



The Interplay Between Individual and Dyadic/Common Coping in Female Patients With Cancer

Antonia Paschali¹, Alexandra Palli², Christoforos Thomadakis²,
and Evangelos C. Karademas²

¹Faculty of Nursing, National and Kapodistrian University of Athens, Greece

²Applied Psychology Laboratory, Department of Psychology, University of Crete, Rethymnon, Greece

Abstract: Both individual and dyadic coping behaviors are important for adaptation to a severe illness. However, there is a theoretical controversy regarding the interplay between these two forms of coping. In this cross-sectional study, we examined (a) whether recently diagnosed cancer patients engage mostly with one form of coping or whether they use both in parallel; (b) the relationship of individual and supportive dyadic/common coping to emotional well-being and relationship satisfaction. Participants were 92 women recently diagnosed with cancer (mostly breast cancer) and receiving medical treatment ($M_{\text{age}} = 49.37$ years; $SD = 10.52$). All had been living with their partner for at least 2 years. The parallel use of individual and supportive dyadic/common coping behaviors was frequently reported. Individual and dyadic/common coping proved to be related to each other ($p < .01$), and both were related to emotional well-being and relationship satisfaction ($p < .05$). The combination of high individual and high supportive dyadic/common coping was associated with greater satisfaction with the relationship ($p < .01$). Patients probably use individual and dyadic coping behaviors in concert to better deal with the different aspects of their illness experience. Both types of coping should be considered in the context of personalized intervention programs to facilitate adaptation to cancer.

Keywords: individual coping, dyadic coping, emotional well-being, relationship satisfaction, adaptation to cancer

A key factor in the adaptation to a distressing condition is coping. Coping refers to the cognitive and behavioral efforts of a person to manage a stressful condition, by undertaking action to change the interaction with the environment (e.g., problem-solving) or/and by regulating their emotions (e.g., emotion suppression; Lazarus & Folkman, 1984). Equally important to the personal efforts to cope with stress are dyadic coping behaviors.

In differentiation from the individual perspective, which was traditionally employed to understand the stress process (e.g., Lazarus, 1966), the concept of dyadic coping describes an effort to characterize stress and coping in couples (Bodenmann et al., 2019). Based on Lazarus' transactional theory of stress and coping (Lazarus, 1966; Lazarus & Folkman, 1984), new theories, such as the systemic transactional model (STM; Bodenmann, 1997, 2005), emphasized the interdependence between romantic partners and, consequently, the importance of joint efforts to support each other or together to deal with a stressor (i.e., dyadic coping; Bodenmann et al., 2016). Although there is some overlap between the concept of dyadic coping and that of social

support, they are not the same. Dyadic coping expanded the view of coping to include both members of the couple and refers to both positive (e.g., active support) and negative coping behaviors (e.g., overprotection, criticism), whereas social support generally refers to the buffering role of social resources in the stress process (Cutrona et al., 2018).

Coping is a crucial aspect of adaptation to any stressful condition, including severe illness. Indeed, there is extensive evidence about the key role of individual (e.g., Hagger et al., 2017) and dyadic coping (e.g., Falconier & Kuhn, 2019; Helgeson et al., 2019; Johnson et al., 2015) in adaptation to illness. However, there is an interesting controversy regarding the interplay between individual and dyadic coping. Certain theories suggest that both types of coping can be used in parallel (e.g., Berg & Upchurch, 2007), whereas others posit that they can be used only serially (e.g., Badr & Acitelli, 2017). In this context, this study examined whether and in which ways individual and dyadic coping behaviors interact in a sample of women facing a major stressful condition, that is, a recently diagnosed cancer.

Individual Coping and Adaptation to Cancer

The evidence about the relationship of individual coping efforts of patients with cancer to their well-being and adaptation to illness is extensive. Coping behaviors such as problem-solving and positive attitude are generally related to better physical and psychological health outcomes, whereas coping behaviors such as avoidance, denial, or giving-up are related to higher levels of psychological distress, fatigue, anxiety, and depression as well as lower levels of physical well-being, across several types of cancer, including head and neck cancer (e.g., Dunne et al., 2017; Morris et al., 2018), gynecologic cancer (e.g., Roland et al., 2013; Siwik et al., 2020), breast cancer (e.g., Abrahams et al., 2018; Casellas-Grau et al., 2017; Gall & Bilodeau, 2020; Glinder et al., 2007; Ozdemir & Tas Arslan, 2018; Tu et al., 2020), and prostate cancer (e.g., Roesch et al., 2005). Furthermore, a recent meta-analysis in breast cancer patients showed that the impact of individual coping on cancer-related well-being and quality of life is long term (Brandão et al., 2017).

