

A systemic-transactional understanding of disorders

Interpersonal view on physical illnesses and mental disorders

Lorena Leuchtman, Guy Bodenmann

Institut für Klinische Psychologie, Universität Zürich, Schweiz

Summary

Physical illnesses and psychological disorders are typically viewed as individual phenomena, with causes for the diseases lying in the organism, either in medical conditions (severe infections, cancer, coronary heart problems, diabetes, arteriosclerosis, etc.) or in pathological mental processes within the person (dysfunctional information processing, deficient social skills, deficient emotion-regulation skills, etc.). In consequence, the treatment of physical and psychological disorders is commonly individual-centered, aiming to improve health conditions within the person affected by the disease. In this article a systemic-transactional understanding of disorders is presented, where both partners are viewed as suffering from the disease but also able to engage in joint coping efforts (“we-disease”). The notion of we-disease is explained and its implications for clinical work is outlined.

Key words: psychological disorders; physical illness; couple; dyadic coping; we-disease; systemic-transactional model (STM)



Physical illnesses and psychological disorders are typically viewed as phenomena primarily caused by sources lying in the individual, either in medical conditions (severe infections, cancer, coronary heart problems, diabetes, arteriosclerosis, etc.) or in pathological mental processes within the person (dysfunctional information processing, deficient social skills, deficient emotion-regulation skills, psychodynamic processes, etc.). Although the bio-psycho-social model of illnesses and mental disorders is commonly recognised, researchers and health professionals mostly target the biological and psychological components (both rooted in the individual). The social component, however, is less considered. Some researchers and clinicians accept its contribution to the aetiology of the condition of poor health (e.g., social stressors such as divorce, death of a significant other, chronic destructive relationship problems), and many believe in the usefulness of mobilising social support for accelerating the process of recovery. Apart from these two aspects, the social component of the bio-psycho-social model remains marginally considered. In consequence, the treatment of physical and psychological

disorders commonly focuses on the ill individual but neglects to take social factors into account (except for social support in some cases).

If physical health is at stake, medical interventions (medication, radiation therapy, surgery) are primarily applied, whereas in the case of psychological disorders, medication (psycho-pharmaceuticals) or psychosocial interventions (counselling, psychotherapy) are typically used. However, these treatment approaches are often not as effective as expected. Although many international studies indicate that psychotherapy is effective in treating psychological disorders, the relapse rate is high; in depression, for example, it varies between 30–50% after treatment [1]. Most likely, the reason for this high relapse rate is not the quality of treatment, but frequent stress conditions in general or more specific social stressors. Similarly, the Minnesota heart failure study showed that 48 months after a severe heart attack, 70% of the patients in happy relationships were still alive whereas only 45% in unhappy marriages survived [2].

The rather low level of attention paid to social factors in the treatment of physical and psychological disorders contrasts with the high relevance of close relationships for physical and mental disorders. Research on the concept of expressed emotion, an attitude towards the partner characterised by high criticism, hostility, and overprotection [3], indicates that a negative attitude of the partner triggers deleterious developments in various mental disorders [4]. Thus, the quality of close relationships seems to matter particularly and was repeatedly found to be one of the best predictors of a negative development of mental disorders and a higher likelihood for relapse ($d = 0.39-0.45$) [3]. Close relationships also play a central role in physical illnesses such as diabetes [5] and cancer [6]. For example, people suffering from cancer showed worse psychological adjustment after the medical treatment when they felt that they could not talk about their cancer-related thoughts and feelings with close others [7], when they did not feel supported by close others [8], and when they perceived their spouse as emotionally disconnected from them [6]. Given that psychological distress of cancer patients affects treatment adherence, the

length of hospital stay, and even mortality rate [9, 10], the quality of close relationships affects the course of cancer diseases.

