single "interventive communal coping interview," using diabetes as an index chronic illness, and described the modules in manual-like detail [4]. As this 2021 paper explains, our approach aligns with the narrative or social-constructivist tradition in family systems work identified with pioneers such as de Shazer [23], Tomm [24], White and Epston [25], and Sluzki [26], which assumes that problematic health behaviors, like the couple and family interactions that sustain them, persist in relation to the meanings and understandings people attribute to what they do. An interviewer's questions contribute to a developing conversation that opens and amplifies alternative pathways and communal resources for dealing with the illness.

A narrative framework fits nicely here because communal coping is not just a cognitive stance – it is constructed through language, interaction, and repeated clinical encounters. For example, clinicians (physicians, nurses, behavioral health providers) can subtly shape communal coping by selective pronoun use ("How are *you both* managing the symptoms?" "What have *you two* noticed when his breathing worsens?"); by externalizing HF as "the thing you're up against together," rather than a flaw in the patient; and by inviting joint authorship ("When this condition pushes back, how do the two of you usually respond?"). In other words, meaning is co-constructed, coping follows meaning, and even routine clinical interactions already shape communal coping, whether intentionally or not. This means that clinicians are already intervening – whether they realize it or not. Even brief shifts can promote shared illness meaning, reduce conflict around adherence, and potentially affect morbidity and mortality. This perspective positions communal coping squarely within medical care – not as a psychotherapeutic add-on.

Rather than attempting to adapt the full modular diabetes intervention I describe elsewhere [4] to HF, a more manageable, clinic-friendly approach could entail embedding *micro-interventions* that nudge couples toward shared appraisal and collaborative action in routine care. Some additional dyad-oriented nudge questions are:

1. *"When heart failure flares up, how do the two of you usually make sense of what's happening?"* This may help surface discrepancies in symptom interpretation, legitimize joint meaning making, and reduce patient-only blame for nonadherence.
2. *"What parts of managing this condition feel like a team effort, and what parts feel harder to coordinate?"* This may help identify over- vs. under-control, normalize strain without pathologizing the relationship, and open space for negotiation of roles.
3. *"If heart failure throws you a curveball in the next few months, how would you want to handle that together?"* This may help encourage anticipatory communal coping, frame uncertainty as a shared challenge, and reinforce agency at the dyadic level.

Such questions align with symptom monitoring, medication management, and advance care planning. They are not intended to resolve entrenched relationship conflict, but to scaffold shared appraisal and collaboration around illness-related tasks. Crucially, they do not lengthen visits, do not require mental health training, and do not medicalize the couple's relationship. They simply redirect the clinical gaze from individual adherence to dyadic regulation.

All of this said, it is important to account for *maladaptive* communal coping as well, which can reflect relational patterns such as overinvolvement/overcontrol (when the illness becomes *too* shared, eroding patient autonomy); asymmetric *we*-ness (when one partner says "we" the other experiences surveillance or coercion); or protective buffering (when partners withhold fears or symptoms to "protect" the other, undermining shared appraisal). HF clinicians may sometimes enable such patterns inadvertently – for example, by speaking only to the spouse when the patient is fatigued or praising "good caregiving" without checking how it is experienced. They may also detect maladaptive coping when partners answer questions for one another, disagree sharply about symptoms, or use moralized language around adherence.

Another issue is whether the appropriate conceptual unit for understanding and promoting communal coping should be individual or dyadic. Despite the dyadic (couple-level) emphasis, the active ingredients of communal coping appear to operate at least partly at an individual level. For example, several studies indicate that spouse *we*-talk predicts patient health outcomes better than the patient's own *we*-talk, and individual communal coping measures often do not correlate highly across partners [9,10]. Interestingly, the shared appraisal component of the construct is inherently individualistic while the collaboration component, by definition, requires joint action by two people. This leaves open the possibility that unilateral intervention targeting shared appraisal by only one partner could have positive therapeutic effects.

In conclusion, research on couples coping with chronic illness suggests that outcomes depend not only on individual adherence or spousal support, but on whether the illness is construed as a shared problem requiring coordinated action. In heart failure – an unpredictable, behaviorally demanding condition – patients and partners must continually interpret symptoms, negotiate roles, and respond to uncertainty. Routine clinical interactions can either reinforce an individualistic framing ("your disease, your responsibility") or foster communal coping by inviting shared appraisal and joint problem-solving. Simple shifts in clinical language – addressing both partners, externalizing the illness, and asking how couples manage heart failure together – can help construct a sense of "we-ness" that reduces conflict, supports collaboration, and offers a plausible pathway linking relationship processes to survival. Communal coping thus offers a mechanism, a clinical target, and a practical bridge between cardiology and relational science – without asking physicians to become therapists.

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Varda Shoham, who contributed enormously to this work, died in March 2014 following a spirited trial of communal coping with lung cancer.