Dyadic Coping and Adaptation to Cancer

A mounting number of studies show that partners' dyadic coping, that is, partners' behaviors directed toward patients to facilitate in some way their experience with illness and adaptation, are closely related to patients' health and well-being. For example, partner overprotectiveness has been associated with worse outcomes (e.g., worse psychological and physical well-being) in patients with cancer (e.g., Hagedoorn et al., 2000; Kuijer et al., 2000; Lyons et al. 2016), whereas actively engaging the patient in conversations about their experience has been associated with higher levels of well-being (e.g., Hagedoorn et al., 2011; Kuijer et al., 2000).

Also, problem-solving and emotion-regulation-oriented dyadic coping as well as common coping (i.e., the involvement of both partners in the effort to effectively deal with the stressor) have been positively related to cancer patients' physical and psychological health, while hostile dyadic coping has been related to worse health (e.g., Acquati & Kayser, 2019; Badr et al., 2010; Dagan et al., 2011; Rottmann et al., 2015; Zimmermann et al., 2010).

The Relationship Between Individual and Dyadic Coping

Although there is strong evidence about the important role of both individual and dyadic coping in the well-being of patients with cancer, controversy remains regarding their exact relationship. Specifically, according to the STM

(Bodenmann, 1997), a person first engages in individual efforts to cope with a stressor. If the problem is severe or long-standing and the personal coping efforts turn out to be unsuccessful, then they turn to dyadic coping (Bodenmann et al., 2016). Likewise, Badr and Acitelli (2017) suggested that if a patient's individual efforts to cope with illness are effective, they stick to these. If these efforts fail to effectively deal with the situation, this gives rise to dyadic coping efforts. However, if all dyadic efforts also turn out to be ineffective, then the patient may retreat to individual coping. In other words, according to this model, personal and dyadic coping are used only *in sequence*. On the other hand, the developmental-contextual model (DCM; Berg & Upchurch, 2007) posits that individual and dyadic coping may be used *in parallel*. Likewise, a new model, the dyadic-regulation connectivity model (DR-CM; Karademas, 2021) proposes that there is no specific order to how individual and dyadic coping are employed, as this depends on the characteristics of the individual (e.g., personal preferences, skills, experience) and the situation (e.g., type of problem, relationship quality; see also Staff et al., 2017). Individual and dyadic coping behaviors may be employed even in a parallel or complementary way.

To our knowledge, no study has ever examined the interplay between individual and dyadic coping behaviors in the context of illness, though an examination of this issue is important for two reasons: First, it may provide us with an answer regarding the theoretical controversy of whether individual and dyadic coping behaviors work in parallel or serially, which would permit the development of more accurate theoretical models about adaptation to cancer and chronic illness. Second, it may inform intervention programs on whether the focus should be placed on both individual and dyadic coping concurrently or only on one of them, depending on situational factors (e.g., the special characteristics of illness or available resources; Acitelli & Badr, 2005; Staff et al., 2017).

The Present Study

The study was conducted in a sample of female patients recently diagnosed with cancer who were in a long-term relationship. Coping plays a crucial role after a cancer diagnosis and the beginning of treatment as this is a highly stressful time (e.g., Mansano-Schlosser et al., 2017). Based on the DCM (Berg & Upchurch, 2007) and the DR-CM (Karademas, 2021), our first hypothesis was that many patients use both forms of coping (i.e., individual and dyadic/common) in parallel as opposed to only or mostly one form of coping, as the STM suggests (Bodenmann et al., 2016). Patients likely use every recourse available to cope with the cancer diagnosis and its consequences, without concentrating first on personal resources and only later on dyadic ones.

Our second hypothesis was that individual coping and dyadic/common coping (as perceived by the patients) are related to each other. Patient-active coping behaviors (e.g., problem-solving) may facilitate open communication with the partner about the problem, which in turn may result in more active and supportive involvement of the partner (Bodenmann, 2005). Of course, the positive dyadic (e.g., active partner support) and common coping may also facilitate a more positive patient representation of the situation and thus the use of more active individual coping behaviors. In any case, we expected the more “active” individual coping behaviors to be related to higher levels of positive dyadic coping and common coping, whereas the more “passive” individual coping behaviors (e.g., giving up, fatalism) to be related to lower levels of positive dyadic and common coping.