The role of social factors

A mental or physical disorder in married patients or those living in a committed relationship is still often regarded as being rooted primarily in problems that are specific to the patient. This view is widespread and grounded in a biomedical model of disease, which stipulates that a physical or mental disorder is caused by an anatomical, physiological, or biochemical abnormality of the individual. Thus, the disorder is seen as the patient's problem, and the causes, symptoms, progression, and outcomes, as well as the treatment, are primarily related to the individual. The *bio-psycho-social model* of disease [11] adds a layer of analysis to this existing view by taking into account social factors that are believed to influence the patient at every stage of the disease. Here, the disease is viewed as a *multi-level process*, where genetic aspects, as well as biological, psychological, and social processes are involved in bidirectional and circular relationships and thus become indistinguishably intertwined both in meaning and effect. Thus, the disturbance emerges on all levels and dynamically shapes daily functioning of the individual and his or her environment. Although this model has gained acceptance among health professionals (physicians, psychiatrists, psychologists) and has highlighted the importance of social factors in disease aetiology and treatment, social contributors to disease are still not adequately incorporated into practice and research. The model's strongest *social implications* lie in the role of the partner and of friends and family (the social network), which may trigger the disease (e.g., by a social stressor such as interpersonal tension, chronic severe relationship conflicts, separation/divorce, or the experience of personal losses), alleviate, aggravate, or maintain the symptoms or play an important role in relapse prediction. In a salutogenic view within this model, social support plays a crucial role as a resilience and protective factor.

The concept of *social support* has become significantly impactful over recent decades and has been studied intensely as a buffer variable that moderates the effect of stress on well-being. In addition to a protective effect of social support on health, a positive effect on relationship satisfaction, particularly in women, has been observed [12]. Social support provided by the partner, but also by third parties (kin, friends, neighbours), is thought to have important implications in terms of health and disease. Social support and joint

coping processes in couples dealing with disorders are particularly addressed in the systemic transactional model (STM) [13]. The main assumptions of the STM are that (1) stress in close relationships is always a dyadic phenomenon, affecting both partners, (2) therefore, health and disorders are interdependent in partners and mutually influenced, and (3) partners in a committed relationship share the synergy of coping resources (dyadic coping) and thus have more resources in dealing with the disease. Building on the assumption that stress in relationships always affects both partners, conjoint effort to cope with stress (dyadic coping) is of central importance in the STM. Support provided by the partner is distinct from support received from close friends or family, and studies show that partner support plays a key role in the coping process, which cannot be replaced or compensated by any other type of social support [14]. The model assumes both partners to be affected by stressors encountered by one (e.g., daily hassles) and by common stressors (stress that concerns both partners directly such as a severe disease of one partner). The functions or goals of dyadic coping are the restoration of *individual homeostasis* (the problem is solved and partner A's emotions are regulated, resulting in improved daily functioning and efficiency), restoration of *dyadic homeostasis* (both partners reestablish their inner equilibrium, tension between partners is reduced) and the improvement of the couple's cohesion, sense of "we-ness", mutual trust, and intimacy (relationship-enhancing function). A multitude of international studies provides evidence for the predictive power of dyadic coping in relationship satisfaction, psychological and physical health, and stability of the union, for example, [15, 16]. Regarding physical well-being, dyadic coping has been shown to promote cortisol recovery after a stress experience [17], reduces systemic inflammatory markers in the blood in couples with chronically high psychological stress [18] and was found to protect couples from negative affect during conflict discussions (reduced interleukin-6) [19].

Disease as a common problem (we-disease)

Based on the STM, physical or psychological disorders are viewed as interdependent phenomena. When one partner is afflicted by a severe disease, disability, or mental disorder, both partners are always highly affected by such an event, and individual as well as dyadic management of the stressor is needed. Empirical findings support this assumption. Studies with cancer patients, for example, showed that not only

patients but also spouses of patients are psychologically distressed (in general and regarding depression and anxiety symptoms) and affected in their quality of life [8, 20], and a meta-analysis based on 46 studies showed that distress of cancer patients and their partners are moderately correlated ($r = 0.29$). Such a mutual impact can even manifest itself in symptom interdependency. In a 1-year longitudinal study with 758 independently questioned couples it was shown that anxiety and depressive symptoms of both partners affected each other mutually across time [21]. These findings indicate that illness is the concern of the whole couple (interpersonal view) and not just of one member of the couples (individual-centered view). Both are affected, both suffer, but both may also contribute to coping with it. In the context of severe physical or psychological disorders the term “we-disease” was proposed for depicting this view [22]. Thus, the concept of we-disease transcends the previously existing view of the partner’s role mainly as a potential support resource. In the bio-psycho-social model of disease, the partner and significant others were mainly considered in terms of their ability to aid in the recovery process, with the primary concern being how offers of support by significant others could

