"When He Forgets Them [Medicines]…I Can Hardly Stand to be Around Him": The Influence of Stress, Frequency of Challenges, and Coping on the Relational Quality of Partners whose Significant Other Has a Mental Health Condition.

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the Center for International Studies of Ohio University

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This thesis titled
"When He Forgets Them [Medicines]…I Can Hardly Stand to be Around Him": The Influence of Stress, Frequency of Challenges, and Coping on the Relational Quality of Partners whose Significant Other Has a Mental Health Condition.

by

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Abstract

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"When He Forgets Them [Medicines]…I Can Hardly Stand to be Around Him": The Influence of Stress, Frequency of Challenges, and Coping on the Relational Quality of Partners whose Significant Other Has a Mental Health Condition.

Director of Thesis: Charee M. Thompson

This study applied Lazarus and Folkman’s (1984) stress and coping framework and the concept of dyadic coping (Bodenmann, 1995, 1997) to explain why individuals with mental health conditions have less successful romantic relationships. I constructed a direct path model to test the extent to which: stress is negatively associated with relational quality, frequency of challenges is negatively associated with relational quality, and frequency of challenges moderates the negative association between stress and relational quality. I also constructed simple and multiple mediation models to show which coping strategies, and at which level of dyadic and individual coping, mediate the aforementioned associations.

The models partially supported the study’s hypotheses. Specifically, findings fully supported the hypotheses that stress and the frequency of challenges due to mental health conditions are negatively associated with relational quality, and partially supported the hypothesis that frequency of challenges moderates the negative association between stress and relational quality. Additionally, results showed that dyadic coping and several individual coping strategies (e.g., behavioral disengagement) mediate the association between stress and relational quality. Furthermore, findings
from the simple mediation models suggest that frequency of challenges might exacerbate the negative association between stress and relational quality through strengthening the negative association between stress and dyadic coping.
Dedication

To the Lord, he who has been both my strength and my comfort throughout my life journey. Also to you, Evelyn and Alberto, my parents, who gave so much of your lives and love to allow me to and see me achieve my goals...no step of my way would have been possible without your constant support.
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So many minds and hearts were invested in this project and its process, the first of them being those of Charee Thompson, my thesis chair. I do not foresee this project being the same, or even being, without your sharp intellectual insight, your incomparable dedication of time and energy, and your always refreshing confidence that I would be able to jump through the hoops of the process. Your faith in me, which many times exceeded my own, is something that I will always cherish, and one of the myriad reasons why I have great respect for you. I will always, too, hold dearly your rigorous and thoughtful feedback, which taught me many lessons about research, writing, and myself. Your input really helped me optimize my resources for this study, and I have no doubt that these lessons will yield great rewards way beyond having completed my thesis. I can only be grateful and feel blessed for this amazing opportunity to work with you, and hopeful that there will be many more down our paths.

I must certainly also acknowledge the role of Amy Chadwick, another mentor who I also respect tremendously and look-up to, in making this project possible. First of all, your teachings in methodology equipped me with the tools and encouraged me to critically think and make decisions necessary to carry-out this project. Also, your engaging class in communication campaigns, although not directly tied to my research focus, solidified my confidence in my decision to pursue my doctoral degree in Communication Studies, which at all times remained an important source of motivation to complete this thesis. Even more, your sustained support for my work was a gift that gave me renewed strength to work towards my goals during very rough times.
There are so many things that I could say about my gratitude to both Dr. Thompson and Dr. Chadwick, but for space considerations I must limit myself to say that it is an honor to know these two bright and kind doctors 😊.

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Chapter 1: Introduction

A substantial percentage of partners report distress associated with their significant other’s health condition (Caska & Renshaw, 2011; Dekel, Solomon, & Bleich, 2005; Dirkzwager, Bramsen, Ader, & van der Ploeg, 2005; Geriani, Babu Savithry, Shivakumar, Kanchan, 2015; T.Lambert, Engh, Hasbun, & Holzer, 2012; van der Voort, Goossens, & van der Bijl, 2009; Zaider, Richard & Heimberg, 2010). The distress that partners experience is a result of the symptoms of the condition (Conway, Hammen, & Brennan, 2012; Ha, Geertjan, Overbeek, Cillessen, & Engels, 2012; Seeman, 2012), as well as of the effects that the condition has on their significant other’s life functioning (Goossens, Van Wijngaarden, Knoppert-Van Der Klein, & Van Achterberg, 2008). Moreover, condition symptoms and their corresponding effects can influence how significant others behave towards partners, potentially creating more stress for partners. Partners’ experiences of stress due to their significant other’s health condition, and the way in which partners respond to this stress, are the foci of this project.

At the same time that partners feel stress due to their significant other’s mental health condition, individuals with mental health conditions have shorter romantic relationships (Kessler, Walters, & Forthofer, 1998); lower rates of marriage (Hammen & Brennan, 2002); higher rates of divorce (Breslau et al., 2011); and less satisfied romantic partners than their counterparts (e.g., Idstad, Ask, & Tambs, 2010). In short, previous research has also found that mental health conditions are typically linked with less successful romantic relationships (e.g., Monson & Taft, 2005). In this project I studied how the stress partners experience as a result of their significant other’s mental health
condition leads them to respond to this stress in ways that are associated with their perceived relational quality.

Parsing out the association between stress and relational quality is especially important in the case of mental health conditions for at least two reasons. The first reason why it is important to break-down the link between stress and relational quality is that mental health conditions are highly prevalent in the U.S, where nearly half of the population meets the criteria for diagnosis at some point in their life and around a quarter does it in any given year (McCall-Hosenfeld et al., 2014). The second reason why we should understand the connection between stress and relational quality in couples managing mental health conditions is because, from recent decades, the management of such conditions takes place largely at home, rather than hospitals and medical care units (Goossens et al., 2008; Idstad et al., 2010). Both the high prevalence of mental health conditions and the fact that it is currently less common for individuals with mental health conditions to be hospitalized increase the chance that partners will have to manage the condition, the stress associated with it, and its potential influence on their relationship. Additionally, these two factors suggest that there is a high proportion of partners, both within population of partners whose significant other has a mental health condition and in the general population, who will have to do this management.

In populations other than individuals with mental health conditions and/or their partners, literature shows that when partners experience stress they find their relationship less satisfying (for a review see Randall & Bodenmann, 2009), and the relationship deteriorates (Meier et al., 2012; Mooney, 2013; Randall & Bodenmann, 2009; Thompson & Vangelisti, 2014; Zaider, Richard & Heimberg, 2010). The negative
influence of stress on relational quality holds whether their stress is due to their partners’
actions (Mooney, 2013; Thompson & Vangelisti, 2014; Zaider, Richard & Heimberg,
2010) or due to external circumstances (Meier et al., 2012; Mooney, 2013; Randall &
Bodenmann, 2009). Yet, despite a great deal of research linking mental health
conditions to stress in partners and stress in partners to relational quality, researchers
have seldom assessed the connection between stress and relational quality for partners
managing their significant other’s mental health conditions and its consequences within
the relationships (cf. Baucom, Whisman & Paprock, 2012; Boeding et al., 2013). Thus,
a first aim of the present study was to connect these typically independent lines of
research by testing whether stress is what accounts for the negative consequences that
mental health conditions appear to bring to romantic relationships, adding to the existing
body of literature on the relational implications of mental health conditions.

In addition to finding that mental health conditions are challenging for both the
individual and for their partner, previous research on mental health conditions and
relationships suggests that stressful challenges for partners whose significant other has a
mental health condition are common and frequent (Caska & Renshaw, 2011; van der
Voort, Goossens, & van der Bijl, 2009; Zaider et al., 2010). The fact that stressful
challenges are common and frequent means that the exposure of partners to stress
accumulates, in the face of limited resources to address it, which can have even more
negative implications for relational quality. Thus, the association between stress and
relational quality might be even stronger for partners of individuals with mental health
conditions, as a group often exposed to stress located within the relationship.
Considering the possibility that the frequency of challenges can have even more
detrimental effects on relational quality, a second aim of this study was to test whether more frequent challenges are negatively associated with partners’ reports of relational quality, and whether this higher frequency of challenges makes the negative association between stress and relational quality stronger.

Notably, although mental health conditions present many difficulties to romantic relationships, they do not negatively affect all romantic relationships (Kronmüller et al., 2011; Seeman, 2012; Zaider et al., 2010). In fact, some partners even report that the mental health condition has strengthened their relationship (Lawn & McMahon, 2014). Perhaps, some partners follow the old adage “when life gives you lemons, make lemonade”, which teaches us that although challenges might be inevitable, the way people respond to them makes a great difference for whether the outcomes from these challenges are positive or negative. Maybe, then, the way in which partners respond to the challenges and stress of mental health conditions makes a difference in their relational quality? This proposition is consistent with Lazarus & colleagues’ (1966, 1984, 1998) stress and coping perspective, which posits that whether and the extent to which stress influences relationship quality depend on partners’ coping, where coping refers to the actions that individuals take in order to manage or alleviate the problem that is causing their stress and the stress itself. Consistent with the potential role of coping as a mediator of the associations between both stress and the frequency of challenges have and relational quality, a third and central aim of this study was to evaluate the extent to which dyadic and individual coping account for the influence of the aforementioned variables on relational quality.
It is helpful to incorporate coping strategies because, from a stress and coping perspective (Lazarus & Folkman, 1984), partners will engage in various coping strategies to deal with their stress and to maintain their relationship (Mooney, 2013). At the same time, not all coping strategies are productive, or equally so, for individuals (Lazarus & Folkman, 1984; Mooney, 2013) and their relationships (Bodenmann, 2000; Mooney, 2013). As such, what may ultimately affect relational quality might be the ways in which partners manage the stress associated with the condition through coping (Baucom, Whisman, & Paprock, 2012; Boeding et al., 2013; Fredman et al., 2014; Lawn & McMahon, 2014; Seeman, 2012; Zaider et al., 2010). Research on partners whose significant other has a mental health condition should identify the variable(s) that account for these differences in the connection between stress and relational quality because locating these factors can help researchers and practitioners to delineate potential areas for future early intervention. Incorporating coping as a mediator in these associations is a promising path to explain, in a conceptually sound way, why not all relationships facing a mental health condition are negatively affected, in spite of the many difficulties that mental health conditions present to romantic relationships (Kronmüller et al., 2011; Seeman, 2012; Zaider et al., 2010). In other words, the mechanism of coping provides a promising avenue to understanding what differentiates partners whose significant other has a mental health condition and have a satisfying relationship with them from those who do not. I expect that partners in this study engage in coping at two different levels: individually and dyadically. Utilizing both the framework of stress and coping and the concept of dyadic coping (Bodenmann, 1995, 1997; Meier et al., 2007), I predicted that these coping strategies will explain the
relationship between stress and relational quality for partners whose significant other has a mental health condition.

In sum, and drawing on the assumption that mental health conditions are challenging for partners, I assessed associations between partners’ perceived relational quality and a) their stress associated with the challenges of mental health conditions; b) the frequency with which they have to face these challenges; and c) the individual and dyadic coping strategies that they use to respond to these challenges. Next is a review of relevant literature, followed by an outline of the methodology that I followed to test the hypotheses that guided this project. Then, in the fourth chapter of this document, I present the findings from preliminary and main analyses of the data. Finally, in the last chapter, I discuss other results, including contributions and limitations of the present project, and I draw conclusions from this study.
Chapter 2: Literature Review

I have divided this chapter into three main sections. In the first section I review the relationship between mental health conditions and the functioning of romantic couples. In the second section and third section, I present conceptual frameworks that can help understand the connection between mental health conditions and relational functioning, using relational quality as an indicator of this functioning. In particular, in the course of these two sections I forward Lazarus and colleagues’ stress and coping framework (1966, 1984, 1998) as a helpful lens to study the challenges and responses of partners whose significant other has a mental health condition. Towards this proposition, in section two I briefly summarize Lazarus and colleagues’ framework of stress and coping, outline some of the challenges that partners face due to their significant other’s mental health condition, and provide evidence to support the notion that these challenges can be stressful for partners. Meanwhile, in section three I review research that addresses the association that each stress and coping, respectively, have with relational quality, both in the context of mental health conditions and in other contexts. Moreover, in this section I present the hypotheses, research questions, and a visual model that guides the methodology and analyses of the present study.
Section One: The Prevalence of Mental Health Conditions and Its Threats for Romantic Relationships

Psychiatric disorders or mental illnesses (mental health conditions hereto) are prevalent, debilitating, and chronic health conditions (Lokkerbol, Adema, de Graaf, ten Have, Cuijpers, Beekman, & Smit, 2013; McCall-Hosenfeld, Mukherjee, & Lehman, 2014; Ratnasingham, Cairney, Manson, Rehm, Lin, & Kurdyak, 2013). Indeed, mental health conditions affect a quarter of the global population at some point in their lives (Vaingankar, Rekhi, Subramaniam, Abdin, & Chong, 2013). In the United States alone, close to half of the population will experience a mental health condition in their lifetime and nearly one fourth of the population meets the criteria to be diagnosed with a mental health condition in any given year (McCall-Hosenfeld et al., 2014). These indicators demonstrate how commonplace mental health conditions are. For both theoretical and practical reasons, it is important to understand the consequences that mental health conditions can have for close relationships, in light of two facts, a) the high prevalence of mental health conditions across the globe, and b) mounting evidence corroborating that romantic partners are central interpersonal connections after adolescence (Beyers & Seiffge-Krenke, 2007; Seiffge-Krenke, Overbeek, & Vermulst, 2010; Seiffge-Krenke, 2003). Thankfully, a significant number of studies have attended to the relational outcomes that are associated with mental health conditions and this extensive research suggests that mental health conditions are associated with negative relational consequences (Awad, Lakshmi, & Voruganti, 2008; Erten, Alpman, Özdemir, & Fistikci, 2014; Goossens et al., 2008; Idstad et al., 2010; Lawn & McMahon, 2014; Perlick, 2005; Vasudeva, Sekhar & Rao, 2013; Winefield, 2000). In the present
subsection, I will summarize findings concerning the relational consequences research has linked to couples where an individual has mental health conditions.