Third, as suggested by both the DCM and the DR-CM, we hypothesized that both individual and dyadic/common coping are important concurrent correlates of two indicators of patients’ personal and social well-being: emotional well-being and relationship satisfaction, respectively. Finally, based on the DR-CM (Karademas, 2021), our fourth hypothesis was that individual and dyadic/common coping interact “synergistically”: The combination of active individual coping behaviors and supportive involvement of the partner may advance patients’ chances for a more successful adaptation. Thus, we expected that the combination of higher levels of active individual and higher levels of positive dyadic/common coping is linked to better emotional well-being and more relationship satisfaction, compared to the collection of all other possible combinations between personal and dyadic/common coping behaviors, that is, high personal/low dyadic or common, low personal/high dyadic or common, low personal/low dyadic or common coping.

Overall, the examination of these hypotheses serves to provide insight into the type of relationship between patients’ individual and dyadic coping. The lack of associations and interaction between the two – or the possible finding that only one type of coping is related to patients’ well-being at any given time – may indicate that they operate serially and probably independently. Opposite findings provide initial support to those models, which suggest a more dynamic relationship between individual and dyadic coping behaviors in the context of illness.

Method

Participants and Procedure

We employed a cross-sectional, correlational study design to examine our hypotheses. The study was conducted at

the Departments of Medical Oncology in two public hospitals in Greece. A convenience sample of female patients diagnosed with cancer less than 60 days before was invited to participate. Inclusion criteria were age over 18, newly diagnosed with cancer, being able to understand the Greek language and provide informed consent, and being in a romantic relationship for over a year. The hospital medical files were used to identify eligible participants. Subsequently, a research assistant approached patients who met the inclusion criteria during one of their scheduled visits at the oncology outpatient department and invited them to participate in the study. The study was approved by the University of Crete Ethics Committee (No. 224/19-12-2019).

Measures

Patient Individual Coping

Current cancer-related coping behaviors were assessed with the Mental Adjustment to Cancer Scale (Watson et al., 1988). We used the two-factor structure proposed by Watson and Homewood (2008), based on a large cohort study that also included a Greek sample. The first factor, the “summary positive adjustment” coping, consists of 17 items that reflect a patient’s determination to cope with illness (e.g., problem-solving) and preserve a positive attitude (e.g., “I have been doing things that I believe will improve my health”; Cronbach’s $\alpha = .72$; all alphas refer to the current study). The second factor, the “summary negative adjustment” coping, is composed of 16 items reflecting more passive coping, such as avoidance/denial, anxious preoccupation, and helplessness/hopelessness (e.g., “I feel like giving up”; Cronbach’s $\alpha = .88$). Respondents used a 4-point Likert type scale (1 = *definitely does not apply to me*, to 4 = *definitely applies to me*), with higher scores indicating more use of each type of coping behavior.

Dyadic Coping

Dyadic coping (DC) behaviors were assessed with the Dyadic Coping Inventory (DCI; Bodenmann, 2008), as adapted in Greek (Roussi & Karademas, 2016). Two DCI subscales were used in the study: (a) the overall supportive DC as reported by the patients, which includes both problem- and emotion-focused supportive actions provided by their partner (4 items; e.g., “My partner expresses that he is on my side”; Cronbach’s $\alpha = .85$); (b) the overall problem- and emotion-focused common coping (i.e., what both partners do together to cope with adversity; 5 items; e.g., “We help one another to put the problem in perspective and see it in a new light”; Cronbach’s $\alpha = .87$). Participants responded on a 5-point Likert scale ranging from 1 (*very rarely*) to 5 (*very often*).

Emotional Well-Being

To assess patients' emotional well-being, we used the Emotional Well-Being Scale from the RAND 36-item Health Survey (http://www.rand.org/health/surveys_tools/mos/mos_core_36item.html). The scale consists of 5 items regarding personal feelings during the past 4 weeks (e.g., have been a very nervous person; Cronbach's $\alpha = .88$). Responses were transformed in order for the final score to range from 0 to 100, with higher scores indicating better well-being.