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be mobilised and included in the treatment process. This implies a view where one partner is the (deficient) patient and the other the supporting, healthy (resourceful) counterpart. The concept of we-disease rejects this unidirectional view of the healthy partner supporting the ill partner. Instead, a new, more holistic view of disease as a shared challenge is proposed, thereby redefining the roles of both partners in the case of physical disease or mental disorder. In this approach, there is no longer a juxtaposition between the *patient*, who is afflicted by a disease or disorder, and the healthy *partner*, who provides resources to support the patient, but rather, an interaction between two protagonists who both have their strengths and weaknesses, who are both affected by the condition and suffer consequences from it, but who also both have the power to shape outcomes and can work together to overcome the disorder. The couple as a *unity*, as an entity, is at the centre of this concept. Both partners must be committed to managing and overcoming the shared problem – the disease or disorder – with joint forces.

This approach goes beyond the bio-psycho-social model of disease and demands the systematic and con-

sistent inclusion of both partners in managing and overcoming a disorder or disease. In doing so, it surmounts the dominant deficit-oriented view of disorders in which patients, while conceded the possession of some resources, are still primarily seen as deficient. The concept of we-disease regards the partner as equally suffering and affected by the problem. It concedes that the partner may also feel fearful, anxious, insecure, depressed, overwhelmed, or guilty, and alleviates the pressure exerted onto the partner by the healthcare system, family, and society to care for the patient without regard for his or her own wellbeing and current resource availability.

We-disease might also overcome different problems of classical social support. That is, partner support is often *ambivalently* received [23]. Even support that is provided with good intentions (without negativity) often has a destructive effect. Requiring and receiving support has negative consequences for one’s *self-worth*; individuals often feel that they are deficient, fail, depend on the partner, are plagued by feelings of guilt, suffer from low self-worth, and may feel useless or even without purpose. It can be extremely difficult for the patient to be the cause of the partner’s worry, and to feel that his or her life is being made more difficult and burdensome. In a qualitative study (135 couples), couples affected by depression explicitly reported such problems [24]. These couples described the emotional cost for both, the lack of understanding for each other (what the depression means for the patient and for the partner), and the alternating emotional distance and codependency. Another study added to these findings in a 5-year longitudinal study with 103 couples [25]. Here, the authors found that even *one* excessive act of social support by the partner can have destructive effects on long-term relationship satisfaction. Moreover, being able to provide support instead of being solely the recipient of support seems to be particularly important [26]. In a 5-year longitudinal study with 846 older couples, those who were able to provide support to others had a lower *mortality rate* over the course of five years, whereas dependency on others significantly increased mortality. A study of 139 couples with the husband suffering from prostate cancer and receiving laparoscopic radical prostatectomy further supports the importance of support provision of patients. The patient’s provision of support, but not the amount of received support, predicted better erectile functions 1 year after surgery [27].

The notion “we-disease” means a shared view of the illness and joint efforts of both partners (the patient as well as the other partner) to deal with the disease, and thus might lead to better outcomes for both partners.

A recent longitudinal study involving 538 couples in which the woman had been diagnosed with breast cancer [28] supports this assumption. They found that couples who engaged in *common/joint dyadic coping* [13], a way of coping in which both partners are involved in managing the stressor jointly in terms of a *we-disease-view* of the stress condition, presented fewer depressive symptoms and higher relationship satisfaction over the course of the disease within 12 months after surgery. This manner of managing the stressor proved to be distinctly superior to that of partner support.