## References

1. Coyne JC, Rohrbaugh MJ, Shoham V, Sonnega JS, Nicklas JM, Cranford JA. Prognostic importance of marital quality for survival of congestive heart failure. Am J Cardiol. 2001 Sep 1;88(5):526–9.
2. Rohrbaugh MJ, Shoham V, Coyne JC. Effect of marital quality on eight-year survival of patients with heart failure. Am J Cardiol. 2006 Oct 15;98(8):1069–72.
3. Lyons RF, Mickelson KD, Sullivan MJ, Coyne JC. Coping as a communal process. J Pers Soc Relationships. 1998 Oct;15(5):579–605.
4. Rohrbaugh MJ. Constructing We-ness: A Communal Coping Intervention for Couples Facing Chronic Illness. Fam Process. 2021 Mar;60(1):17–31.
5. Hibbard JH, Pope CR. The quality of social roles as predictors of morbidity and mortality. Soc Sci Med. 1993 Feb;36(3):217–25.
6. Kiecolt-Glaser JK, Newton TL. Marriage and health: his and hers. Psychol Bull. 2001 Jul;127(4):472–503.
7. Rohrbaugh MJ, Shoham V, Coyne JC, Cranford JA, Sonnega JS, Nicklas JM. Beyond the "self" in self-efficacy: Spouse confidence predicts patient survival following heart failure. J Fam Psychol. 2004 Mar;18(1):184–93.
8. Kraemer HC, Stice E, Kazdin A, Offord D, Kupfer D. How do risk factors work together? Mediators, moderators, and independent, overlapping, and proxy risk factors. Am J Psychiatry. 2001 Jun;158(6):848–56.
9. Helgeson VS, Jakubiak BK, Van Vleet M, Zajdel M. Communal Coping and Adjustment to Chronic Illness: Theory Update and Evidence. Pers Soc Psychol Rev. 2018 May;22(2):170–95.
10. Rohrbaugh MJ, Mehl MR, Shoham V, Reilly ES, Ewy GA. Prognostic significance of spouse we talk in couples coping with heart failure. J Consult Clin Psychol. 2008 Oct;76(5):781–9.
11. Agnew CR, Van Lange PA, Rusbult CE, Langston CA. Cognitive interdependence: Commitment and the mental representation of close relationships. J Pers Soc Psychol. 1998;74:939–54.
12. Simmons RA, Gordon PC, Chambless DL. Pronouns in marital interaction. Psychol Sci. 2005 Dec;16(12):932–6.
13. Karan A, Rosenthal R, Robbins ML. Meta-analytic evidence that we-talk predicts relationship and personal functioning in romantic couples. J Pers Soc Rel. 2019 Sep;36(9):2624–51.
14. Rohrbaugh MJ, Shoham V, Skoyen JA, Jensen M, Mehl MR. We-talk, communal coping, and cessation success in a couple-focused intervention for health-compromised smokers. Fam Process. 2012 Mar;51(1):107–21.
15. Zajdel M, Helgeson VS. Communal coping: A multi-method approach with links to relationships and health. J Pers Soc Relations. 2020 May;37(5):1700–21.
16. Zajdel M, Helgeson VS. A Communal Coping Intervention for Couples Managing Chronic Illness: Proof-of-Concept Study. Couple Family Psychol. 2024 Sep;13(3):188–201.
17. Scott JL, Halford WK, Ward BG. United we stand? The effects of a couple-coping intervention on adjustment to early stage breast or gynecological cancer. J Consult Clin Psychol. 2004 Dec;72(6):1122–35.
18. Bodenmann G, Shantinath SD. The Couples Coping Enhancement Training (CCET): A new approach to prevention of marital distress based upon stress and coping. Fam Relations. 2004 Oct;53(5):477–84.
19. Rohrbaugh MJ, Shoham V. Family consultation for change-resistant health and behavior problems: A systemic-strategic approach. In: Consoli AJ, Beutler LE, Bongar B, editors. Comprehensive textbook of psychotherapy. 2nd ed. New York: Oxford University Press; 2017. p. 170–87.

20. Rentscher KE, Soriano EC, Rohrbaugh MJ, Shoham V, Mehl MR. Partner Pronoun Use, Communal Coping, and Abstinence during Couple-Focused Intervention for Problematic Alcohol Use. Fam Process. 2017 Jun;56(2):348–63.
21. Shoham V, Rohrbaugh MJ, Trost SE, Muramoto M. A family consultation intervention for health-compromised smokers. J Subst Abuse Treat. 2006 Dec;31(4):395–402.
22. Rohrbaugh MJ, Shoham V, Spungen C, Steinglass P. Family systems therapy in practice: A systemic couples therapy for problem drinking. In: Bongar B, Beutler LE, editors. Comprehensive textbook of psychotherapy: Theory and practice. New York: Oxford University Press; 1995. p. 228–53.
23. de Shazer S. Keys to solution in brief therapy. New York: W.W. Norton & Company; 1985.
24. Tomm K. Interventive interviewing: Part II. Reflexive questioning as a means to enable self-healing. Fam Process. 1987 Jun;26(2):167–83.
25. White M, Epston D. Narrative means to therapeutic ends. New York: W.W. Norton & Company; 1990.
26. Sluzki CE. Transformations: a blueprint for narrative changes in therapy. Fam Process. 1992 Sep;31(3):217–30.