Relationship Satisfaction

We used the Relationship Assessment Scale (Hendrick et al., 1998) to assess relationship satisfaction. It is a 7-item measure (e.g., "In general, how satisfied are you with your relationship?") using a 5-point Likert scale ranging from 1 to 5, with higher scores indicating more satisfaction (Cronbach's $\alpha = .87$).

Analyses

We performed a MANOVA to examine the potential impact of the sociodemographic factors on the variables included in the study. Education level (0–9 vs. > 9 years of education) and the presence of children (yes vs. no) served as the independent variables, while dyadic (i.e., supportive dyadic coping and common coping) and individual coping (i.e., summary positive adjustment and summary negative adjustment coping), emotional well-being, and relationship satisfaction served as the dependent variables. Pearson r correlations were used to examine the association between age, relationship duration, and the other study variables.

We used a chi-square test to examine whether there is a significant difference in the reported use of individual and dyadic/common coping behaviors (i.e., relatively equal use of both types of coping vs. more frequent use of only one type). To this end, we split the total score of the respective scale for each type of coping behavior into two categories based on the median value (i.e., more vs. less frequent use). Also, we used a correlation analysis to examine the relationship between individual and dyadic/common coping behaviors. This analysis was performed after controlling for disease-related factors (i.e., partial correlation analysis), given their well-known impact on cancer patients' well-being (e.g., Ferreira et al., 2019; Ganz et al., 2004). Specifically, we controlled for the type of diagnosis (breast vs. other types of diagnosis), the stage of cancer, and the type of therapy (coded as a series of dummy variables).

We used hierarchical regression analyses to examine the relationship of individual and dyadic/common coping (as the independent variables) to patient emotional well-being and relationship satisfaction (as the dependent variables),

after controlling for the disease-related factors described above. Given the modest number of participants, we also report the bootstrapping (N samples = 5,000) confidence intervals (CIs) for the regression analyses results.

Finally, to examine the potential interactions between individual and dyadic/common coping behaviors, we performed a series of ANCOVAs (after controlling for the disease-related factors) using the Bonferroni correction for multiple comparisons, with emotional well-being and relationship satisfaction as the dependent variables and the interaction between individual and dyadic/common coping behaviors (i.e., high use of both individual and dyadic coping vs. all other conditions grouped into a single category, based on median split) as the independent variable. In particular, we compared two groups in each ANCOVA: that of patients who reported higher levels of individual coping and also higher levels of dyadic or common coping vs. the combined group of all other patients who reported either lower use of individual/higher use of dyadic coping, higher use of individual/lower use of dyadic, or lower use of individual and dyadic coping. Bootstrapping CIs are reported as well.

IBM SPSS v21 was used to perform the analyses; we also performed tests of multicollinearity and multivariate normality (by determining the Mahalanobis distance from the available data and calculating the relevant chi-square values). No outliers were identified. A post-hoc examination revealed a statistical power equal to about .80 at an alpha level equal to 5% and medium effect size for the analyses performed. The level of statistical significance was defined at $p < .05$.

Results

Participants' Characteristics and Preliminary Findings

A total of 126 (126) patients were identified as eligible for participation. Thirty-four patients refused participation because they were not interested or felt unable to participate, so that the final sample consisted of 92 patients (73% positive response). The patients' mean age was 49.37 years ($SD = 10.52$ years). Regarding education, 12% of the patients had finished the 9-year mandatory education or less, 40.3% had finished high school, and 47.7% were holders of a higher education degree.

Most patients had been diagnosed with breast cancer (81.5%), 7.6% with gastrointestinal cancer, 4.3% with gynecological cancer, and 6.6% with various others types of cancer. Regarding the cancer stage, 30.8% had been diagnosed with a stage I cancer, 44% with stage II cancer, 15.4% and 9.9% with stage III and IV cancer, respectively. Also, 31.1% were receiving chemotherapy, 53.3% a combination

Table 1. Percentages (%) of patients reporting higher and lower use (based on median split) of individual and dyadic/common coping behaviors ($N = 92$)

Dyadic/common coping behaviors	Individual coping behaviors			
	Summary PA coping		Summary NA coping	
	Lower use	Higher use	Lower use	Higher Use
Dyadic supportive coping – lower use	26.1%	23.9%	21.7%	28.3%
Dyadic supportive coping – higher use	25.0%	25.0%	23.9%	26.1%
Common coping – lower use	31.5%	22.8%	21.7%	32.6%
Common coping – higher use	19.6%	26.1%	23.9%	21.7%

Note. PA = positive adjustment; NA = negative adjustment.

of therapies, and 15.5% were receiving radio, hormone, or other therapy. About 85% of the participants were enrolled in the study 6–8 weeks after diagnosis.

