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HEART BEATS: A DYADIC RESEARCH ON PATIENTS WITH HEART DISEASE AND THEIR PARTNERS

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Here is my secret.

It is very simple:

It is only with the heart that one can see rightly;

what is essential is invisible to the eye.

The Little Prince, Antoine de Saint Exupéry

Abstract

This research has a dyadic approach involving both patients with cardiovascular disease and their partner during the hospitalization. After a review of the literature on the complexity of self-management in the cardiovascular patients and partner support, as well as dyadic coping, i.e. the ability of partners to deal with stressful events together as a team, the research aims to investigate the role of dyadic coping on different fronts when the patient and his/her partner are facing heart disease. Specifically, the first study investigates the effect of dyadic coping on partners' marital satisfaction. It is also intended to consider whether the effect is moderated by the level of psychological distress of the partners, in terms of anxiety and depression. The results show that the beneficial effect of positive and common dyadic coping on marital satisfaction occurs when the psychological distress of partners is low, on the contrary negative dyadic coping decreases marital satisfaction among those who have high levels of psychological distress. The second study aims to investigate the relationship between dyadic coping, adherence to medications and patient activation, i.e. the patient's ability to play an active role in the care. The relationship between the constructs is mediated by the patient health self-efficacy, in particular: A positive and common dyadic coping increase patient health self-efficacy which in turn increases adherence to medication and patient activation; on the contrary, a negative dyadic coping decreases the patient's self-efficacy. The deleterious action of negative dyadic coping also occurs over time, because it is related, through the mediation role played by patient health self-efficacy, to lower patient activation after six months from hospital discharge. The third study investigates the relationship between psychological distress and the quality of partner support (overprotection, hostility and support to patient engagement) and the moderating role of dyadic coping in this relationship. The results show that high psychological distress increases worse partner support (high overprotective support, high hostile support and low patient engagement support) among those with low levels of positive dyadic coping and high negative dyadic coping. These three reports present new contributions in the panorama of studies on cardiovascular disease, either for the methodological approach, taking into account the interdependence between the partners, either for the new concept of dyadic coping, as well as for the deepening of the role of the partner as caregiver in the couple, of which are studied not only in terms of consequences of his/her actions on the patient's management outcomes, already widely investigated in the literature, but also focusing on the factors that promote an effective caregiving. All these findings demonstrated empirically that positive and common dyadic coping are virtuous relational processes for both patients and partners during the adjustment to cardiac illness, for both individual and relational outcomes related; conversely negative dyadic coping is dangerous, because

has negative impacts for patient and partner. Not many studies are executed in the field of cardio-psychology and even less so apply a dyadic approach when investigating patients' self-management and psychological outcomes. In that respect, the current project sheds novel light on possible processes happening among couples facing a major medical life event. Furthermore, these results imply a need for couple psychosocial interventions in cardiac illness. In fact, first of all, couples may benefit from increased awareness about their dyadic coping skills, given the strong association with relationship satisfaction and health outcomes. Secondly, training dyadic coping skills could be important especially for couples lacking relational competences.

Keywords: Cardiovascular Disease; Dyadic Coping; Marital Satisfaction; Psychological Distress; Adherence to Medications; Patient Activation; Partner Support.

Introduction

An illness presents itself as a sudden and unchosen event that can gravely influence personal and relational life by transforming the organism and even the identity. Each disease, severe or mild, chronic or acute, disrupts the balance by marking time with a "before" and "after", altering our mental life and our private and public relationships. An illness does not only entail limitations and resignations, but it also allows for new perspectives to be considered. In fact, etymologically, the word "diagnosis" means to "know through": it is not a process descended from above and carried out by the person making the diagnosis, but instead a decisive moment for the knowledge of oneself as well as one's relationships. Since it is a crucial transition for the person that has been impacted, but also for the family members surrounding them, the illness, embracing Scabini and Cigoli's Relational Symbolic Model (2012), which will guide the discussion of this text, presents itself as an *"acme"* event. In other words, it is an epiphanic moment that reveals relational and family dynamics.