Generally, individuals with mental health conditions have difficulty developing and maintaining satisfying romantic relationships (Ha et al., 2012; Idstad et al., 2010; Forthofer, Kessler, Story & Gotlib, 1996; Gustavson, Røysamb, Soest, Helland, Karevold & Mathiesen, 2012; Kessler, Walters & Forthofer, 1998; Kronmüller et al., 2011; Porter & Chambless, 2014; Zaider et al., 2010). For example, the relationships of individuals with mental health condition are less long-lasting than those of their counterparts (Breslau et al., 2011; Kessler et al., 1998). Similarly, previous research indicates that the marriages of individuals with mental health conditions are more likely to end up in divorce (Breslau et al., 2011; Kessler et al., 1998). Concerning differences in the likelihood of getting married, a multinational study of 19 countries found that an individual’s likelihood of getting married during adulthood was negatively associated with them having anxiety, mood, and/or substance use disorders (Breslau et al., 2011), which is consistent with findings from previous studies (e.g., Forthofer, Kessler, Story, & Gotlib, 1996; Kessler et al., 1998). In particular, the authors found that individuals without mental health conditions were between 1.25 and 1.7 times more likely to get married during adulthood than individuals with mood, anxiety, and substance use disorders. Breslau and colleagues (2011) hypothesized that individuals with these type of mental health conditions are less likely to get married potentially because their partners and potential partners evaluate them more negatively than partners of individuals without these conditions evaluate their significant other. In particular, the authors suggest that individuals with anxiety, mood, and/or substance abuse disorders
may elicit more negative evaluations from their potential partner as a result from “a combination between stigma and functional limitations” (Breslau et al., 2011, p. 483). Furthermore, previous research on the consequences of mental health conditions for relationships shows that individuals with mental health conditions tend to have shorter romantic relationships and that, when established, their romantic relationships are more likely to end (Forthofer et al., 1996). For example, Breslau and colleagues (2011) also found that there were higher rates of divorce among individuals with any of the mental health conditions included in their study (i.e. anxiety, impulse control, mood, and substance use) when compared to individuals who did not have a mental health condition, even after controlling for demographic (e.g., sex, country, education) and relational variables (e.g., months dated, years married). Similarly, Kessler and colleagues’ (1998) research showed that 48.2% of individuals who were diagnosed with a mental health condition either before or during their first marriage had had a divorced, compared to 35.9% of their counterparts without mental health conditions (p. 1093).

Though research has established that individuals with mental health conditions have trouble maintaining romantic relationships, what is less established in research are the relational dynamics and processes that underlie this fact. Potentially contributing to the fact that individuals with mental health conditions have trouble maintaining romantic relationships is the possibility that their condition makes their partners feel less satisfied. Effectively, previous research has found that, across mental health conditions, spouses and cohabitating partners experience dissatisfaction with the relationship because of the symptoms of mental health conditions and the implications of these symptoms for the relationship (Beach, Katz, Kim, & Brody, 2003; Boyes,
Garth, Fletcher & Latner, 2007; Brown, Banford, Mansfield, Smith, Whiting & Ivey, 2012; Canu, Tabor, Michael, Bazzini & Elmore, 2014; Coyne & Benazon, 2000; Gustavson et al., 2012; Whisman & Uebelacker, 2009). Relational characteristics that are associated with mental health conditions and that elicit dissatisfaction in romantic partners include: increased relationship burden (Fadden, Bebbington & Kuipers, 1987), high relational conflict and low harmony (Baucom et al., 2012; Benazon & Coyne, 2000; Hammen & Brennan, 2002; Joutsenniemi et al., 2011; Seeman, 2012), and increased sexual problems (Lam et al., 2005). Together, the above research shows that mental health conditions can impair relational activities, cause strain the romantic relationship, decrease the satisfaction that romantic partners get from the relationship, and result in negative relational outcomes such as divorce.

Although previous research has uncovered the threats that mental health conditions present to partners, and in doing so has made an important contribution to the existing literature, it is important to clarify that not every partner of an individual with a mental health condition is dissatisfied with their relationship (Goossens et al., 2008). Furthermore, many partners are happy with their relationship (Lam et al., 2005). For instance, Goossens and colleagues (2008) surveyed caregivers, most of whom were romantic partners, of individuals with bipolar disorders and found that 81% of caregivers were happy with their relationship (Goossens et al., 2008). This is consistent with Lam and colleagues’ (2005) findings, which identified that 34 out of the 37 partners of individuals with bipolar disorder reported feeling happy in their relationship. Recognizing that some partners remain satisfied with their relationship in spite of their significant other’s mental health condition, it is reasonable to argue that mental health
conditions do not cause partners to become dissatisfied in and of themselves. In other words, mental health conditions are not a “death sentence” for partners’ satisfaction or for the relationship. Indeed, challenges associated with a significant other’s mental health condition may cause a decline in the relational quality for some partners.

By identifying what factors and mechanisms lead to lower levels of relational satisfaction in some partners and not others, I can provide insight into the ways that partners whose significant other has a mental health condition can remain satisfied in their romantic relationships. Preventing negative consequences for relationships where either one or both partners has a mental health condition becomes that much more pressing given the high prevalence of mental health conditions. However, research has not directed much attention to understanding these factors and mechanisms. Thus, this study addresses a gap in the literature, which has significant practical applicability. I draw from Lazarus and colleagues (1966, 1984, 1998) and from the dyadic coping literature (e.g., Bodenmann; Bodenmann et al., 2008; Meier et al., 2007) to understand the connection between the challenges of a significant other’s mental health conditions and partners’ relational quality. In particular, I predicted that the challenges of mental health conditions cause stress in partners; that the stress that partners experience due to these challenges drives them to engage in different strategies and levels of coping, individual and dyadic, to deal with the challenges and their stress; and that both partners’ stress and their coping in response to the challenges associated with their significant other’s mental health conditions can explain the differences in partners’ evaluations of their relationships.
Section Two: Theory of Stress and Coping and The Challenges of Mental Health Conditions as Sources of Partner’s Stress

**Stress and coping.** Stress can be broadly defined as an emotional experience that occurs when individuals or groups evaluate or appraise an interaction between them and their environment as interfering with their relevant goals, and requiring them to expend scarce and valuable resources (Lazarus, 1966, 1998; Lazarus & Folkman, 1984). In other words, in order for individuals to evaluate an interaction with their environment as a stressful one, they must perceive that an effective response to the demands of the situation requires “taxing or exceeding” personal or group resources that they value (Lazarus, 1966, 1998; Lazarus & Folkman, 1984). Once an individual appraises a situation as stressful, behave in ways that respond to the underlying problem and/or to the stress that ensues from the situation (Lazarus, 1966, 1998; Lazarus & Folkman, 1984). The name of this process, by which individuals respond and act towards managing to the stressful situation, and the emotions associated with it, is coping (Lazarus, 1966, 1998; Lazarus & Folkman, 1984).

Coping can be broadly sub-classified into two categories: problem-focused coping, which focuses on managing the underlying problem, and emotion-focused coping, which focuses on managing the emotions associated with appraisals of the situation (Lazarus, 1966; Lazarus & Folkman, 1984). Individuals can engage in emotion-focused and problem-focused coping complementarily, and there are more and less effective strategies for both emotion-focused and problem-focused coping. For example, Lawn and McMahon (2014) conducted semi-structured interviews with married partners whose significant other has a mental health condition, and they found that focusing on the
positive aspects of the relationship and using humor, a form of emotion-focused coping aimed at “generating” or eliciting positive emotions in the situation, helped their participants feel more positively about their marriage. Conversely, Zaider et al. (2010) showed that dating partners whose significant other had Obsessive Compulsive Disorder (OCD) were less satisfied with their relationship when they avoided discussing behaviors that they found problematic in their significant other and instead participated in behaviors that they found problematic in order to calm their significant other’s anxiety, a form of avoidant problem-focused strategy.

Given research demonstrating that some ways of coping are more effective to alleviate partner’s stress than others and that some coping strategies are more helpful for partners to remain satisfied in their relationship, while others leave partners even more frustrated and dissatisfied with the relationship, I focused on coping as a bridge connecting stress due to challenges with relational quality. Specifically, in this study I assessed how coping strategies explain the association between stress that partners feel due to challenges of their significant other’s mental health condition and partners’ relational quality.

**Challenges of mental health conditions and partner’s stress.** Managing mental health conditions demands considerable time and resources for both the individual with the condition and their loved ones, making these conditions debilitating and costly (Lokkerbol et al., 2013; McCall-Hosenfeld et al., 2014; Ratnasingham et al., 2013; Sickel, Nabors & Seacat, 2014). In particular, resources are required to manage the many challenges and losses associated with mental health conditions. The challenges that individuals with mental health conditions must deal with include lower rates of
educational attainment and difficulties with academic performance (Schindler & Kientz, 2013), difficulties with occupational performance (Andersen, Nielsen, & Brinkmann, 2014; Stahl & Edvardsson Stiwne, 2014), discrimination from service providers (Lawn & McMahon, 2015), lower employment rates (Schindler & Kientz, 2013), and, important to this study, problems with relationship development and quality (Breslau et al., 2011; Conway, Hammen, & Brennan, 2012; Starr, Hammen, Phillips, Connolly, & Brennan, 2014). Exogenous factors also contribute to the difficulties of living with mental health conditions, including conditions’ early onset (Kessler et al., 2007; Ratnasingham et al., 2013; Sickel, Nabors & Seacat, 2014; Vaingankar et al., 2013), their chronic nature, and the stigma attached to them. For instance, the early onset and chronic nature of some conditions contribute to the accumulation of challenges, financial and otherwise, over time. Meanwhile, the stigma attached to mental health conditions decreases the incentives that individuals with mental health conditions have to seek both professional help and informal support.

Significantly, close family and significant others of individuals with mental health conditions assume many responsibilities tied to the care of individuals with mental health condition (Goossens et al., 2008; Ildstad et al., 2010). Particularly, as primary support providers in adult relationships (Furman, Simon, Shaffer, & Bouchey, 2002; Ha et al., 2012, p. 1247), the partners of individuals with mental health conditions are also at the center of the struggles associated with the illness (Goossens et al., 2008; Perlick et al., 2007; van der Voort et al., 2009). Said differently, committed partners must also cope with aforementioned challenges (e.g., employment, difficulties performing daily
activities), which are also potential sources of stress for them (Goossens et al., 2008; Perlick et al., 2007; van der Voort et al., 2009).

Given that the challenges of living with a mental health condition extend beyond the individual with the condition, researchers have raised the concern and provided support for the fact that stress affects partners as well (Baucom et al., 2012; Goossens et al., 2008; Idstad et al., 2010; Kronmüller et al., 2011; Lawn & McMahon, 2014; Manguno-Mire et al., 2007; Seeman, 2012; van der Voort et al., 2009; Zaider et al., 2010). Studies have consistently found that romantic partners of individuals with mental health conditions report stress and other negative emotions associated with the condition. The negative emotions that romantic partners face due to their significant other’s mental health condition include fear and worry, uncertainty, loneliness, as well as frustration and anger in relation to specific symptoms of the condition (Boeding et al., 2013; Caska & Renshaw, 2011; Goossens et al., 2008; Joutsenniemi et al., 2011; Lam et al., 2005; Seeman, 2012; Voort et al., 2009; Zaider et al., 2010).

Furthermore, research has found that the partners of individuals with mental health conditions exhibit higher symptoms of anxiety and depression than partners of individuals without mental health conditions (Benazon & Coyne, 2000; Caska & Renshaw, 2011; Gilbar et al., 2012; Idstad et al., 2010; Magliano et al., 2005). This held true in Caska & Renshaw’s (2011) study of spouses of service members with PTSD even when service members’ symptoms were at subclinical levels. Also, in a study of caregivers of patients with bipolar disorder who were in euthymic (i.e., non-episodic) state, Erten and colleagues (2014) found that 44% of the sample (i.e., around 40 caregivers) reported moderate to severe levels of caregiver burden. They concluded that
caring for an individual with bipolar disorder can result in considerable levels of
caregiver burden, even during non-episodic periods of the mood disorder (Erten et al.,
2014).

The stress that partners face due to the mental health condition comes from two
main sources: a) stress linked directly to the symptoms of the mental health condition,
whether witnessing or anticipating them, and b) stress linked to consequences that the
symptoms or the illness in general have on different life domains (Conway et al., 2012;
Gilbar et al., 2012; Ha et al., 2012; Idstad et al., 2010; Starr et al., 2014; van der Voort et
al., 2009; Zaider et al., 2010). In the first case, the stress that partners face is, in part,
directly tied to their significant other’s symptoms (Caska & Renshaw, 2011; Conway et
al., 2012; Coyne, 1976; Ha et al., 2012; McLaughlin & Nolen-Hoeksema, 2012; Starr et
al., 2014; Seeman, 2012; Zaider et al., 2010). For example, a longitudinal study of
depressive symptoms and evaluations of relational quality by Gustavson and colleagues
(2012) found that depressive symptomatology in one partner predicted lower evaluation
of relational quality in both partners. Likewise, a cross-sectional study by Brown and
colleagues (2012) found that PTSD symptoms were negatively associated with dyadic
adjustment ratings. Also, in their study of partners of previously deployed service
members, Caska and Renshaw (2011) found service members’ symptoms of post-
traumatic stress (PTSD), anxiety, and depression were significantly associated with
spousal psychological distress.

