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Constructing We-ness:

A Communal Coping Intervention for Couples Facing Chronic Illness

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Abstract

Communal coping occurs when relationship partners view a stressful health problem as “ours,” rather than yours or mine, and take collaborative action to deal with it. Although research employing linguistic (*we-talk*) and other measures of communal coping demonstrates relevance to a variety of chronic illnesses, the literature offers little about how clinicians can actively promote *we-ness* and teamwork to help patients and their partners achieve the health benefits this appears to confer. This paper highlights clinical and supporting scientific features of a narrative intervention designed to foster communal coping by couples in which one partner has a chronic illness. The illustrative illness is diabetes, but with modification the protocol is suitable for other chronic conditions as well. Grounded in systemic and narrative models of problem maintenance and change, the communal coping intervention represents a distillation of research and clinical experience with family consultation over several decades. In contrast to more directive and educational approaches, the intervention consists entirely of questions, with no direct suggestions or instruction about how patients, partners, or couples should change. These questions comprise 8 sequential modules (*Coping Challenges, Trajectory and Focus, Illness as External Invader, You as a Couple, Past Teamwork in Overcoming Adversity, Present and Future Teamwork, Obstacles to Teamwork, and Wrap-Up*), described here in manual-like detail.

Keywords: Communal coping, couple intervention, chronic illness, *we-talk*, narrative therapy, health behavior change

Constructing We-ness: A Communal Coping Intervention for Couples Facing Chronic Illness

This paper describes clinical and supporting scientific features of an interview designed to promote *communal coping* by couples in which one partner has a chronic illness. The illustrative illness is diabetes, but with modification the intervention is suitable for other chronic conditions as well. The protocol itself represents a distillation of research and clinical experience with family consultation over several decades, grounded in systemic and narrative models of problem maintenance and change (Rohrbaugh, 2014; Rohrbaugh & Shoham, 2011, 2017). Although the communal coping intervention as presented here has not yet been the focus of systematic investigation, we offer this operationalization in hope of stimulating further clinical adaptation and research.

Communal coping occurs when partners view a stressful health problem as “ours,” rather than yours or mine, and take shared or collaborative actions to deal with it (Lyons, Mickelson, Sullivan and Coyne, 1998). The construct thus includes both an appraisal component and a behavioral (action) component, with shared (social) appraisals taking priority over individualistic ones and collaborative problem solving (teamwork) supplanting individual coping efforts. Communal coping is related to but more specific than the construct of relationship quality because the former is explicitly instrumental with regard to some particular health problem or stressful situation (Helgeson, Jakubiak, Van Vleet & Zajdel, 2018).

Although research documents the relevance of communal coping to chronic health problems such as diabetes, heart disease, cancer, and addiction (Helgeson et al., 2018; Rentscher, 2019; Rohrbaugh & Shoham, 2011), the literature offers relatively little about how clinicians can actively promote *we-ness* and teamwork to help patients and their partners achieve the health benefits communal coping appears to confer. Most of the limited intervention work in this area has been in the context of couple enrichment/enhancement programs involving psycho-education or directed communication training (Helgeson et al., 2018). For example, one successful project improved joint spousal coping in a cohort of women with early stage breast or gynecological cancer by teaching more effective forms of stress communication, such as empathic listening after personal disclosure (Scott, Halford & Ward, 2004), and another employed “couple coping enhancement training” to increase couples’ dyadic coping abilities (Bodenmann & Shantinath, 2004).

In contrast, the protocol outlined here consists entirely of questions, with no direct suggestions or instruction about how patients, partners, or couples should change. The aim instead is to promote active reflection and the sense of partner agency that direct advice and instruction can easily (albeit inadvertently) undermine. Such a “narrative” approach assumes that problematic health behaviors, like the couple and family interaction patterns that sustain them, persist in relation to the meanings and understandings people attribute to what they do (White and Epston, 1990). The clinician’s questions contribute to a developing conversation that opens and amplifies alternative pathways and communal resources, consistent with the clients’ preferences, for dealing with the chronic illness (cf. Sutherland, Sametband, Silva, Couture & Strong, 2013). The interview thus aims to bolster shared partner appraisals of the illness as “ours rather than yours or mine,” reinforce

partner agency, and highlight possibilities for collaborative action without directly suggesting or prescribing them.