The analyses showed that there were no significant differences in individual coping, dyadic/common coping, emotional well-being, and relationship satisfaction across education levels or the existence of children, Wilks' $\lambda < .99$, $F_s(6, 82) < 1.24$, $p > .05$, partial η^2 's $< .09$. Also, we found no significant correlations of these variables to age or the duration of the relationship (r 's $< .20$, $p > .05$). Thus, none of these sociodemographic variables was included in the analyses as a covariate.

The Use of Individual and Dyadic/Common Coping and Their Interrelations

Across all possible combinations of individual and dyadic/common coping behaviors (see Table 1), 22–26% of patients reported equally frequent use of individual and dyadic/common coping behaviors, whereas 24–32% reported more frequent use of individual coping, and 20–25% reported more frequent use of dyadic coping. We could not identify any statistically significant differences in the reported use of both or either type of coping behavior (χ^2 's(1) $< .68$, $p > .10$).

After controlling for disease-related factors, we were able to relate positive individual coping to dyadic supportive and common coping (partial r 's $> .31$, $p < .01$; see Table 2), whereas negative individual coping was negatively related to dyadic supportive and common coping (partial r 's $> -.24$, $p < .05$). Emotional well-being was related to all coping behaviors (partial r 's $> .121$, $p < .05$). Relationship satisfaction was significantly related to all coping behaviors (partial r 's $> .21$, $p < .05$), except for negative individual coping.

After controlling for covariates, we found that individual and dyadic/common coping behaviors accounted for an additional 41% of the variance in emotional well-being, $F_{\text{change}}(4, 82) = 16.67$, $p < .01$. Positive individual ($\beta = .20$, $t = 2.01$, $p < .05$; CI = .47/21.59) and negative individual coping ($\beta = -.49$, $t = -5.25$, $p < .01$; CI = $-25.73/-11.02$), as well

as common coping ($\beta = .36$, $t = 2.57$, $p < .05$; CI = 2.75/15.99) were significantly related to emotional well-being. Dyadic supportive coping was not related to emotional well-being ($\beta = -.26$, $t = -1.85$, $p > .05$; CI = $-13.69/.78$).

With respect to relationship satisfaction, individual and dyadic coping behaviors accounted for an additional 48% of its variance, $F_{\text{change}}(4, 82) = 20.50$, $p < .01$. Dyadic supportive and common coping were significantly related to relationship satisfaction (β 's = .36 and .40, $t = 2.73$ and 3.02, $p < .01$; CI = .28/.63 and .12/.62, respectively). Individual coping was not related to relationship satisfaction (β 's $< .04$, t 's $< .40$, $p > .05$; CI = $-.39/.24$).

Synergy Between Individual and Dyadic/Common Coping

According to the results, higher levels of emotional well-being were reported by those patients who also reported more use of positive individual coping (i.e., above the median value) as well as common coping than all other patients (i.e., patients who reported either low positive individual/high common, or high individual/low common, or low individual/low common coping, grouped into a single category; see Table 3). No other statistically significant differences were found, $F(1, 91) < 2.88$, $p > .05$, partial η^2 's $< .04$, CI for pairwise comparisons = $-18.59/6.82$.

Higher levels of relationship satisfaction were reported by those patients who also reported (a) a higher use of both positive individual and dyadic supportive coping; (b) a higher use of both negative individual and dyadic supportive coping; (c) a higher use of both positive individual coping and common coping (see Table 3). No statistically significant differences resulted with respect to negative adjustment/common dyadic coping, $F(1, 91) = .77$, $p > .05$, partial $\eta^2 = .01$, CI for pairwise comparison = $6.82/-16.13$.

Discussion

This study examined the role of individual and dyadic/common coping in 92 women recently diagnosed with cancer.