Across mental health conditions, previous studies have linked individuals’
behaviors, such as excessive withdrawal or dependence, physical and verbal
aggressiveness, and suicidality with higher stress in spouses (Lam et al., 2005; Gilbar et
Poignantly, Benazon & Coyne (2000) found that individuals with depression’s feelings of “worthlessness” were reported as the main source of their partner’s burden. There are many reasons why the symptoms of a significant other can cause partners to become stressed, not the least of which is seeing a loved one in pain. Truly, as Boading and colleagues (2013) argue, “…it can be painful to observe a loved one in distress” (p. 320). Though a comprehensive list of the reasons why symptoms are stressful for partners is beyond the scope of this review, a cursory reading of the literature shows that the conditions’ manifestations are a source of partners’ stress.

A second source of stress for partners of individuals with mental health conditions is related to the functional and social consequences associated with their significant other’s mental health conditions. The consequences of mental health conditions include: difficulties in family finances; effects on children (e.g., symptoms of anxiety and depression); decreased intimacy; and increased social isolation and strain in other social relations (Conway et al., 2012; Gilbar et al., 2012; Ha et al., 2012; Idstad et al., 2010; Starr et al., 2014; van der Voort et al., 2009; Zaider et al., 2010).

In sum, research shows that mental health conditions affect partners of individuals with mental health conditions, partly because they present challenges that partners also have to manage, and because some of these challenges bring negative consequences for their own (i.e., the couples) relationship, for other relationships (e.g., family), and for other domains of life (e.g., parenting, financial, employment). In the following section, I argue that the stress that partners experience due to these challenges can deteriorate the relationship, leading to a decrease in partners’ perception of relational quality.
Section Three: The Influence of Stress and Coping on Relational Quality: An Application to Partners whose Significant Other has a Mental Health Condition

The implications of partner’s stress for relational quality. To this point, I have forwarded two arguments from the literature. First, mental health conditions can impair relationship quality, although there are exceptions to this. Second, partners of individuals with mental health conditions experience stress associated with the condition. Therefore, it is reasonable to expect that partners’ experiences of stress in relation to their significant other’s mental health conditions partially explain the overall lower relational success found in these relationships. Stress affects individuals and their relationships (Afifi et al., 2015; Bodenmann, 2008; Mooney, 2013; Papp & Witt, 2010), particularly when stressors accumulate, persist, or are countered with maladaptive responses (Afifi et al., 2015; Bodenmann, 2000, 2008; Herzberg, 2013), such as it happens for couples in which an individual has a mental health condition (Goossens et al., 2008; Perlick et al., 2007; van der Voort et al., 2009).

A potential reason why stress can be harmful for individuals and relationships is that stress calls for focused attention and direction of resources towards the stimulus and towards responding to it, with an aim to adaptation (Afifi et al., 2015; Muraven & Baumeister, 2000). Because resources are limited, such direction of resources takes from other activities and tasks (Muraven & Baumeister, 2000). For example, Muraven and Baumeister (2000), found that after exposure to a stressful situation, self-control strength was diminished in participants. Thus, if an individual or couple is continually faced with stress, attending and responding to such stress can drain resources that could be employed towards personal and relational advancement, such as spending time with their significant
other in social settings. This might explain why greater stress, even when the source of stress is located outside of the relationship, leads to outcomes such as poorer communication (Bodenmann, 2000, 2005). In turn, poor communication can contribute to the lower levels of relational satisfaction (Bodenmann, 2000, 2005) and to a higher likelihood of divorce. Exemplifying how the stress from mental health conditions can drain partner’s resources, Goossens and colleagues (2008) found that a third (33%) of the caregivers (most of them romantic partners) felt constantly under strain as a result of the illness; over a fourth (27%) reported being less able to enjoy regular activities and the same percentage reported feeling more depressed; and more than a fifth (22%) felt unable to cope with the challenges associated with their loved one’s health condition.

Surprisingly, although research has attended considerably to both of these facets (i.e., mental health conditions in relation to partner stress and mental health conditions implications for relational outcomes), researchers have devoted less efforts to systematically integrating these two through a sound theoretical framework (see van der Voort et al., 2009; Zaider et al., 2010 for exceptions). In other words, research finds that mental health conditions are stressful and that they affect relational quality, but little research explains the link between the two. Though the association between stress and relational satisfaction has not been widely explored in the context couples in which a partner has a mental health condition, research employing the framework of stress and coping in other contexts support this association. Thompson and Vangelisti (2014) found that greater stress associated with unmet standards predicted lower relational quality, which provides support for the assumption that stress has negative consequences for relationships in this study. Also, in a study of stress and coping in long distance
relationships (LDRs) of college students, Maguire and Kinney (2010) found that “low distress LDRs were significantly more satisfied… than did those in high distress LDRs” (p. 36). Similarly, in a study assessing the association between immigration stress and relational satisfaction, Falconier, Nussbeck, and Bodenmann (2013) found that increases in the former were significantly associated with decreases in the latter. Given that the partners experience significant stress associated with their significant other’s mental health condition and that stress has been tied to relational deterioration in other research contexts, I expected to find that partners’ greater level of stress would be associated with decreased relational quality. Thus:

**H1: Stress is negatively associated with relational quality.**

Challenges require expenditure of limited resources, more frequent challenges will impose higher demands on the stock of resources that partners have available to cope with these challenges. As a result, the frequency of challenges presumably has a negative association with relational quality because, as they increase, challenges can overwhelm and over burden partners, as well as strain their existing resources to cope in effective ways (Afifi et al., 2015). Thus:

**H2: Frequency of challenges is negatively associated with relational quality.**

Furthermore, the taxing or exhaustion of resources that can result from stressful challenges, and its potential consequences for relational quality, is likely to be exacerbated when these challenges are more frequent. Thus,

**H3: The interaction of stress with frequency of challenges is negatively associated with relational quality, such that a greater frequency of challenges will strengthen the relationship between stress and relational quality.**
Coping with challenges of mental health conditions and partner's relational quality. “According to Lazarus and Folkman (1984), coping is the mechanism through which stress affects relational quality” (Thompson & Vangelisti, 2014, p. 6). That is, partners respond to stress by coping, and in turn coping affects relationship satisfaction (Mooney, 2013; Zaider et al., 2010). Previous findings in the literature suggest that there are more helpful or harmful ways of coping with the stress in a relationship, in the sense that increases in the use of some strategies are associated with increases in relational quality (e.g., reframing), while other strategies (e.g., avoidance) are associated with decreases in relational quality (Mooney, 2013; Zaider et al., 2010). In research outside the context of mental health conditions, studies have suggested that one important feature of coping that influences outcomes is the extent to which couples cope with stressors together versus separately (e.g., Meier, Bodenmann, Mörgeli, & Jenewein, 2011; Meier, Bodenmann, Moergeli, Peter-Wight, Martin, Buechi, & Jenewein, 2012). The extent to which couples cope with stressors together is referred to as dyadic coping, and previous research indicates that dyadic coping is positively associated with reports of relational quality (Badr, Carmack, Kashy, Cristofanilli, & Revenson, 2010; Bodenmann, 2000; Bodenmann et al., 2008; Meier et al., 2011, 2012).

H4: Partner’s dyadic coping will mediate the association between stress and relational quality.

RQ1: Will dyadic coping mediate the association between frequency of challenges and relational quality?

RQ2: Will dyadic coping mediate the association between the interaction of stress with frequency of challenge and relational quality?
Whereas research consistently supports the existence of a positive relationship between dyadic coping and relational quality, the relationship between individual-level coping and relational quality is more nuanced, contingent on the strategies in which partners engage when coping with stress. In the context of mental health conditions, studies concerning the outcomes of partner coping conclude that avoidance (Boeding et al., 2013; Fredman et al., 2014; Goossens et al., 2008; Zaider et al., 2010) and hostility (e.g., criticism; Boeding et al., 2013; Baucom et al, 2012; Kronmüller et al, 2011) towards the individual and his or her symptoms are associated with lower relational quality in partners whose significant other has a mental health condition. Meanwhile, primarily qualitative studies show that the use humor (Lawn & McMahon, 2014; van der Voort et al, 2009), positive reappraisals (Seeman, 2012; van der Voort et al, 2009), and engaging in shared activities with their significant other (Baucom et al, 2012; van der Voort et al, 2009) are all strategies that help partners to alleviate their pressure from the challenges and feel more positively about the relationship.

One form of avoidant coping that research has associated with lower relational quality in a number of previous studies is partners’ accommodation of their significant other’s symptoms, e.g., enabling the compulsions of a significant other who has Obsessive Compulsive Disorder (OCD). Compulsions are repeated and ritualistic behaviors that are grounded in irrational or exaggerated fears (e.g., repeatedly checking the stove to verify that it is turned off to prevent a fire). Partners who accommodate symptoms are those who allow their significant other to enact their compulsions, as well as those who enact the compulsions themselves in order to satisfy their significant other’s impulse. Studies have linked accommodation of symptoms and other avoidant coping
strategies with greater distress and lower relational quality in partners of a significant 
other with either anxiety or depressive disorders (Boeding et al., 2013; Goossens et al., 
2008; Zaider et al., 2010). For example, Boeding and colleagues (2013) found that 
partners who accommodated the OCD-related compulsions of their significant other felt 
less adjusted to the relationships than partners who did not accommodate these 
compulsions. This finding is consistent other studies (Baucom et al., 2012), including 
Fredman and colleagues’ (2014) study of couples facing a significant other’s PTSD. 
Authors of these studies concur that accommodation constitutes an avoidant coping 
strategy that ignores the underlying problem and that, for this reason, it is harmful for the 
relationship in the long term (Baucom et al., 2012; Boeding et al., 2013; Fredman et al., 
2014). In fact, it is possible that this strategy (i.e., symptom accommodation) actually 
contributes to the underlying problem and, thus, to partners’ stress. Indeed, Boeding and 
colleagues (2013) suggested that partner accommodation of their significant other’s 
symptoms can contribute to the maintenance and exacerbation of said symptoms 
(Boeding et al., 2013). This potential for maintenance and exacerbation of symptoms can, 
therefore, increase the potential for future stress and stress build up in the relationship. 

Similarly, Boeding and colleagues’ (2013) study of couples in which a member of 
the relationship had OCD found that when partners accommodated their significant 
other’s OCD symptoms they became frustrated over time, leading them to be more 
critical and hostile towards the significant other. Of note, partners who are more hostile 
and critical towards their significant other with the mental health condition are also the 
partners who are less satisfied with the relationship, although there is no consensus about 
the causality (Boeding et al., 2013; Baucom et al., 2012; Fredman et al., 2014;
Kronmüller et al., 2011). Although it might be that partners who are less satisfied are more willing to be hostile, or less motivated not to be hostile, it is also possible that when partners are more hostile towards their significant other, this presumably leads to negative responses from the significant other, as Thompson & Vangelisti, 2014 suggested in the context of unmet relational standards, and this in turn makes partners less satisfied with the relationship.

Fredman and colleagues (2014) found similar results in their study of couples facing a partner’s PTSD. This research suggests that partners in this study will engage in different coping strategies in response to their stress and, in turn, partners’ strategies for coping will explain why changes in experienced stress lead to changes in relational quality.

\textit{H5: Partner's individual coping will mediate the association between stress and relational quality.}

\textit{RQ3: Will partner's individual coping mediate the association between frequency of challenges and relational quality?}

\textit{RQ4: Will partner's individual coping mediate the association between the interaction of stress with frequency of challenge and relational quality?}

Figure 1 shows the different hypotheses and research questions that I have proposed up to this point.
In reality, partners probably engage in more than one coping strategy in response to stress (Lazarus, 1966, 1999; Lazarus & Folkman, 1984; Thompson & Vangelisti, 2014). Moreover, they are likely to engage in both individual and dyadic coping to manage this stress (Herzberg, 2013). Consequently, in line with previous studies, it is reasonable to expect that juxtaposing individual and dyadic coping (Herzberg, 2013) and different individual coping strategies (Thompson & Vangelisti, 2014) in the model provides a more rounded and realistic picture of the association between the independent variables (e.g., stress, frequency of challenges, and interaction of stress and frequency of challenges) and relational quality, and the extent to which these associations are mediated.
by coping. Thus, I constructed a multiple mediation model with dyadic and individual coping in order to respond to the following questions:

In a multiple mediation model:

**RQ5:** What dyadic and individual coping strategies mediate the association between stress and relational quality?

**RQ6:** What dyadic and individual coping strategies mediate the association between frequency of challenges and relational quality?

**RQ7:** What dyadic and individual coping strategies mediate the association between the interaction of stress with frequency of challenges and relational quality?

In short, studies support the potential of the stress and coping framework to explain the difference in the relational quality among the partners whose significant other has a mental health condition. However, the literature needs further and systematic assessment of the role that stress and coping, both dyadic and individual, play for relational quality in the context of couples managing mental health conditions. In their study testing the mediating role of intimacy behaviors in explaining the relationship between depression and decreased relationship satisfaction in the (non-depressed) partner, Finkbeiner and colleagues (2013) found that when female partners experiencing depression engaged in less intimate behaviors, the non-depressed male partner also engaged in less intimate behaviors and reported less satisfaction with the relationship (Finkbeiner et al., 2013). In discussing their results, they acknowledge that these patterns of intimacy potentially lead to relationship distress and encourage researchers to “…assess how individuals react …to uncover processes that may influence…relationship satisfaction” (Finkbeiner et al., 2013, p. 419). This study answered this call to understand
how coping mediates the relationship between stress and relationship satisfaction, identifying the more or less effective ways of coping for relational quality.
Chapter 3: Methodology

Study Design and Recruitment Protocol

I designed a cross-sectional study via online surveys, in which I targeted adult (romantic) partners whose significant other has a mental health condition, who are aware of their significant other’s mental health condition, and who were living in the U.S at the time of recruitment. The study focuses on adult partners specifically because it is during adulthood that romantic relationships become central to interpersonal lives, garnering more attention than peer and family relationships (Seiffge-Krenke, Overbeek, & Vermulst, 2010). Moreover, in adulthood “…romantic partners assume the highest position in the support-provider hierarchy” surpassing parents and close friends (Beyers & Seiffge-Krenke, 2007; Seiffge-Krenke et al., 2010; Seiffge-Krenke, 2003).