Most notably in the context of depression, but ultimately with any other psychological disorder (assuming high comorbidity between other disorders and depression), and probably also in the context of physical disorder (regarding the interplay between psychological well-being and physical disorders), the question about one's purpose and value as a patient is of paramount importance. What role does one still play in others' lives, can one still be useful to others, is one not a burden to everyone else, causing them worry and

Integrating the partner in the treatment of illness and psychological disorders yields beneficial outcomes.

concern? The given example demonstrates how the receipt of support can further fuel such dysfunctional cognitions. Others' help further mirrors one's own need and lack of value. Additionally, partners of patients often feel primarily responsible for the well-being of their ill partners and subjugate their own feelings and needs to those of their partners [29]. Thus, the suffering from the partner gets easily elided, resulting in a highly burdened partner who does not receive adequate support. In contrast, when both partners consider themselves responsible for overcoming the crisis together in the sense of a *we-disease*, define the disorder or disease as a common concern ("we-stress"), and both attempt to contribute to the management of the problem through available resources (*common dyadic coping*) [13], a more balanced state with improved chances of sustainability may result. A well-balanced give-and-take, even if contributions need not and cannot always be equal, and a more favourable coping process – both for the patient and the partner – result from such an approach.

A 1.5-year catamnestic follow-up study with patients suffering from moderate to severe depression provided evidence for the role of common stressor management in keeping with dyadic coping not only in symptom reduction, but also in increasing relationship quality (re-

duced expressed emotion) [30]. Patients undergoing couple therapy focusing on the enhancement of dyadic coping showed not only a significant reduction of symptoms but also a lower rate of relapse. Integrating the partner in the treatment of illness and psychological disorders (e.g., depression) yields beneficial outcomes (e.g., [31]). Moreover, through strengthening the individual health of both partners and the quality of the relationship, the whole family system benefits. Research has repeatedly shown that healthy parents and a well-functioning relationship between the parents have a positive impact on children's development [32]. The concept of *we-disease* easily transfers to the context of families that are affected by a member's disorder or disease as a group and thus form a sort of *community of common fate* that must mobilise common resources in reacting to the stressor. However, family constellations and resulting boundaries between sub-systems (parents, children) may differ depending on the children's ages. It is essential to bear in mind such boundaries to prevent the *parentification* of children. Additionally, it should be noted that the concept of *we-disease* is not transferable to other types of social connections, but instead primarily focuses on close ties such as couple or family relationships.

Clinical implications

Given that physical and psychological disorders always affect both partners and given that unbalanced support processes can be detrimental for both partners in the long run, a *we-disease-view* seems to be promising in the treatment of patients in a committed relationship. Practitioners should treat both partners as suffering from the problem and should see both partners as persons with resources to jointly overcome the problem. This will enhance not only the psychological adjustment of the patient but also the psychological adjustment of the partner and, moreover, strengthen the relationship within the two.

Some limitations regarding the applicability of the concept of *we-disease* have to be mentioned. Obviously, it is only feasible for patients in a committed close relationship. Moreover, it seems to be most useful in neurotic disorders such as affective disorders, anxiety and compulsive disorders, eating disorders, or sexual dysfunctions. In contrast, in patients suffering from personality disorders or having psychotic symptoms the *we-disease* approach is less or not indicated. In terms of physical diseases, the concept of *we-disease* is also limited when one partner suffers from severe cognitive impairments (due to the illness itself or due to the treatment, e.g., medication) and an equal give

and take is not possible. Other constraints such as limited mobility or low resources, in contrast, are no reason for not applying the concept of we-disease. On the contrary, especially in cases where the ill partner is strongly handicapped, it is important to foster mutual dyadic coping processes as it is particularly likely that (1) the ill partner perceives him-/herself mainly as a burden for his/her partner [24, 25] and (2) the healthy partner provides unidirectional support without taking care of his/her own needs [29]. Hence, especially when one partner is strongly burdened, it is important to go beyond the bio-psycho-social model and beyond simple social support, and it is crucial to involve the healthy partner in the treatment process not only as a source of social support but as an equally affected person.

Besides these limitations, the concept of we-disease is a promising approach to further enhance the treatment of various physical and mental illnesses. It goes beyond the social component of the bio-psycho-social model by viewing both the patient and the partner as affected by the disease and as potential mutual support providers in the sense of joint dyadic coping. This approach potentially strengthens the self-worth of the patient and releases the partner and, moreover, fosters a sense of “we-ness” within the couple resulting in a strengthened relationship and a strengthened family system and by these means better health outcomes.

Funding / potential competing interests

No financial support and no other potential conflict of interest relevant to this article was reported.

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Correspondence:

Guy Bodenmann, MD
Universität Zürich
Binzmühlestrasse 14/23
CH-8050 Zürich
guy.bodenmann[at]
psychologie.uzh.ch