Table 2. Descriptive statistics and intercorrelations of coping behaviors, emotional well-being, and relationship satisfaction, after controlling for disease-related factors ($N = 92$)

	Mean	SD	Correlations (Pearson's r)						
			1	2	3	4	5	6	
1. Summary PA coping	3.05	0.35	1.00						
2. Summary NA coping	2.08	0.54	-.43**	1.00					
3. Dyadic supportive coping	3.13	0.82	.31**	-.24*	1.00				
4. Common coping	3.02	0.81	.35**	-.27**	.80**	1.00			
5. Emotional well-being	57.09	20.93	.45**	-.60**	.21*	.35**	1.00		
6. Relationship satisfaction	4.21	0.73	.21*	-.17	.68**	.67**	.32**	1.00	

Note. PA = positive adjustment; NA = negative adjustment. * $p < .05$, ** $p < .01$.

Table 3. Emotional well-being and relationship satisfaction at high levels of both individual and dyadic/common coping vs. all other conditions combined ($N = 92$)

Coping behavior combinations	Emotional well-being			
	Mean (SE)	$F(1, 85)$	η^2	CI for pairwise comparison
High positive individual/high common	68.93 (4.23)	10.79*	.11	7.08/25.14
All other conditions combined ¹	52.83 (2.44)			
Coping behavior combinations	Relationship satisfaction			
	Mean (SE)	$F(1, 85)$	η^2	CI for pairwise comparison
High positive individual/high supportive	4.60 (0.15)	9.68*	.10	.25/.82
All other conditions combined	4.07 (0.08)			
High negative individual/high supportive	4.58 (0.15)	8.79*	.09	.23/.79
All other conditions combined	4.06 (0.09)			
High positive individual/high common	4.57 (0.15)	8.22*	.09	.20/.78
All other conditions combined	4.08 (0.09)			

Note. SE = standard error; CI = confidence intervals (N bootstrapping = 5,000). ¹Low individual/high dyadic, high individual/low dyadic, low individual/low dyadic coping, all combined into a single category. * $p < .01$.

Specifically, it examined (a) whether patients clearly engage with one form of coping or whether they use them in parallel; (b) what the interrelations are between individual and dyadic/common coping as well as their relationship to emotional well-being and relationship satisfaction; (c) whether they interact as far as their association with well-being and relationship satisfaction is concerned. Overall, the findings seem to provide partial support to our hypotheses.

According to certain theoretical models, such as the systemic transactional model (Bodenmann, 1997) or the cognitive-transactional model (Badr & Acitelli, 2017), a person first engages in individual efforts to cope with the stressor and then turns to dyadic coping if the stressor is severe and individual coping efforts prove unsuccessful. The findings of this study, however, do not support these theories. Although all patients were very recently diagnosed, almost one-quarter of them reported more frequent use of individual coping, another quarter reported more frequent use of dyadic/common coping, and another quarter of the

patients reported equally high use of individual and dyadic/common coping.

These findings offer a first indication that not all patients prefer the same form of coping, with several of them using individual and dyadic/common coping at the same time. Thus, the findings seem to provide preliminary support to those theoretical models (e.g., Berg & Upchurch, 2007), which suggest that there is no specific order in the way these forms of coping can be used, while they can be used in parallel. The kind of resources available, the personal and couple characteristics, and the situation likely determine the type of coping employed by the patient (e.g., Falconier & Kuhn, 2019; Staff et al., 2017) – rather than some predetermined process that urges patients to focus first on personal efforts to deal with the health problem and only later move toward the use of dyadic or common coping.

The close association between individual and dyadic/common coping behaviors and the importance of both for adaptation to cancer are also reflected in their intercorrelations. As hypothesized and in accordance with theory

(e.g., Berg & Upchurch, 2007), the more active individual coping behaviors (such as problem-solving) were positively related to supportive dyadic and common coping, whereas individual coping behaviors such as like avoidance and anxious preoccupation were negatively associated with supportive dyadic and common coping. This finding possibly indicates that individual and dyadic/common coping behaviors are not used in a mutually exclusive manner but may reinforce and promote each other (Karademas, 2021). For example, a more active management of the health problem may facilitate open communication with the partner and the development of dyadic efforts to deal with it (Bodenmann, 2005). Also, receiving support from the partner can enhance a sense of control over the situation and thus the employment of more dynamic individual coping behaviors as well (e.g., Pierce et al., 1996). The interplay between individual and dyadic/common coping behaviors, especially over the trajectory of illness, is a key issue for which far more research is needed.