I subjected the project to approval by Ohio University Institutional Review Board (IRB) before I started recruitment, complying with standards for protection of human subjects, and received IRB approval on March 16th of 2015. After I received IRB approval, I constructed the online survey instrument through Qualtrics. Then, I programmed Qualtrics to give participants a unique survey completion code after they reached the end of the survey, which allowed them to collect the compensation for their participation. Following, I convened participants through Amazon Mechanical Turk’s (Mturk) recruiter platform, a web crowdsourcing service that serves as an intermediary between researchers or employers (e.g., businesses) and individuals interested in completing tasks in exchange for monetary compensation (Chandler, Mueller, & Paolacci, 2014; Simcox & Fiez, 2014). I selected Mturk as a medium for recruitment for three reasons: a) to improve the study’s ecological validity through a sample that was
more representative of the U.S. population than a college student sample or a localized community sample; b) to get a higher response quality than that of a typical sample of college students; and c) to increase the reach of the survey and therefore decrease time spent on recruitment and collection. Concerning the first reason, evidence shows that samples obtained from this medium are more diverse and more representative of the general U.S. population, when compared to traditional participant pools (e.g., college students) (Chandler et al., 2014; Simcox & Fiez, 2014). Demographic information about participants in this study is available later in this section. In relation to the second reason, there is evidence suggesting that this channel is associated with better response quality (Chandler et al., 2014; Simcox & Fiez, 2014). As Chandler and colleagues (2014) indicate, “...investigations of crowdsourcing (all investigating MTurk in particular) have demonstrated that online populations...produce data of equal or better quality than do more traditional participant pools in a variety of domains, including social psychology” (pp. 2).

After I constructed, set up, and activated the survey, I posted the survey link on the MTurk platform. In doing so, I posted the link after a brief description of the study and the consent form associated it (see Appendix 2). In the description of the study, I specified that I was looking for romantic partners whose significant other has a mental health condition and know that their partner has the condition. I made this specification in order to minimize the possibility that third parties (e.g., family members) would refer partners whose significant other does have a mental health condition, but who do not know this, to take the survey. I also instructed potential participants that they should access the link only if they agreed to participate in the study, and I encouraged them to
select alternative tasks if they were not interested in participating. Additionally, I reminded participants that I welcomed any questions, and that their participation was voluntary at all times of the process. Finally, I mentioned that individuals who wanted to participate had to click on the link that was below the consent form, which directed them to the survey instrument.

The questionnaire starts with two control questions to screen participants for the study’s inclusion criteria (i.e., in a romantic relationship and significant other has a mental health condition). Specifically, the first two questions in the instrument are: “Are you currently in romantic relationship?” and “Does your partner have any one (or more) of the following mental health conditions? Please select the one(s) that apply.” I included these two questions in case potential participants had not paid attention to the description of the study. I programmed Qualtrics to direct out of the survey participants who indicated either that they were not in a romantic relationship or that their partner did not have a mental health condition. Because the study was open to partners of individuals with any mental health conditions and not only those listed, the second question includes the option “Other? Please specify”.

**Sample Characteristics and Data Screening**

**Sample characteristics.** The resulting sample consists of 325 participants. In terms of educational attainment, 97 (29.8%) participants, about a third of all participants, do not have a high-school degree; 33 (10.2%), more than a tenth, have up to a high-school degree; 55 (16.9%) have some higher education but not a college-level degree; 37 (11.4%) have a two-year college-level degree; 19 (5.85%) have a Master’s degree; and seven participants (2.2%) have a doctoral degree. Broadly speaking, 195 participants
(60%) have at least some exposure to college-level education, and 26 (8%) have some form of graduate-level education. In relation to racial identification, most participants self-identified as White/Caucasian (n = 185, 56.9%), followed by African-American (n = 38, 11.7%), Hispanic (n = 30, 9.2%), Asian (n = 24, 7.4%), Native American (n = 14, 4.3%), Pacific Islander (n = 12, 3.7%), and other (n = 6, 1.8%). Sixteen participants (4.9%) did not provide any racial identification. The mean age of the participants in the sample is slightly over thirty years old (M = 30.37) and most participants in the sample are emerging adults or young adults. Specifically, 165 (50.8%) participants are between 18 and 26, and 193 of them (59.4%) are less than 30 years old. From this information, it is visible that the sample is negatively skewed with respect to age, given that the sample mean is to the right of the sample median and mode. Most participants are married with children (n = 106, 32.6%), followed by single and no children (n = 76, 23.4%), life-partners and no children (n = 56, 17.2%), married and no children (n = 38, 11.7%), life-partners with children (n = 18, 5.5%), and, finally, the rest of the participants (n = 16, 4.9%) are single with children. At the time of the survey, 144 participants (44.31%) were legally married and 140 participants (43.1%) had children. Close to a fifth of participants, (n = 15, 4.6%) chose not to report their family structure.

**Data screening.** I removed any identifying information from the data before I began the analyses, particularly Mturk worker ID and IP addresses, in line with standard research procedures for protection of confidentiality (see Chadwick, 2014a guidelines). Then, I searched for missing data points in the SPSS file (cases with missing points = 31, variables with missing points = 4) in order to detect issues with respondents, as well as issues in the items or variables (Chadwick, 2014b; Kline, 2011; Osborne, 2013). I deleted
participants who had missing points in variables that are part of the models. In this case, one participant did not respond to one of the items on the instrumental support scale of the BRIEF cope inventory for individual coping strategies. I excluded this participant from further analyses because coping strategies are central to the study’s models and because the instrumental support scale only has two items. Notably, this participant did not report their family structure either. I found missing data points in the following variables as well: a) race (n = 16), b) family structure (n = 14), and c) relational length (n = 2), some of the missing points overlapping in the same participants. However, I included in the analyses participants who did not answer to one or more of these three questions because these questions are not included in the study’s models.

After I dealt with missing data points in the data, I identified univariate outliers in the data ($Z > |3.00|$) (Chadwick, 2014b; Osborne, 2013b), and I made decisions on whether to delete them on a case by case basis. Ultimately, I deleted nine participants from the analyses of outliers. In particular, I deleted those who had a $Z$ score higher than $|3.00|$ in more than one variable, and those who had a $Z$ score higher than $|4.00|$ in any given variable. Finally, I conducted an ocular test to identify participants who responded uniformly across items, but I did not find such cases. In sum, I identified potential problems with the sample by: a) screening for missing cases, b) identifying outliers, and c) doing an ocular test in case there were obvious “unmotivated” respondents. I also included an attention check asking them to select “Almost always, more than 90% of the time” for that question, which all participants passed. As a result of these four procedures, I deleted a total of 10 cases from the database. The final sample consists of 315 participants.
Description of Measures and Scale Analyses

**Stress.** I measured partners’ stress using an adaptation of Lazarus and Folkman (1984)’s classification of emotions (e.g., Mooney, 2013). I use negative emotions as proxy for stress because emotions are central components of the experience of stress (Lazarus & Folkman, 1984; Mooney, 2013). Specifically, personally relevant occurrences or changes in the environment are what activates both stress and emotions (Frijda, 1993; Lazarus & Folkman, 1984). Moreover, the experience of stress is always accompanied and shaped by the presence of different emotions, which result from and inform appraisals about the subjective valence of the stressful situation and about its specific relation to the subject goals (Lazarus, 1966; Lazarus & Folkman, 1984; Lazarus, 1999). I first asked participants to think about challenges associated with their significant other’s mental health condition, and then I asked them to report how much they experienced each of the nine emotions included in the scale (i.e., anger, anxiety, fright, sadness, shame, disgust, envy, and jealousy) as a result of those challenges. In particular I asked participants to, on a seven-point scale (1 = Almost never to 7 = Almost always, more than 90% of the time), “Please indicate...how often do you feel each of the following emotions when you are facing a challenging aspect of your partner’s mental health condition.” I preface each emotion with the statement “I feel (emotion/stress) when I am in that kind of situation.” I computed scores for this scale by calculating the mean of the nine items. See Table 1 for scale descriptive statistics.

**Coping.** This study assumes that individuals in a romantic relationship cope with stress at two levels, individually and dyadically. As such, I measured coping using two instruments: an adaptation of the brief version of the COPE Inventory (Carver, 1997),
and a shorter adaptation of the Dyadic Coping Inventory (Meier, Bodenmann, Mörgeli, & Jenewein, 2011). I asked participants to think about challenges associated with their partner’s mental health condition, before responding to each inventory and then I asked them to report how commonly they respond to the challenge in the ways listed. I asked participants to report on their use of the coping strategies on a seven-point scale (1 = Almost never to 7 = Almost always, more than 90% of the time). I evaluated the extent to which both partners engage in dyadic coping with the common coping subscale of Meier et al.’s (2011) dyadic coping inventory (e.g., “We engage in a serious discussion about the problem and think through what has to be done”). Participants in the sample report that they engage in intermediate levels of dyadic coping with their partner, on average, based on the scale’s descriptive statistics.

I included eight of ten subscales from the brief COPE measure in the survey, to evaluate individual coping. The brief COPE consists of ten subscales, each one representing a potential strategy for coping, namely: self-distraction (e.g., “I turn to work or other activities to take my mind off things”), active coping (e.g., “I concentrate my efforts on doing something about the situation I’m in.”), denial (e.g., “I refuse to believe that it has happened.”), use of emotional support (e.g., “I get emotional support from others.”), use of instrumental support (e.g., “I get help and advice from other people.”), behavioral disengagement (e.g., “I give up trying to deal with it.”), venting (e.g., “I say things to let my unpleasant feelings escape.”), positive reframing (e.g., “I try to see it in a different light, to make it seem more positive.”), planning (e.g., “I think hard about what steps to take.”), humor (e.g., “I make fun of the situation.”), and acceptance (e.g., “I accept the reality of the fact that it has happened.”), excluded from the analyses due to low
reliability), religion (e.g., “I try to find comfort in my religion or spiritual beliefs.”), self-blame (e.g., “I blame myself for things that happened.”).

I did not collect information from the participants on coping through either religion or denial because they are similar to other strategies, and therefore potentially redundant. Denial, for instance, is a form of avoidant coping, similar to self-distraction. Religion is a form of emotion-focused approach coping, similar to seeking emotional support. Although I acknowledge the conceptual and practical distinctness of these two coping strategies, including religion and denial was not central to the purpose of the study, which is to identify the role that dyadic and individual coping play in mediating the association between stress and relational quality in partners of individuals with mental health conditions, rather than to be exhaustive in covering every possible coping strategy that partners could use. Once we better understand the role that coping plays in the association between stress and relationship quality, future studies can replicate these findings in the context of specific coping strategies of interest. I computed scores for both dyadic and individual coping by calculating the mean of their items. Table 1 contains descriptive statistics for the coping strategies in the study.

**Frequency of challenges.** I measured frequency of challenge with one item I created for this study. I asked participants in this study to report how often they faced a challenging aspect associated with their significant other’s mental health condition. I first asked participants to please describe what aspect of their significant other’s condition is most challenging. After responding to this open-ended item, I asked them to respond to the question, “How commonly would you say that you encounter the challenge?”
Participants rated this item on a seven-point scale (1 = Not at all to 7 = Extremely), and their score was equal to their selection.

**Relational quality.** I assessed relational quality with the Positive-Negative Relationship Quality Scale (PNRQ; Fincham & Rogge, 2013). It is helpful to assess a relationship both in terms of how negative individuals perceive it to be (with more negativity signifying worse relational quality) and in terms of how positive individuals perceive it to be (Zaider et al., 2010). This is because even if two individuals experience the same level of negativity in their relationship, one might perceive their relationship to be of higher quality than the other one, if they experience a higher level of positivity in the relationship. Thus, I asked participants in this study to report to what extent did positive qualities (four items; pleasant, strong, alive, and enjoyable) and negative qualities (four items; bad, miserable, empty, and lifeless) characterized their relationship.