More broadly, our communal coping intervention aligns squarely with the narrative or social-constructivist tradition in therapeutic family systems work identified with pioneers such as DeShazer (1985), Tomm (1987, 1988), White and Epston (1990), and Sluzki (1992). In fact, when Varda Shoham and I began developing the systemic family consultation model from which this communal coping interview grew, we made a point of including ideas and techniques from this tradition while attempting to integrate them with more familiar elements of strategic and structural family therapy (Rohrbaugh, Shoham, Spungen & Steinglass, 1995). In the next section I will outline the background of this work as well as research findings that provide some foundation for a stand-alone communal coping intervention. The centerpiece of the paper then describes the interventive interview itself in manual-like detail, and a final section considers clinical and theoretical issues along and implications for future research.

Background

In the early 1990s, before Lyons et al. (1998) brought communal coping into focus as a construct, Shoham and I worked with colleagues on a randomized trial comparing family systems and cognitive behavioral therapies for couples in which one partner was a problem drinker. In developing the manualized family systems intervention (Rohrbaugh et al., 1995; Rohrbaugh & Shoham, 2002), we integrated ideas and techniques from a variety of then influential systemic treatment approaches. Although many of the tactics were fairly direct, we also incorporated emerging narrative methods such as solution-focused and circular questioning (Berg & Miller, 1992; Tomm, 1988) and externalization strategies intended to build collaboration against alcohol as an invader of family life (White & Epston, 1990; cf. Steinglass et al., 1987). In retrospect, the heart of this intervention was the preliminary consultation-assessment phase, which mixed detailed queries about interaction patterns with a sequence of indirect intervention modules, culminating in a tailored “opinion” session inviting the couple to begin “treatment” by setting a quit date. In contrast to traditional alcoholism approaches, a central guideline for the consultation phase was remaining neutral about sobriety and behavior change so that the partners would actively *choose* treatment and work together toward changing their situation. The indirect intervention components, couched in an overriding focus on “you as a couple,” served to highlight couple strengths and teamwork. Although we initially viewed these narrative, relationship-building elements as preparatory for the family detoxification and pattern interruption interventions that would come later, it soon became evident to the clinical team that these indirect “preliminary” interventions were having therapeutic impacts in and of themselves. “*We-ness*” was the central theme in this, and over the next two decades these narrative elements evolved into pieces of the communal coping intervention I describe below.

Just before the millennium Shoham and I redirected our work toward couples coping with chronic illness, taking up two interrelated lines of research that would bring communal coping into sharper focus. One, initiated by James Coyne several years earlier, was a longitudinal assessment study of couples in which one partner had congestive heart failure. A major finding was that the composite quality of a couple’s relationship at baseline

predicted all-cause patient mortality over the next 8 years, independent of how well the patient's heart functioned initially, and did so much better than individual-level predictors such as the patient's self-efficacy, personality traits, or psychological distress (Coyne, Rohrbaugh, et al., 2001; Rohrbaugh, Shoham & Coyne, 2006). The best single predictor of survival was the frequency of a couple's useful discussions about managing the patient's illness – which has obvious relevance to what Lyons et al. (1998) had by then called “communal coping.”

A follow up study with another sample of heart failure couples focused on communal coping more specifically, incorporating an unobtrusive measure based on partners' use of first-person plural pronouns (*we-talk*) when they discussed the patient's illness (Rohrbaugh, Mehl, Shoham, Reilly & Ewy, 2008). Analysis of pronoun counts from both partners revealed that *we-talk* by the spouse, but not the patient, independently predicted positive change in the patient's symptoms and general health over the next 6 months and did so better than direct self-report measures of communal coping and marital quality. *We-talk* by the patient and spouse did not correlate, however, and pronoun measures were only modestly related to self-reports. Although previous studies had linked *we-talk* to relationship quality in romantic couples (Agnew, Van Lange, Rusbult, & Langston, 1998; Simmons, Gordon, & Chambless, 2005), ours was among the first to identify prognostic implications of pronoun use for couples coping with chronic illness.