The mechanistic conceptual model of medicine, the so-called mechanical paradigm of the Seventeenth and Eighteenth century, is based on a divisive assumption rooted in the Cartesian dualism of mind-body and anatomy, which means "to cut" in Greek. This paradigm is responsible for the fact that the psychosocial aspects of the disease, among which the presence of a support system and relational and contextual resources surrounding the ill, are at times neglected. The linear biomedical logic that assumes the body is an engine and that describes health as "organ silence," and the spasmodic research on the cause which undoubtedly explains the effect, answer to Engel's (1980) biopsychosocial model in a clearly systemic outline. This model exceeds the simplified vision of *reductio ad unum* – the biological- (Bertini, 2012) and defines illness as a multifaceted entity, resulting from a complex interaction among evolutionary, individual, relational dynamics, genetically determined biological processes, and critical social experiences. This model approaches a direction of enhancing complexity through a holistic vision of the mind-body system, placing more importance on the psychosocial aspects, and leading to dialectic and integrated debate among professionals. It suggests that if an illness is observed in relation to multiple intrapersonal and interpersonal systems, there is an increased chance of at least treating, and possibly even healing. Even the World Health Organization (WHO) at the beginning of the 1950s assumed that: *"Health is a state of complete physical, mental and social well-being, and not merely the absence of disease."* From this definition, a lot of progress was made in studying the relational aspects involved in the treatment and healing process. Nonetheless, there seems to be a disconnect between the discoveries

in the scientific field and research leading to the enhancement of the relational context surrounding the ill, starting with the cherished presence of the caregiver, who is often the partner, and the clinical practice.

After more than half a century, "modern" medicine seems to have forgotten that patients live in a relational context and within families, with whom they have relationships and exchanges of affection. It further seems to have disregarded that within patients themselves there are not only organs that are more or less sick, but also emotions, feelings, fears, and hopes, that accompany and often influence the course (Cigoli, 2002). General medicine, which is more capable of assuming a holistic vision of the ill, disappears, and in its place the more specialized and hyper-specialised medicine advances: the body as a unit gives way to organs and parts, leaving patients to be reduced to specific symptoms. And if the patient is a non-whole, disjoined to be precise, the doctor is also a half-doctor, struggling to keep the pieces together, unable to synthesize and summarize, and who often has no time. By using a psychoanalytical metaphor, the doctor should be able to go from partial object, the sick organ, studied from anatomy manuals, to whole object, the person, encountered in a hospital ward and in medical research. Furthermore, there must be a transition from sickness, which is similar for all, to "the sick", the person, who is unique and different from all others. This complies with the "case by case" idiographic logic. In today's dystopic panorama, there is a need to put forward a new epistemology, by humanizing the treatment, in other words referring to a self-reflective, dialogic, and ecosystemic science capable of merging the different components of the individual human. If it seems unthinkable to synthesize these abilities in a single figure, that of the doctor, the answer lies with the ability of all the different professional figures involved, from the doctor, to the nurse, to the psychologist, to work in synergy enhancing the interdisciplinary. This should be done by way of attuning to the patient's emotions, to favour a clear and meaningful rebuilding process so that unspoken pain can become verbalized pain. In fact, if a lot of progress has been made in view of treating the illness *(cure)*, there is a long way to go to taking care of the ill tout-court *(care)*. This can be achieved by starting to imagine that illness represents a challenge for both the person inflicted and those who suffer alongside the sick, especially partners and family members. Indeed, the family members are the ones who take action in the face of an emergency, and some in particular, often the partner, who mediate the relationship between the doctor and the patient, so much so that Cigoli (2002) notes that it would be best to speak of a therapeutic triangle. It is the people who are closest to the patient that can empathize and require clinical attention, as their closeness to the patient can lead to even sharing symptoms.

The attention to the couple in times of sickness, which we hereby argue should not be an optional choice in so far as the partner is indeed a "part-ner," part of the whole, of the system,

reveals how the illness inserts itself as a third party in the family dynamics or "family body" to use a Cigoli's expression[1]. The systemic-relational trajectory, which we argue here, according to the Relational Symbolic Model (Scabini & Cigoli, 2012) and the Transactional Stress Model (Bodenmann, 1997) will certainly take the form of a challenge. This is due to the fact that it contemplates the complexity and looks at the couple's relationship not as a summation of individual psychic processes, but as a relationship *sui generis* with its own characteristics and functions, in line with the "overflow" produced within, that distinguishes it from any other type of small group.

This text chooses to pay particular attention to cardiovascular disease, and to the different ways in which the single patient, the partner, and the couple, act and interact with it.

After having introduced the subject in the first theoretical chapters, three studies will follow which will go into the specifics of the couple's dynamics when a partner falls ill.

[1] To read more about the "family body" clinic, Vittorio Cigoli wrote a trilogy: Cigoli, V. (1992). Il corpo familiare. L'anziano, la malattia, l'intreccio generazionale. Milano: Franco Angeli.; Cigoli V. (2006). L'albero della discendenza. Clinica dei corpi familiari. Milano: Franco Angeli.; Cigoli, V. (2012). Il viaggio iniziatico. Clinica dei corpi familiari. Milano: Franco Angeli.