When I asked participants to evaluate their relationship in terms of positive qualities, I first specified: “Considering only the positive qualities of your relationship and IGNORING the negative ones, evaluate your relationship on the following qualities.” Similarly, when I asked participants to evaluate their relationship in terms of negative qualities: “Considering only the negative qualities of your relationship and IGNORING the positive ones, evaluate your relationship on the following qualities.” Participants answered all items on a seven-point scale (1 = Not at all to 7 = Extremely). I computed scores for this scale by calculating the mean of the items that comprise it. See Table 1 for descriptive statistics.
Table 1: Descriptive Statistics for Scales

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Notes:

*Scales with a reliability score lower than .7 were not computed and were excluded from subsequent analyses.
Chapter 4: Findings

Preliminary Analyses

Descriptive analyses. In this study, the frequency of challenges associated with the mental health condition is high-intermediate (scale of one to seven; M = 4.27, SD = 1.32). On average, participants in this sample experience the most challenging aspect of their significant other’s mental health condition between sometimes and frequently. The degree of stress that participants experience due to the challenges of their significant other’s mental health conditions is, on the other hand, low to intermediate (scale of one to seven; M = 2.5, SD = 0.87), with a maximum of 5.33 among participants in this sample. Moreover, participants experience stress within a relatively narrow range (5.33), as indicated by a SD which is lower than the double of the scale’s crude range (i.e., 1.2). The relational quality of participants in the sample is intermediate to high, with the average participant reporting that their relationship was represented by positive qualities mostly and by negative qualities only a little bit (scale of one to seven; M = 5.23, SD = 1.25). Participants’ scores on relational quality showed acceptable variance, unlike it happened in the case of stress. In terms of coping strategies, Table 1 shows that on average, participants report to use planning, active coping, and dyadic coping, more commonly than the other coping strategies (in that order). The next two most commonly used strategies are reframing and self-distraction, followed by instrumental support and venting. Lastly, participants in this study report coping less commonly through humor, behavioral disengagement, and self-blame (in that order).
Correlations. I estimated Pearson’s product moment correlations among the variables (See Table 2) in order to assess the linear association between the variables in the mediation model. That is, I estimated correlations to test the associations: between stress and relational quality; between frequency of challenges and relational quality; between stress and coping; and between coping and relational quality. Correlations support the negative association between stress and relational quality \((r = -.46, p < .001)\), as well as the negative association between frequency of challenges and relational quality \((r = -.25, p < .01)\), but not the association between the interaction of stress with frequency of challenges and relational quality \((r = -.11, p = .05)\). Further, correlations provide support for an association between dyadic coping and stress \((r = -.19, p < .01)\); dyadic coping and frequency of challenges \((r = -.19, p < .01)\); dyadic coping and the interaction of stress with frequency of challenges \((r = -.12, p < .05)\); and dyadic coping and relational quality \((r = .56, p < .01)\).

Additionally, correlations show statistically significant associations between stress and five of the nine individual coping strategies. In particular, there are linear associations between stress and using humor \((r = .11, p < .05)\); stress and instrumental support \((r = .11, p < .05)\); stress and self-distraction \((r = .34, p < .01)\); stress and behavioral disengagement \((r = .41, p < .01)\); stress and venting \((r = .36, p < .01)\); and stress and self-blame \((r = .45, p < .01)\). On the other hand, correlations reveal no significant linear associations between stress and planning \((r = .03, p = .64)\); stress and active coping \((r = .02, p = .72)\); stress and seeking emotional support \((r = .09, p = .13)\); and stress and reframing \((r = .08, p = .18)\). Because there is no evidence for an association between stress and planning, active coping, seeking emotional support, and...
reframing, there is no support that these coping strategies mediate the association between stress and relational quality. Thus, they are not included in the main analyses below.

Correlation analyses support significant associations between relational quality and six of the nine individual coping strategies. Specifically, relational quality is significantly correlated with self-distraction ($r = -.26, p < .01$), behavioral disengagement ($r = -.48, p < .01$); venting ($r = -.24, p < .01$), self-blame ($r = -.35, p < .01$), planning ($r = -.24, p < .01$), active coping ($r = .25, p < .01$), and reframing ($r = .33, p < .01$).

Conversely, analyses do not show support for an association between relational quality and either using humor ($r = -.01, p = .79$), seeking instrumental support ($r = .09, p = .11$), or seeking emotional support ($r = .06, p = .33$). Given that there is no support for an association between relational quality and humor, seeking instrumental support, or seeking emotional support, these three coping strategies cannot mediate the association between stress and relational quality. Still, keeping in mind that one of the exogenous variables could be suppressing the association between these coping strategies and relational quality, and that correlations show that seeking instrumental support is significantly associated with stress, instrumental support is included in the analyses below. Conversely, humor and seeking emotional support are not included in the analyses below because they were not significantly associated with stress, and therefore cannot mediate its association with relational quality. In short, given evidence from the correlations, there is evidence to hypothesize that only four of the nine individual coping strategies mediate the association between stress and relational quality: venting, behavioral disengagement, self-distraction, and self-blame and there is conflicting
evidence about whether seeking instrumental support mediates the association between stress and relational quality or not.
Table 2: Correlations among Variables in the Model

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*Significant at the .05 level
**Significant at the .01 level
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Notes: \*p < .05, **p < .01, ***p < .001
Main Analyses

I tested hypotheses and research questions using maximum likelihood procedures within structural equation modeling software, SPSS Amos 23.0. Structural equation modeling is a sub-type of path analysis, and more generally of multivariate regression, which allows for simultaneous estimation of indirect and direct effects, as well as for the inclusion of both latent and observed variables within the same model (Hayes, 2013; Kline, 2011). I also programmed the software to do bootstrapping, a resampling technique to test the reliability of the parameters, with 5000 iterations and the confidence intervals at 95% (as recommended by Kline, 2011). Before I conducted the analyses, I estimated a correlation matrix for the variables in SPSS 23 and then used the matrix as data input to Amos. In the remainder of this section, I report path coefficients in standardized terms, both in the text and in the figures, in order to allow the reader to compare the effect sizes of different variables within a given model (Kline, 2011). I used the standard 95% level of significance in conjunction with effect sizes, to evaluate statistical evidence supporting (or not) the study’s hypotheses.

For H1 – H5 and RQ1 – RQ4, I constructed simple mediation models which, in this study, are saturated or have no degrees of freedom, and thus have “perfect fit”. For the final multiple mediation model (RQ5 – RQ7), I evaluated the model’s fit with the data using three different criteria that Kline (2011) outlines: non-significant chi-square, comparative fit index greater than (CFI) .95, and root mean square error of approximation (RMSEA) less than .08. In other words, if the chi-square was non-
significant, CFI > .95, and RMSEA < .08, then I conclude that the model has good fit with the data (Kline, 2011).

**Stress, frequency of challenges, and relational quality: H1 – H3.** In the model depicted in Figure 2, I assessed the extent to which stress is negatively associated with relational quality (H1); frequency of challenges is negatively associated with relational quality (H2); and frequency of challenges moderates the association between stress and relational quality (H3). Estimates of this model support all three hypotheses; stress and relational quality are negatively associated, controlling for H2 and H3 and frequency of challenges and relational quality are negatively associated, controlling for H1 and H3. Results also provided evidence that frequency of challenges moderates the association between stress and relational quality. A graphical representation (Figure 2) of this moderation reflects how the negative association between stress and relational quality becomes stronger as frequency of challenges increases. Put another way, frequency of challenges exacerbates the negative effect of stress on relational quality. In sum, estimates supported H1 - H3.

![Figure 2. Model without Coping Strategies with Standardized Direct Effects.](image)

*Notes: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$
Figure 3. Standardized Moderation of Frequency of Challenges in the Association between Stress and Relational Quality.

Notes:

The mediating role of dyadic coping: H4, RQ1, and RQ2. H4 predicts that dyadic coping mediates the association between stress and relational quality. Meanwhile, RQ1 asks whether dyadic coping mediates the association between relational quality and frequency of challenges. Finally, RQ2 inquires if dyadic coping mediates the association between the interaction of stress with frequency of challenges and relational quality. I constructed a model that incorporates H4, RQ1, and RQ2 and I estimated: the indirect effects of stress and frequency of challenges on relational quality through dyadic coping. I also estimated the indirect moderation of frequency of challenges in the association between stress and relational quality, through its moderation in the association between stress and dyadic coping. I picture results from the model in Figure 4, and it shows two non-significant paths--between
frequency of challenges and relational quality, and between the interaction of stress with frequency of challenges and relational quality--which were deleted one by one, beginning with the least significant path (Kline, 2011). In Figure 6, I present the results of the final model which shows acceptable fit with the data, $\chi^2 = 4.86, p = .30,\text{CFI} = 1.00, \text{RMSEA} = .03$.

The final model supports H4, as the standardized direct effects among stress, dyadic coping, and relational quality are significant (see Figure 4). Moreover, the model supports H4 by the significant indirect effect of stress on relational quality through dyadic coping, $\beta = -.08 p < .05$; 95% CIs [-.13, -.03]. Notably, the association between stress and relational quality remains significantly negative.

*Figure 4. Final Model for Dyadic Coping with Standardized Direct Effects. Notes: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$*
In response to RQ1, the final model shows that dyadic coping mediates the association between frequency of challenge and relational quality, as the standardized direct effects among frequency of challenges, dyadic coping, and relational quality are statistically significant (see Figure 4). Additionally, the indirect effect of frequency of challenges on relational quality is significant, $\beta = -.07; p < .05; 95\% \text{ CIs} [-.13, -.02]$.

To answer RQ2, the final model indicates that dyadic coping mediates the association between the interaction of stress with frequency of challenges and relational quality, as the standardized direct effects among the interaction of stress with frequency of challenges, dyadic coping, and relational quality are significant (see Figure 4) as is the indirect effect of the interaction of stress with frequency of challenges on relational quality, $\beta = -.05 p < .05; 95\% \text{ CIs} [-.11, -.01]$. In fact, model results suggest that dyadic coping fully mediates the association between frequency of challenges and relational quality, and between the interaction of stress with frequency of challenges and relational quality, given the statistical insignificance of the direct paths between both relational quality and frequency of challenges, $\beta = -.07 p = .08; 95\% \text{ CIs} [-.15, .01]$, and between relational quality and the interaction of stress with frequency of challenges, $\beta = -.05 p = .31; 95\% \text{ CIs} [-.14, .04]$.

Findings for the moderation of frequency of challenges are as explicated above for RQ2 and are depicted in Figure 4. Briefly, the negative relationship between stress and dyadic coping is stronger for those who report greater frequency of challenges. Put another way, as the frequency of challenges increases, individuals are less likely to engage in dyadic coping as a response to increasing stress. Importantly, results suggest that the moderating effect that frequency of challenge has on the
relationship between stress and relational quality only exists through the mediating influence of dyadic coping.

**The mediating role of individual coping: H5, RQ3, and RQ4.** H5 anticipates that individual coping mediates the association between stress and relational quality. Meanwhile, RQ3 asks whether individual coping mediates the association between frequency of challenges and relational quality. Finally, RQ4 inquires if individual coping mediates the association between the interaction of stress with frequency of challenges and relational quality. I constructed a model that incorporates H5, RQ3, and RQ4 and, for each of the five coping strategies that were significantly associated with stress in the correlations: instrumental support, venting, self-distraction, behavioral disengagement, and self-blame. For each of these five individual coping strategies I estimated the indirect effects of stress and frequency of challenges on relational quality through individual coping. Moreover, I estimated the indirect association of the interaction of stress with frequency of challenges and relational quality, though its association with individual coping. I picture results from the model in Figures 5-9, for instrumental support, venting, self-distraction, behavioral disengagement, and self-blame (in that order).

For H5, models show that instrumental support, venting, self-distraction and behavioral disengagement mediate the association between stress and relational quality, as standardized direct effects among stress, individual coping, and relational quality are significant for instrumental support (see Figure 5), venting (see Figure 6), self-distraction (see Figure 7), and behavioral disengagement (see Figure 8). Also, the models show significant indirect effects of stress on relational quality through
instrumental support, $\beta = .02 \ p < .05$; 95% CIs [.004, .05]; through venting, $\beta = -.08 \ p < .001$; 95% CIs [-.13, -.04]; through self-distraction, $\beta = -.04 \ p < .05$; 95% CIs [-.08, -.005]; and through behavioral disengagement, $\beta = -.13 \ p < .001$; 95% CIs [-.18, -.09]. However, the models do not support that self-blame mediates the association between stress and relational quality, as the standardized direct path between self-blame and relational quality is non-significant (see Figure 9) and the indirect effect of stress on relational quality through self-blame is also non-significant, $\beta = -.02; \ p = .42$; 95% CIs [-.07, .03]. Thus, individual models support that instrumental support, venting, self-distraction, and behavioral disengagement each, independently, mediate the association between stress and relational quality. On the other hand, tests indicate that self-blame does not mediate the association between stress and relational quality. Notably, in all cases, the negative association between stress and relational quality remains significant (see Figures 5–9).

To answer RQ3, models show that instrumental support and behavioral disengagement mediate the association between frequency of challenges and relational quality, as standardized direct effects among frequency of challenges, individual coping, and relational quality are significant for instrumental support (see Figure 5), and behavioral disengagement (see Figure 8). Also, the models show significant indirect effects of frequency of challenges on relational quality through instrumental support, $\beta = .02 \ p < .01$; 95% CIs [-.06, -.01], and through behavioral disengagement, $\beta = -.07 \ p < .001$; 95% CIs [-.11, -.03]. Conversely, the models do not support that any of the other three individual coping strategies mediate the association between frequency of challenges and relational quality, as the standardized direct
paths among frequency of challenges, individual coping, and relational quality are not significant for either venting (see Figure 6), self-distraction (see Figure 7), or self-blame (see Figure 9). Additionally, the indirect effect of frequency of challenges on relational is not significant through either venting, $\beta = -.01; p = .40; 95\% \text{ CIs } [-.04, .01]$; self-distraction, $\beta = .0; p = .37; 95\% \text{ CIs } [-.02, .01]$; or self-blame, $\beta = .0; p = .42; 95\% \text{ CIs } [.0, .01]$. Thus, individual models support that instrumental support and behavioral disengagement --but not venting, self-distraction, or self-blame-- each independently mediate the association between frequency of challenges and relational quality. Notably, in every case, the association between frequency of challenges and relational quality remains significant.