The importance of both forms of coping behaviors is reflected in their relationship to patients' emotional well-being. The relationship of both forms of coping to patients' well-being is well established (e.g., Acquati & Kayser, 2019; Brandão et al., 2017). In this study, the relationship of coping behaviors to emotional well-being and relationship satisfaction was similar to that found in previous studies (e.g., Brandão et al., 2017; Rottmann et al., 2015). Moreover, the findings offered preliminary support to our hypothesis that both individual and common coping behaviors (supportive dyadic coping was not related to emotional well-being) are *concurrently* linked to emotional well-being. Patients probably use both types of coping behaviors to more effectively manage their health problems. Yet, contrary to our hypotheses, when we examined individual and dyadic/common coping together, only the latter was related to relationship satisfaction.

One possible explanation for the weak association of individual coping to relationship satisfaction – in combination with the weak association of supportive dyadic coping to emotional well-being – might be that patients use different coping behaviors to achieve different goals. For example, individual coping likely aims mostly (but probably not exclusively) at personal well-being, while dyadic coping probably aims mostly at relationship satisfaction (see, e.g., Falconier et al., 2015; Falconier & Kuhn, 2019). The concurrent use of different coping strategies may serve this very purpose, namely, to better manage the multiple aspects of adaptation to illness. This possibility also warrants further research in the future.

A final important finding refers to the interaction between individual and dyadic/common coping. The combination of higher use of individual and higher use of dyadic/common coping strategies was associated on

several occasions with higher levels of well-being. A closer look reveals that these significant interactions refer more to relationship satisfaction than to emotional well-being. In addition, the combination of higher negative individual coping and higher dyadic coping was associated with more relationship satisfaction, a puzzling finding that runs contrary to our hypotheses. Thus, although our findings seem to provide some support for the hypothesis that individual and dyadic coping interact, they also underline the complexity of links to the different aspects of adaptation to illness (Karademas, 2021). Far more theoretical and empirical efforts are needed to clarify these relationships and shed light on the interplay between personal and interpersonal coping efforts.

Taken together, the findings of this study provide some indication that individual and dyadic/common coping behaviors are not truly independent; they are likely related to each other, they may be used in parallel, and their combination may facilitate adaptation. As theoretically suggested (Berg & Upchurch, 2007; Karademas, 2021), their relationship is dynamic, and their interaction is relevant to patients' well-being.

However, the findings of this study should be considered carefully and after regarding its limitations. First, this is a cross-sectional, correlational study, so that the direction of the relationships cannot be examined. Prospective studies are needed to further examine the interplay between individual and dyadic forms of coping. The sample was rather modest, and only women with a cancer diagnosis participated in the study. The inclusion of male patients as well might have impacted the findings, while it would be interesting to compare the coping behaviors of male and female patients. In addition, because of the modest size of the sample, the impact of potentially important illness- and treatment-related factors was not examined. Only a few individual and dyadic/common coping behaviors were examined. Future studies should focus on more such behaviors (e.g., negative dyadic coping behaviors, more specific individual coping behaviors). Also, this study assessed only a few indices of well-being and adaptation to illness. However, the examination of multiple outcomes is necessary to more efficiently comprehend how individual and dyadic coping may impact adaptation. Finally, the categorization of patients based on the median split of their coping scores resulted in a significant loss of information. Future studies using more elaborate methods (e.g., ecological momentary assessment) could address this limitation and provide more accurate and reliable findings regarding the use of individual and dyadic coping behaviors.

Despite the several limitations, our study generates certain theoretical and practical implications. To the best of our knowledge, this is the first study to examine the role of both individual and dyadic/common coping behaviors.

It provides initial support for our hypothesis that both types of coping are relevant to adaptation to breast cancer simultaneously, and that they are used by many patients in parallel. Also, the findings of the study underline the importance of considering both individual and dyadic efforts to cope with illness in the development of personalized intervention programs. This may facilitate a more effective combination of the two, which in turn will better promote well-being. Above all, the findings of this study call for further research on the topic. The adoption of longitudinal dyadic study designs or the analysis of real-time interactions between partners (e.g., Lau et al., 2019) are probably necessary to better describe and explain such complicated relationships.

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Evangelos C. Karademas

Department of Psychology

University of Crete

Gallos, 74100

Rethymnon

Greece

karademas@uoc.gr