Other investigators have since employed diverse measurement methods with different chronic illnesses to thicken the evidence base regarding adaptive features of communal coping. Most notable in this arena is Helgeson's program of research using self-report, *we-talk*, and observational measures with a large sample of couples where one partner has diabetes (Helgeson, Jakubiak, Seltman, Hausmann & Korytkowski, 2017; Helgeson, Jakubiak, Van Vleet & Zajdel, 2018; Van Fleet, Helgeson, Seltman, Korytkowski & Hausmann, 2018; Zajdel, Helgeson, Seltman, Korytkowski & Hausmann, 2018). Helgeson et al. (2018) also offer a cogent theoretical model of communal coping with testable implications for disentangling the synergistic contributions of shared appraisal and collaboration to health outcomes (cf. Rentscher, 2019).

The second line of work with Shoham involved developing a family consultation (FAMCON) intervention for health-compromised smokers who continued to use tobacco despite having or heart or lung disease. This essentially streamlined what we had done in the alcohol project and framed the entire (6-10 session) intervention as “consultation.” A three-session assessment phase incorporated some of the same indirect intervention modules intended to foster communal coping – for example, queries about smoking as an external invader of the couple's relationship, reflections on past teamwork in overcoming adversity, prospects for future teamwork, and more. As before, consultants remained neutral about change before presenting the team's opinion, inviting the couple to set a quit date, and addressing problem-maintaining patterns more directly. The results of a FAMCON open trial with both single- and dual-smoker couples were promising: Primary smokers (those with chronic illness) achieved a 50% rate of stable cessation, approximately twice that cited in Fiore et al.'s (2000) meta-analysis involving other, comparably intensive intervention. The FAMCON intervention appeared especially helpful

for female smokers and smokers whose partner also smoked – two groups at high risk for relapse (Shoham, Rohrbaugh, Trost & Muramoto, 2006).

Putting the FAMCON and *we*-talk lines of research together, we examined cessation outcomes in relation to partners' *we*-talk *during* the intervention, using word counts from pre-consultation couple interaction tasks as a baseline covariate. As in the heart failure study, *we*-talk by the primary smoker's partner at baseline predicted the patient's cessation success a year later – but more importantly, *we*-talk by *both* partners in later consultation sessions also predicted success (Rohrbaugh, Shoham, Skoyen, Jensen & Mehl, 2012). Other investigators found similar associations between *we*-language and sustained reductions in drinking during a behavioral couples treatment for alcohol problems (Halgren & McGrady, 2015), suggesting that communal coping could be a common change mechanism across different forms of couple-focused intervention.

Finally, in a creative dissertation project, Rentscher (2017) used session video recordings from the FAMCON alcohol and smoking cases to investigate communal coping interventions in a more fine-grained manner. By selecting sessions where therapist/consultants used specific narrative and solution-focused interventions (e.g., reflections on dealing with a past adversity), Rentscher was able to document within-session increases in partners' communal coping – indexed by both *we*-talk and observer ratings of partners' behavior – from before to after the solution-focused target segments. This evidence directly supports the likely effectiveness of the communal coping protocol outlined below, as many modular elements were represented in Rentscher's study.

After the FAMCON smoking study we further refined this approach through ad hoc applications to a variety of other health problems, including diabetes, cancer, heart disease, dementia, depression, pediatric obesity, and non-adherence to medical regimen. I continued this work with colleagues at George Washington University, the University of Arizona, and elsewhere after Shoham's untimely death in 2014, mostly employing a FAMCON-like format to resolve health-related problems via communal coping and strategic pattern interruption (Rohrbaugh, 2014; Rohrbaugh & Shoham, 2011, 2017). From my scientist-practitioner perspective the narrative communal coping component stands out as both clinically underappreciated and underrepresented in mainstream intervention research. The latter reflects understandable tensions between the languages of narrative theory and evidence based clinical science (Stillman & Erbes, 2012) – i.e., whether it is really possible to translate the ideas and practices of narrative therapy into the language of science (e.g., tools, techniques, and treatment manuals) without losing the essence of narrative therapy. Our attempt to operationalize communal coping modules in a manner amenable to replicable scientific inquiry therefore seems a useful challenge, albeit one whose fidelity to narrative theory and practice may remain open to question.