In response to RQ4, models show that venting mediates the association between the interaction of stress with frequency of challenges and relational quality, as standardized direct effects among the interaction of stress with frequency of challenges, individual coping, and relational quality are significant for venting (see Figure 6). Also, the model show significant indirect effects of the interaction of stress with frequency of challenges on relational quality through venting, $\beta = .02 p < .05; 95\% \text{ CIs } [.003, .05]$. On the other hand, the models do not support that any of the other four individual coping strategies mediate the association between the interaction of stress with frequency of challenges and relational quality, as the standardized direct paths among the interaction of stress with frequency of challenges, individual coping, and relational quality are not significant for either instrumental support (see Figure 5), self-distraction (see figure 7), behavioral disengagement (see Figure 8), or self-blame (see Figure 9). Also, the indirect effect of the interaction of stress with frequency of
challenges on relational quality is non-significant through each instrumental support, \( \beta = -.01 \ p = .12; \) 95% CIs [-.03, .00]; self-distraction, \( \beta = .00 \ p = .76; \) 95% CIs [-.01, .02]; behavioral disengagement, \( \beta = -.01 \ p = .52; \) 95% CIs [-.05, .02]; and self-blame, \( \beta = .00 \ p = .92; \) 95% CIs [-.01, .01]. Thus, individual models support that among the individual coping strategies only venting mediates the association between the interaction of stress with frequency of challenges and relational quality. Notably, the indirect effect of the interaction of stress with frequency of challenges on relational quality, through venting, is positive. This means that when the frequency of challenges increases, the negative association between stress and relational quality becomes slightly weaker, through the exacerbation of the association between stress and venting.

Figure 5. Model for Instrumental Support with Standardized Direct Effects. 
Notes: * \( p < 0.05 \), ** \( p < 0.01 \), *** \( p < 0.001 \)
Figure 6. Model for Venting with Standardized Direct Effects. 
Notes: * p < 0.05, ** p < 0.01, *** p < 0.001

Figure 7. Model for Self-Distraction with Standardized Direct Effects. 
Notes: * p < 0.05, ** p < 0.01, *** p < 0.001
The simultaneous mediating role of multiple coping strategies: RQ5 – RQ7.

I tested RQ5 – RQ7 through a multiple mediation model, where I include the coping strategies that significantly mediate the associations between relational quality and either stress, frequency of challenges, or the interaction of the two in the simple mediation models. Specifically, I include seeking instrumental support, venting, self-
distraction, behavioral disengagement, self-blame, and dyadic coping in a multiple mediation model, where I only drew paths that were significant in the simple mediation models. The model allows me to see which coping strategies mediate these associations after accounting for the influence of the other coping strategies included.

The multiple mediation model that I constructed based on the single mediator analyses has good fit with the data, $\chi^2 = 7.16; p = .62; \text{CFI} = 1.00; \text{RMSEA} = .00$ but it also has a few non-significant paths (Figure 10). First, instrumental support is no longer associated with relational in the omnibus model, $\beta = .02 \ p = .70; 95\% \text{ CIs} [-.13, .06]$, and neither is self-distraction, $\beta = -.04 \ p = .38; 95\% \text{ CIs} [-.13, .06]$, which suggests that in the simple mediation models other coping strategies confound estimates of standardized path coefficients and significance for the associations between relational quality and these two coping strategies. Also, in the multiple mediation model, the indirect effect of the interaction of stress with frequency of challenges and relational quality is not significant either, $\beta = -.03 \ p = .28; 95\% \text{ CIs} [-.08, .02]$. Therefore, the model shows that none of the coping strategies mediates the association between the interaction of stress with frequency of challenges and relational quality. Furthermore, this findings suggest that, contrary to hypothesis three, frequency of challenges does not strengthen the relationship between stress and frequency of challenges. In other words, although stress and frequency of challenges each are independently negatively associated with relational quality, they do not influence the relationship that the other one has with relational quality. Thus, one by one, I deleted the non-significant paths and variables from the model.
The final version of the omnibus model (Figure 11) has good fit with the data, \( \chi^2 = 2.16; p = .34; \) CFI = 1.00; RMSEA = .02. In relation to research question five, this model shows that stress has a significant and negative indirect association with relational quality through dyadic coping, behavioral disengagement, and venting mediate, as standardized direct effects among stress, coping, and relational quality are statistically significant for these three coping strategies (see Figures 10 and 11). Thus, when individuals are stressed this leads them to engage in more venting and behavioral disengagement and, at the same time, to engage in less dyadic coping. In turn, when individuals engage in more behavioral disengagement, more venting, and less dyadic coping in response to stress, their relational quality decreases. Also, findings show that the indirect effect of stress on relational quality was significant, \( \beta = -.16; p < .001; 95\% \text{ CIs } [-.23, -.10]. \)

In response to research question six, the omnibus model also shows that dyadic coping and behavioral disengagement fully mediate the association between frequency of challenges and relational quality, as standardized direct effects among frequency of challenges, coping, and relational quality are statistically significant for these two coping strategies (see Figures 10 and 11). Additionally, coefficients show a statistically significant indirect effect of frequency of challenges on relational quality, \( \beta = .09 \ p < .01; 95\% \text{ CIs } [-.14, -.03]. \)
Figure 10. Hypothesized Model for Both Dyadic Coping and Individual Coping with Standardized Direct Effects.
Notes: *p < 0.05, **p < 0.01, *** p < 0.001

Figure 11. Final Model for Both Dyadic Coping and Individual Coping with Standardized Direct Effects.
Notes: *p < 0.05, **p < 0.01, *** p < 0.001
Chapter 5: Discussion, Implications, and Future Directions

Overview of the Study

Many partners experience stress when their significant other has a mental health condition because these health conditions present many challenges for them, their significant other, and the relationship. Existing literature shows that stress can be detrimental for romantic relationships (Mooney, 2013; Thompson & Vangelisti, 2014; Zaider et al., 2011), especially when it occurs repeatedly (Afifi, Merrill, & Davis, 2015), such as it occurs for many couples managing mental health conditions. In light of these issues and the high prevalence of mental health conditions in the U.S, the major goal of this study was to show how stress and frequency of challenges associated with mental health conditions affect partners’ perceptions of relational quality. Specifically, this study focused on coping as a central process through which both stress and frequency of challenges can affect the relational quality of partners, combining Lazarus and Folkman’s (1984) framework of stress and coping, which Thompson and Vangelisti (2014) previously applied to the context of unmet relational standards, with Bodenmann and colleagues concept of dyadic coping (2000, 2005, 2008), which they applied previously to the context of Chronic Obstructive Pulmonary Disease (COPD). In particular, because individuals in a relationship are not isolated from their partners, I argued that partners not only cope by themselves, but also cope with their significant other. Moreover, they are often engaging in these two forms of coping at the same time.

Generally, results provide support for the hypotheses of this study. The degree of stress that partners experience due to challenges their significant other’s mental
health condition, and the frequency with which these challenges come up, do have negative associations with relational quality. Moreover, analyses show that three of ten coping strategies included in this study mediate the association between stress and relational quality (i.e., dyadic coping, venting, and behavioral disengagement) and that dyadic coping and behavioral disengagement fully mediate the association between frequency of challenges and relational quality. In the next section of this chapter, I discuss the findings of this study, one by one, in greater detail.

**Discussion of Findings**

**The negative association between stress and relational Quality: H1.** The first hypothesis of this study states that partners’ stress is negatively associated with their reports of relational quality. Both simple correlational and structural equation analyses support this hypothesis. Importantly, results show that this association persists, and continues to be strong, above and beyond the mediating role of individual and dyadic coping. There are at least three reasons why stress associated with a significant other’s mental health conditions could lead to lower evaluations of relational quality for partners.

The first reason why partners’ stress might be associated with lower relational quality is that some of the challenges of mental health conditions that partners find stressful might be directly related, or directly affect, relational dynamics, such as communication. If the ways in which individuals with mental health conditions act or respond to their condition are directly tied to other relational processes or activities, then the stress is relationship-specific, and this might affect partner’s relational quality above and beyond their coping (Finkbeiner et al., 2013). Finkbeiner and colleagues
(2013) found that when female partners experiencing depression engaged in less intimate behaviors, the non-depressed male partner reported less satisfaction with the relationship (Finkbeiner et al., 2013). It may also be the case that the more stressful the challenges, the less resources individuals with mental health conditions have to respond to these challenges effectively. This is particularly applicable to the case of individuals with mental health conditions, who, compared to the overall population, have lower emotional and social skills (Goldsmith, Chesney, Heath, & Barlow, 2013; Haynos, Roberto, & Attia, 2015), which might be required for coping with stressful situations. If significant others respond to their illness by complaining, seeking constant reassurance, becoming agitated, or engaging in other socially punished behaviors, this in itself might stress partners and affect their perceptions of relational quality, above and beyond how partners cope with these behaviors. Afifi and colleagues’ (2013) explain, for example, that research shows that “…When people verbally ruminate, it can adversely affect their social networks” (pp. 395). Thus, if individuals with mental health conditions increasingly engage in venting, partners might start feeling annoyed and, overtime, evaluate their relationships more negatively.

Moreover, the inability, unwillingness, or ineffectiveness of significant others with mental health conditions to deal with challenges, or their poor coping responses to such challenges could put stress on their partners, who subsequently become less satisfied with the relationship. For example, partners’ perceptions of their significant other’s difficulties dealing with challenges might leave partners feeling that their significant other is not investing effort and other resources into making the situation
better for them and for their relationship. Based on economic-driven theories, such as social exchange (Hommans, 1958) and equity theory (Adams, 1965), if partners perceive that their significant other is not investing effort into the situation and/or the relationship, this can leave them feeling dissatisfied with the relationship (Floyd, & Wasner, 1994), or like they are giving more than they are gaining. As results from this study confirm, partners are more likely to engage in venting (conceptually related to verbal rumination) as stress increases, likely because they become saturated or overwhelmed with negative emotion. In this way, partners may be evaluating their significant other more negatively, perceiving them to bring more stress into the relationship and seeing less advantages to having a relationship with this person.

Secondly, stressful circumstances and events demand the concentration and direction of valued resources (e.g., emotional, cognitive, and otherwise; Afifi et al., 2015, pp. 7) in order to cope with the demands that the stressful situation poses. Because challenges that cause stress require the occupation of these resources, fewer resources are available for relationship-enhancing activities, such as sharing tasks and spending time with shared social networks (Canary, & Stafford, 1992; Canary, Stafford, House, & Wallace, 1993; Canary, Stafford, & Semic, 2002; Stafford & Canary, 1991). Moreover, in the context of mental health conditions, many of which are chronic in nature and present repeated challenges, these resources will be strained on a continual basis. If couples fail to build reserves in the form of maintenance behaviors (e.g., complements, nice gestures, etc.) in their relationship during less stressful times, there are fewer emotional reserves to protect the relationship during times of stress (Afifi et al. 2015). As Afifi and colleagues (2015) argue in their
Theory of Resilience and Relational Load, “relationships can become fatigued and experience relational load due to chronic stress and repeated ‘hits’ to one’s emotional, psychological, and relational resources” (p. 6-7). These increases in stress may be particularly detrimental to the relationship if partners perceive their significant other as the source of stress.

Finally, as I noted in the methodology section, it may be the case that the coping strategies here included herein do not exhaust the list of possible ways in which partners cope with their stress. Therefore, coping might mediate a higher portion of the association between stress and relational quality than I am able to capture here. That is, other coping strategies not incorporated in this study could mediate an additional portion of the association between stress and relational quality. This might be particularly true for those coping strategies that partners direct at their significant other, such as criticism (Zaider et al., 2011), other hostile or punitive responses (e.g., Mooney, 2013; Thompson & Vangelisti, 2014), and excessive control at different levels (i.e., psychological, emotional, or physical). Studies show that many family members, including partners, are controlling and hostile towards individuals with mental health conditions. It is possible that hostile or otherwise hurtful coping that partners direct at their significant others ultimately make partners feel less satisfied because, as Thompson and Vangelisti (2014) suggest, these coping strategies might elicit responses from their significant others that are not productive for the relationship, such as withdrawal, hostility, and even active aggressiveness. This is particularly possible in the case of couples where one or both individuals have mental health conditions given that, as I indicated previously, mental health
conditions tend to be associated with difficulties with emotion regulation (Goldsmith, Chesney, Heath, & Barlow, 2013; Haynos, Roberto, & Attia, 2015). Also, a withdrawal coping strategy can be harmful to a relationship (Finkbeiner, Epstein, & Falconier, 2013) because it can decrease intimacy, a predictor of satisfaction in romantic relationships (Finkbeiner et al., 2013).

The negative association between frequency of challenges and relational quality: H2. This study’s second hypothesis stated that frequency of challenges is negatively associated with relational quality such that the more frequently partners face challenges due to their significant other’s mental health condition, the less satisfied they will be with their relationship. Correlational and structural equation analyses support this hypothesis, too, even after accounting for the association between stress and relational quality. That is, even if the degree of stress remains constant, increases in challenge frequency can have detrimental consequences for partners’ perceptions of relational quality. Generally, the explanations that I gave concerning why stress is negatively associated with relational quality largely apply to frequency of challenges as well. It is possible, for example, to make sense of this finding from an exchange perspective. This is because continuously having to manage challenges associated with their significant other’s mental health conditions might be dissatisfying, regardless of the level of stress associated with them, because it detracts from partners time and attention, and they might perceive this to impose a significant cost or burden in their daily lives. In turn, partners might feel that being in a romantic relationship with their significant other is the reason why they have to carry the burden or manage the difficulties, because partners might perceive that their
significant other is at least partly responsible for the challenges or, at a minimum, that these challenges are tied to their significant other. Therefore, partners might perceive that their relationship with their significant other makes their life more difficult. Consequently, as the frequency of challenges increases and demands partners to invest more resources, assuming that partners’ “raw gains” from the relationship are kept constant, the net gains from the relationship (subtracting the costs) will become smaller. Based on social exchange theory (Hammond, 1958), as partners’ perceived net gains from the relationship decrease their evaluation of the relationship will become less positive.

**The association between the interaction of stress with frequency of challenges and relational quality: H3, a test of moderation.** Hypothesis three posits that there is a significant association between the interaction of stress with frequency of challenges and relational quality, such that when the frequency of challenges due to the mental health condition increases the association between stress and relational quality becomes stronger. The direct path model (Figure 2) and the graphical representation of interaction effects (Figure 3) both provide support for this hypothesis. This means that stress is more damaging to the relational quality of partners who have to manage challenges frequently. I propose that frequency of challenges strengthens the association between stress and relational quality potentially because it can narrow partners’ opportunities and room to build and replenish emotional and relational resources that they have invested in dealing with previous stressors of mental health conditions. If more frequent challenges reduces the room for partners to engage in relational building and maintenance, it will then increase the
potential for stress to induce what Afifi and colleagues (2015) refer to as “an erosion in the communicative foundation of the relationship” (p. 4) and in the relational energy of partners. As a result of damaging relationships’ communicative foundation and partners’ relational energy, a greater frequency of challenges can boost the potential for stress to lead to maladaptive coping that may strain the relationship.

Specifically, Afifi and colleagues (2015) contend that when stress “hits” relationships repeatedly it can strain partners’ personal and relational resources and make partners become fatigued with the relationship if partners do not put work into building emotional reserves or capital in their relationship that can help them feel safer when difficulties arise, and more comfortable approaching difficulties as a team (p. 7). Still, relational maintenance held constant, one can infer that the more frequent challenges are, the lower the room that partners have to recover from managing previous challenges and, thus, the more rapidly these challenges can drain the resources that partners have to approach them. Moreover, the more frequent these challenges are, the less room will partners and their significant others have to engage in relational building and maintenance, and to replenish the emotional reserves that they have invested in managing the challenges. As a result of this, the more frequent challenges are, and the greater the reduction in partners’ opportunities to replenish these emotional and relational resources, the higher will be the risk for their relationship to become strained.

Surprisingly, the multiple mediation model did not provide evidence to support hypothesis three. That is, estimates from the multiple mediation model indicate that frequency of challenges does not moderate the association between stress
and relational quality. Presumably, venting and dyadic coping confounded the association between the interaction of stress with frequency of challenges and relational quality, rather than mediating it. This result was unexpected given that, as I mentioned earlier in this section, previous research suggests that when stressful situations are repetitive, their potential to hinder relationships is greater (Afifi et al. 2015). Perhaps a greater frequency of challenges only begins to exacerbate the detrimental association between stress and relational quality when partners’ stress reaches a certain level, and it was thus not visible in the findings of this study because partners in this sample experienced fairly low levels of stress due to the challenges of their significant other’s mental health condition and had relatively high levels of perceived relational quality. Alternatively, the moderating influence of frequency of challenges on the association between stress and relational quality might have a curvilinear shape, such that it has an insignificant effect at low levels of stress, and an increasingly significant effect at higher levels of stress. If this is the case, the analyses might not have detected this moderation because partners in this study experienced on average low levels of stress. This finding warrants further investigation.

**The mediating role of dyadic coping: H4, RQ1, and RQ2.** This study hypothesized that dyadic coping mediates the association between stress and relational quality (H4), and it asked whether it would mediate the association between frequency of challenges and relational quality (RQ1) and between the interaction of stress with frequency of challenges and relational quality (RQ2).

Both the simple and multiple mediation models support the hypothesis that dyadic coping mediates the association between stress and relational quality. In
particular, the findings from this study show that stress associated with a significant other’s mental health condition is negatively related to dyadic coping, which in turn is positively associated with relational quality, making the overall indirect and the overall total effects of stress on relational quality negative.

The finding that dyadic coping is positively associated with relational quality is not surprising, given previous findings in the literature on dyadic coping (Levesque, Lafontaine, Carona, Flescha, Bjornson, 2014) and, more generally, the literature on communal coping and couples’ thriving and resilience (Afifi et al., 2015; Lyons, Mickelson, Sullivan, & Coyne, 1998), which suggest that couples who perceive challenges as joint and approach challenges together have more successful relationships than those who do not. As a popular Spanish phrase celebrates, “Union is strength”. Having a partner who “has your back” likely makes significant others (with the mental health condition) feel more supported and secure, which in turn may cause them to behave more positive towards their partner, leading partners to experience a higher relational quality—other variables equal. In general, approaching difficulties together may be an opportunity to build and strengthen in the relationship (Finkbeiner et al., 2013).

The finding that stress is negatively associated with dyadic coping is, however, less obvious. Why is it that greater stress is associated with lower levels of dyadic coping? One explanation is related to Afifi and colleagues’ (2015) argument that avoiding and countering an overload of stress in a relationship requires partners to consciously and willingly put forth efforts. In as much as dyadic coping requires coordination and cohesion between partners, dyadic coping may require more effort
than individually-based coping strategies. As stress increases, the resources that partners have available to engage in dyadic coping might become scarce, and they might become more cognitively and emotionally overburdened. In turn, they might default to less productive, but also less effortful strategies, such as venting. Even more, partners might become so overwhelmed by stress that they actively decide to quit any attempt to cope, thus, completely disengaging from the challenges, their significant other, and even the relationship.

Simple and multiple mediation models also showed that dyadic coping mediates the association between frequency of challenges and relational quality (RQ1), such that when challenges are more frequent partners engage less in dyadic coping, and this in turn leads them to perceive lower relational quality. There are at least two potential reasons why a greater frequency of challenges could lead partners to engage in less dyadic coping.

First, similarly to my argument for the negative association between frequency of challenges and relational quality, it is possible that partners who experience challenges more frequently see the relationship as more costly and less beneficial than those who experience fewer challenges, and therefore see fewer incentives to investing effort into their relationship, such as the effort that is required to engage in dyadic coping. This is particularly possible if partners perceive that challenges are frequent because their significant other is not investing enough effort into improving their condition, their behavior, or the relationship. As such, they may perceive the relationship as an inequitable one not worth their investment of time, energy, and effort.
The second explanation is consistent with my argument for the negative association between the interaction of stress with frequency of challenges and relational quality. In particular, it is possible that partners who face challenges more frequently have less emotional, personal, and relational resources to engage in dyadic coping, rather than not being motivated to do so. This is because, as I had previously mentioned, partners who have to manage challenges more frequently engage in less dyadic coping is because, as a result of frequently managing challenges, they have had less time to recover personal (e.g., energy, emotional) and relational resources (e.g., intimacy, certainty). Consequently, partners who face challenges more frequently are, all else equal, more likely to be “in short supply” of these personal and relational resources than partners who seldom face challenges, and thus have less resources to invest in doing dyadic coping.

In relation to RQ2, the simple mediation model shows that dyadic coping mediates the association between the interaction of stress with frequency of challenges and dyadic coping. However, the multiple mediation model suggests that, although the association between the interaction of stress with frequency of challenges and dyadic coping is significant, the indirect effect of the interaction of these two variables on relational quality through dyadic coping is not significant. That is, findings of the multiple mediation model indicate that dyadic coping does not mediate the association between the interaction of stress with frequency of challenges and relational quality. In fact, as noted previously, when accounting for the mediating influences and associations of other coping strategies, frequency of challenges did not strengthen the association between stress and relational quality, but they rather
predicted relational quality independently. Still, the fact that the standardized path coefficient connecting the interaction of stress with frequency of challenges and dyadic coping was significant suggests that frequency of challenges does make the negative association between stress and dyadic coping stronger. In other words, the more frequent challenges are, the more negatively stress is associated with dyadic coping. The potential reasons for this are similar to those articulated when explaining the mediating influence of dyadic coping in the association between each stress and frequency of challenges and relational quality.

**The mediating role of individual coping: H5, RQ3, and RQ4.** Concerning H5, four of the nine individual coping strategies included in this study significantly mediate the association between stress and relational quality in the simple mediation models. These strategies are: behavioral disengagement, venting, self-distraction, and seeking instrumental support. Two of these strategies are avoidant coping strategies (e.g., venting and self-distraction), which is notable because research has associated avoidant coping strategies with lower mental health (Mooney, 2013) and with lower relational satisfaction (Mooney, 2013; Zaider et al., 2010). Meanwhile, in the simple mediation models, two individual coping strategies (i.e., behavioral disengagement) significantly mediate the association between frequency of challenges and relational quality (RQ3), and one individual coping strategy (i.e., venting) significantly mediates the association between the interaction of stress with frequency of challenges and relational quality (RQ4).

However, in the omnibus model, only two individual coping strategies (i.e., behavioral disengagement and venting) significantly mediate the association between
stress and relational quality, one individual coping strategy (i.e., behavioral disengagement) significantly mediates the association between frequency of challenges and relational quality, and no individual coping strategies mediate the association between the interaction of stress and relational quality. Moreover, the previously observed association between relational quality and instrumental support and self-distraction is no longer significant in the multiple mediation model. The latter suggests that the apparent mediating role of these two strategies on relational quality was a statistical artifact, resulting from co-variance of each of these two strategies with other coping strategies (e.g., behavioral disengagement and self-distraction) that did have an association with relational quality. However, it might also be the case that these two strategies do have a significant association with relational quality, and a significant mediating role in its association with stress, which this study does not have enough power to capture with the number of variables included in the model.

Following, I will discuss the possible explanation behind the mediating role of venting and behavioral disengagement on the association between stress and relational quality, which is significant even in the omnibus model.

Analyses show that venting mediates the association between stress and relational quality such that partners who are more stressed vent more, and partners who vent more experience less relational quality. Research shows that, when used in excess, venting can lead to more negativity and anxiety (Starr & Davila, 2009), reduce mental wellbeing (Starr & Davila, 2009), and even cause relational problems or distance, particularly when it elicits poor social support or negative responses (Afifi et al., 2013). As suggested previously, the fact that partners vent more when as they
become more stressed might be the result of becoming overloaded with so much stress and negative emotions that they need an outlet for those feelings. Importantly, repetitive venting (i.e., verbal rumination) might then lead to cognitive rumination or excessively focusing on negative emotions of the situation (Afifi et al., 2013). Rumination could cause partners to become increasingly dissatisfied with their relationship (Afifi, Joseph, & Aldeis, 2012), particularly if they blame their significant other for the stressful situation.

Behavioral disengagement also mediated the association between relational quality and both stress and frequency of challenges in both simple and multiple mediation models, leading to overall negative associations between relational quality and both variables. In particular, findings indicate that partners who are either more stressed or who have to manage challenges more frequently tend to disengage more, and in turn this disengagement is associated with lower relational quality. This is consistent with Mooney’s (2013) study finding that escaping as a coping strategy had a mediating role in the association between stress and relational quality. A potential reason why disengagement from the challenges might be detrimental to partners’ evaluations of relational quality is that this strategy might leave their significant other feeling unsupported by them. When one partner withdraws, the other one more likely to withdraw as well, which is in turn associated with decreased perceptions of intimacy and relational satisfaction partners whose significant other has a mental health condition (Finkbeiner et al., 2013).

Ultimately, this study suggests that stress is strongly associated with greater use of negative coping strategies (e.g., behavioral disengagement and venting), when
defined in terms of their negative connection to relational quality and less use of dyadic coping. This poses an important challenge for theorists and practitioners trying to provide couples facing mental health conditions with tools to maintain and strengthen their relationships, as well as their quality of life. Stress was also positively associated with self-distraction, an avoidant coping strategy, and with instrumental support. However, as mentioned previously, these two variables were not associated with relational quality in the multiple mediation model, which suggest that they do not mediate the association between stress and relational quality.

Although these findings were fairly surprising in the case of self-distraction, due to its conceptual similarity with behavioral disengagement, it might be that self-distraction has a more nuanced association with relational quality. Put another way, the association between relational quality and self-distraction might be contingent on the manner in which partners self-distract. For example, it might be that some partners engage in distracting activities with their significant other, and this brings some relief for the relationship. Engaging in distracting activities with their significant other might actually have a beneficial effect on the relationship, because they are spending more time together, which serves as relational maintenance (Canary et al., 1993; Stafford & Canary, 1991). Other partners, however, might push their significant other away when engaging in self-distraction, which will, presumably, have adverse consequences for the relationship. In short, it might not be self-distraction by itself that is associated with relational quality, but the interaction between it and other characteristics or about the specific ways in which partners do self-distraction.
In the case of instrumental support, it is possible that this coping strategy might be associated with improvements in other areas, such as future stress and well-being. At the same time, instrumental support might not be relevant to relational quality, given that the help and advice that partners get from others (e.g., “I try to get advice or help from other people about what to do.”) may be oriented towards solving practical, and not necessarily relational, concerns. Perhaps an exception where instrumental support seeking could mediate the association between stress and relational quality is if partners are seeking instrumental support from their significant other to solve challenges related to their significant other’s mental health condition.

**Implications and Contributions.**

This study made at least three contributions to the existing body of literature. First, this study provided a conceptually sound framework that can help researchers and practitioners understand why individuals with mental health conditions so often have less satisfying and stable relationships than their counterparts. Previous research finds that partners of individuals with mental health conditions have shorter relationships, lower rates of marriage, higher rates of divorce and less satisfied partners than individuals without mental health conditions. This study forwards and supports a theoretical explanation of what can lead to the deterioration of couples managing mental health condition. In this study, I show that the degree of stress that partners experience due to the challenging aspects of their significant other’s mental health conditions, and the frequency with which they encounter these challenging aspects are in fact strongly and negatively associated with their relational quality, and that the association between stress and relational quality is strong even at low levels
of experienced stress, such as the ones in the sample for this study. By providing this theoretical explanation, the study provided a starting point for clinicians and family practitioners to investigate what variables and strategies can help counter the stress of partners who are managing their significant other’s mental health condition, and the negative coping and communication dynamics that result from this stress.

A second important contribution of this study was the integration of individual and dyadic coping into a framework to explain the process that connects stress with relational quality in relationships facing a mental health condition. It is clear from results that partners engage in coping at different levels, namely individually and dyadically, and that they do so simultaneously. Furthermore, results show that both individual and dyadic-level coping have consequences for relationships. In this study, lower relational quality as a result of stressful and frequent challenges can, in part, be explained by the fact that increasing stress and frequency of challenges are associated with ways of coping that are less productive for their relationship (e.g., disengaging or “quitting”, venting, and self-distracting). Thus, it seems necessary to emphasize to partners of individuals with mental health conditions the need to engage in relationship-enhancing strategies, such as dyadic coping. There may be a need to fund initiatives that can provide these partners with communication strategies and tools that facilitate their engagement in dyadic coping with their significant others.

This study makes a third contribution by explicitly testing how an overload of stress can have more detrimental consequences for romantic relationships than an acute stressful incident by testing the association between frequency of challenges and relational quality, as well as its hypothesized moderating influence on the association
between stress and relational quality. Although the test of the moderating influence was not significant in the multiple mediation model, it is still an important contribution to research. In particular, testing the interaction of stress with frequency of challenges is important in as much as provides a ground for a conversation on alternative ways to empirically measure and test the interaction between the frequency and severity of stressful circumstances, and the effects that this interaction can have for partner outcomes and for relational outcomes in the short and long term. Notably, frequency of challenges did significantly moderate the association between stress and a couple of coping strategies (i.e., dyadic coping and venting). This study provides important insight as to whether, and to what extent, repeated stress can lead to less productive coping responses.

**Limitations and Future Directions**

Although this study makes important contributions, the contributions are bound by the study’s methodological limitations. The most salient of these limitations is the cross-sectional design of the study that aims at parsing out causality. Because a central component of causality is the temporal order of changes in the independent and dependent variables, it is not possible given the study’s design to assess whether the causal order hypothesized is certain. It is also plausible that partners who were less satisfied to begin with appraise the challenges in their relationship as more stressful. In this way, because the relationship is perceived as less worthy of effort, higher stress may lead partners to respond in less adaptive ways. Likewise, it is possible that partners who cope less adaptively, whether because they are less satisfied and thus less motivated, or because they lack the skills to cope in more...
productive ways, become more stressed due to their inability to deal with the challenges. Together, these explanations suggest there might be recursive relationships between stress, coping, relational quality, and even frequency of challenges, and future studies should test this thesis within a longitudinal design.

Another important limitation of this study is its individually-based and fully self-report characteristics. This is a limitation because partners in a relationship are interdependent, and when stress emerges within the relationship (Hanneman, 1988), they are attentive and react to one another’s behaviors in ways that will be influential to their relational outcomes. Therefore, a study that includes measures for both partners would yield a more comprehensive understanding of the processes central to this research. Observational research may also provide a complementary method by which to collect data on coping strategies such as venting and seeking support, given the behavioral nature of these strategies. Additionally, physiological indicators (e.g., cortisol levels; Umeanuka, Saheeb, Uguru, & Chukwuneke, 2015) could enhance future research’s ability to assess partners’ stress in this context without relying on self-reported perceptions. In short, including more diverse and complementary measures of the variables of interest might help increase the construct and internal validity of the study, decreasing measurement-related error that can obscure the reality of associations (or lack-thereof) between variables (Kline, 2011).

A third limitation of this study is the low-variance in the levels of stress that partners experience, which might have decreased the ability to detect other significant relationships in the analyses. Given that many partners whose significant other has a mental health condition conditions experience considerable stress (Caska & Renshaw,
2011; Dekel, Solomon, & Bleich, 2005; Dirkzwager, Bramsen, Ad’er, & van der Ploeg, 2005; Lambert, Engh, Hasbun, & Holzer, 2012; van der Voort, Goossens, & van der Bijl, 2009; Zaider, Richard & Heimberg, 2010), it is somewhat surprising that participants reported such a relatively low average degree of stress and high levels of relational quality. Consistent with explanations above, it may be that participants in this study were more satisfied in their relationships and therefore reported less stress. Future studies should include more diverse samples with regard to the variables of interest, perhaps by gathering participants from multiple contexts (e.g., community samples more representative of the U.S. population, hospitals, etc.) and varying circumstances (e.g., current stressors, transitions).

Finally, a fourth limitation of the study is that the mean sample age was skewed and most participants were young adults. One consequence of this skew in age is that the results of this study cannot necessarily be generalized to the overall population of partners of individuals with mental health conditions. Also, young adults may be less emotionally mature and have less skills to deal effectively with stress. As a result of lower emotional and coping skills, younger adults might experience greater declines in relational satisfaction when they experience increases in stress. This means that the relationship between stress and relational quality might have a different slope in this sample than it would have in samples that are more representative of the population of partners whose significant other has a mental health condition. Additionally, older individuals might have different coping tendencies in response to increasing stress than younger individuals do. Again, future research should include samples with greater variance in the variables of interest,
perhaps by gathering participants from multiple contexts (e.g., community samples, hospitals, etc.). Moreover, it is worth testing whether age is in fact a significant moderator of the paths connecting stress, coping, and relational quality.
Chapter 6: Conclusion

This study sought to explain why individuals with mental health conditions have less successful romantic relationships, less satisfied partners in particular, and what makes the difference between partners who remain satisfied and those who become dissatisfied. In doing so, I showed that the trend of dissatisfaction, as well as the differences within this trend, can be understood in terms of the stress and the frequency of challenges associated with mental health conditions, and of the consequences that the stressful and frequent properties of challenges have for the ways in which individuals respond to them. In particular, findings from this study showed that when challenges of mental health conditions are more stressful, more frequent, or both, partners cope in ways that are less productive the relationship (e.g., they disengage, they cope separately from their partners, they ruminate verbally) and that this less productive strategies are in turn associated with lower relational quality. Moreover, results suggested that when challenges are more frequent, the extent to which stress makes partners cope in unproductive ways and, by association, the extent to which partners become less satisfied with the relationship is even greater than when challenges are comparatively infrequent.
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Appendix A: Survey Instrument

Screening Questions

Are you currently in romantic relationship?

Yes

No

Questions about Mental Health Condition and Significant Other

Does your partner have any one (or more) of the following mental health conditions?

Please select the one(s) that apply.

Alcohol/Substance Abuse

Alcohol/Substance Dependence

Anxiety

Adult Attention Deficit/Hyperactivity (ADHD/ADD)

Bipolar

Depression

Dysthymia

Anorexia Nervosa

Binge Eating

Bulimia Nervosa

Generalized Anxiety

Obsessive-Compulsive (OCD)

Panic Disorder

Posttraumatic Stress (PTSD)

Schizophrenia
Seasonal Affective Depression (i.e. depression with a seasonal pattern)

Social Anxiety

Other?

My partner does not have a mental health condition

Has your partner ever been diagnosed mental health condition by a medical professional (e.g. general practitioner, psychiatrist) or therapist?

Has your partner ever received medical or psychological treatment for their mental health condition?

Is your partner currently receiving medical or psychological treatment for their mental health condition?

Has your romantic partner ever been diagnosed mental health condition by a medical professional (e.g. general practitioner, psychiatrist) or therapist?

Yes

No

I am not sure.

Has your romantic partner ever received medical or psychological treatment for their mental health condition?

Yes

No

I am not sure

Is your partner currently receiving medical or psychological treatment for their mental health condition?

Yes
No

I am not sure

Please indicate for how long have you been in your relationship (in years and months)?

Years:

Months:

Relational Demographics

How would you classify your relationship?

Casual

Dating

Boyfriend/Girlfriend

Engaged

Married

Other?

Not willing to answer

We want to know how people feel about the challenges that they face in their romantic relationships, as well as how they respond to these challenges. Keep in mind that there is no correct answer for any question in this survey, we simply want to learn more about your personal experience. Please respond to the questions in this survey honestly and without overthinking.

Frequency of Reported Challenge and/or Difficulty

First, we want you to please think about aspects of your partner’s mental health condition that are challenging and/or difficult for you and/or for your relationship.
Now, in the following text box please describe briefly: what aspect do you think is most challenging?

Please indicate from 1 (almost never) to 7 (almost always, more than 90% of the time), how commonly would you say that you encounter the challenging aspect that you just described?

**Stress/Emotion Appraisals**

We want you to please think again about the aspects of your partner’s mental health condition that are challenging and/or difficult for you and/or for your relationship. Now, please indicate from 1 (almost never) to 7 (almost always), next to each respective emotion, how often do you feel each of the following emotions when you are facing a challenging aspect of your partner’s mental health condition.

- Anger
- Anxiety
- Fright
- Guilt
- Shame
- Sadness
- Envy
- Jealousy
- Disgust
- Happiness
Think about ways and strategies that you use to deal with the challenging aspects of your partner’s mental health condition. Now, indicate how commonly you use each of the following strategies to deal with these challenges and or difficulties.

When my partner's mental health condition is challenging...

*Self-distraction* (items 1 and 19)

I turn to work or other activities to take my mind off things.

I do something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.

*Active coping* (items 2 and 7)

I concentrate my efforts on doing something about the situation I'm in.

I take action to try to make the situation better.

*Use of emotional support* (items 5 and 15)

I get emotional support from others.

I get comfort and understanding from someone.

*Use of instrumental support* (items 10 and 23)

I get help and advice from other people.
I try to get advice or help from other people about what to do.

*Behavioral disengagement* (items 6 and 16)

I give up trying to deal with it.

I give up the attempt to cope

*Venting* (items 9 and 21)

I say things to let my unpleasant feelings escape.

I express my negative feelings.

*Positive reframing* (items 12 and 17)

I try to see it in a different light, to make it seem more positive.

I look for something good in what is happening

*Planning* (items 14 and 25)

I try to come up with a strategy about what to do.

I think hard about what steps to take.

*Humor* (items 18 and 28)

I make jokes about it.

I make fun of the situation.

*Acceptance* (items 20 and 24)

I accept the reality of the fact that it has happened.

I learn to live with it.

*Self-blame* (items 13 and 26)

I criticize myself.

I blame myself for things that happened.

**Dyadic Coping Inventory (Dyadic Coping strategy)**
We want you to think about ways and strategies that you and your partner use to deal with the challenging aspects of his/her mental health condition. Now, indicate how commonly you use each of the following strategies to deal with these challenges and or difficulties.

When my partner's mental health condition is challenging...

*Common Coping Subscale*

- We try to cope with the problem together and search for solutions
- We engage in a serious discussion about the problem and think through what has to be done
- We help one another to put the problem in perspective and see it in a new light
- We help each other relax with things like massage, taking a bath together, or listening to music together.
- We are affectionate with each other, make love, and try that way to cope with stress

*Relationship Quality*

Considering only the positive qualities of your relationship and IGNORING the negative ones, evaluate your relationship on the following qualities:

Not at all (1)  A tiny bit (2)  A little (3)  Somewhat (4) Mostly (5)  Very (6) Extremely (7)  
Enjoyable
Pleasant
Strong
Alive
Considering only the negative qualities of your relationship and 
IGNORING the positive ones, evaluate your relationship on the following 
qualities:

Not at all (1) A tiny bit (2) A little (3) Somewhat (4) Mostly (5) Very (6) 
Extremely (7)

Bad
Miserable
Empty
Lifeless

Demographics

How old are you?

What is the highest level of education you have completed?

Less than High School
High School / GED
Some College
2-year College Degree
4-year College Degree
Master’s Degree
Doctoral Degree
Professional Degree (JD, MD)
Other? Please specify
Please indicate your current family structure.

Single without children
Single with children
Married without children
Married with children
Life partner without children
Life partner with children
Other? Please specify

What is your race?

White/Caucasian
African American
Hispanic
Asian
Native American
Pacific Islander
Other

What is your annual income range?

Below $20,000
$20,000 - $29,999
$30,000 - $39,999
$40,000 - $49,999
$50,000 - $59,999
$60,000 - $69,999
$70,000 - $79,999
$80,000 - $89,999
$90,000 or more
Appendix B: Advertisement of the Study on Amazon Mechanical Turk (MTurk) Relationships Survey

Description: We want to know about adults' experiences in a relationship with someone who has a mental health condition. In order to participate, must be currently in a romantic relationship with someone who has a mental health condition.

Keywords: Survey, romantic relationships, mental health

Qualification Requirement: HIT approval rate (%) for all requesters’ HITs greater than or equal to 95 (Required for preview), location is US (Required for preview).
Appendix C: IRB Approval

The following research study has been reviewed and approved by the Institutional Review Board at Ohio University for the period listed below. This review was conducted through an expedited review procedure as defined in the federal regulations as Category(ies):

Project Title: A Culture-Centered Approach to Chagas Disease Control in Loma Province Ecuador: Analysis of Healthy Living Initiative

Primary Investigator: Claudia Patricio Niello Sanchez
Co-investigator(s): Michelle Anezco Callayas

Faculty Advisor: Benjamin Bates
Department: Grad College

Rebecca Cole, AAS, C.P.
Office of Research Compliance

Approval Date: 4/3/15
Expiration Date: 4/2/16

This approval is valid until expiration date listed above. If you wish to continue beyond expiration date, you must submit a periodic review application and obtain approval prior to continuation.

Adverse events must be reported to the IRB promptly within 5 working days of the occurrence.

The approval remains in effect provided the study is conducted exactly as described in your application for review. Any additions or modifications to the project must be approved by the IRB (as an amendment) prior to implementation.