An Interventive Communal Coping Interview

The communal coping intervention grew not only from the research projects described above but also from our clinical practice experience in medical and non-medical settings, including my own couple and family work with diabetes and other chronic illnesses in primary care. What emerged is a detailed communal coping protocol comprised of eight sequential modules that a clinician familiar with couples and a particular chronic

illness can administer in stand-alone format or as part of a larger intervention package such as FAMCON.

The description of each module below includes a brief explanation of rationale followed by specific questions (in italics) for the interviewer-consultant to use with the patient and partner, along with possible follow-up questions. Interspersed with these (not in italics) are general instructions and bulleted guidelines for conducting the interview. As the rationale descriptions imply, the sequence of modules aims to create a natural flow from identifying specific coping challenges to framing the diabetes as an external invader of the couple's relationship and ultimately highlighting past, present, and future instances of *we-ness* and teamwork in relation to chronic illness and other adversities. An intermediate module (#4), which may be most useful when couples are in conflict or disengaged, steps back from the illness temporarily to reinforce strengths of the couple, and a final wrap-up module (#8) serves to reinforce the broader communal coping narrative emergent across the entire interview.

Module 1 – Coping Challenges

Rationale: The aim of this opening query is to get both partners on the air and develop a preliminary map of the partners' individual and collective stories about coping challenges and resources.

Questions and guidelines:

Let's start with a general question about your experiences with the diabetes [or other index chronic illness] over the past few months. What has been most challenging for you, both as individuals and as a couple? How have you dealt with this?

- Distinguish and pursue explanations for the partners as individuals and the couple as a unit: *What about for you, John? And what's been most difficult for you as a couple?*
- Encourage elaboration by directly requesting it (*Please say more. ...What else?*), repeating significant words and phrases in gentle interrogatory form (*...forgot the insulin? ...very upset?*), and/or offering simple reflections (*So John doesn't tell you when he's feeling bad?*)
- Along the way, invite each partner to comment on what she or he sees as challenges for the other partner: *John, what do you see as most difficult about the diabetes for Mary?*
- Normalize disagreement if/when necessary: *It's ok to disagree; committed partners often do. I want to hear from each of you. Mary, do you see this the same way?*
- When open-ended probes yield no further challenges, invite comment on specific domains the partners may not have mentioned. With diabetes, this would normally include (a) diet, (b) physical activity, (c) medical regimen, (d) individual emotion regulation, and (e) staying connected as a couple: *What about exercise? Any challenges there? How about staying connected as a couple?*
- For each challenge a partner mentions, ask how he or she AND they as a couple have dealt with that challenge.

- Throughout, show only nonverbal empathy for the challenges partners describe and DO NOT in any way attempt to educate, ameliorate, or normalize these challenges. DO, however, listen closely for narrative approximations of communal coping and indirectly reinforce these with nonverbal gestures such as head nods, raised eyebrows and other indicators of interest. Use no verbal reinforcement other than words or phrases like “Interesting!” “Yes!” or “I see!”

Module 2 – Trajectory and Focus

Rationale: The purpose here is to introduce the theme of trajectory, with experiences changing over time, and to sharpen focus on coping challenges the couple finds most difficult. The sequence of questions presents an initial opportunity to explicitly reinforce communal coping with follow-up questions such as those in brackets below.

Questions and guidelines:

Thinking back to when the diabetes was new in your lives (or new in your relationship as a couple), how have these challenges changed since then? How have they changed over time? For example, have some challenges become more or less difficult? Have new challenges emerged? Have others seemed to disappear? If the diabetes predated the relationship, rephrase to ...when the diabetes was new in your relationship as a couple...

- Ask all of these questions together before inviting a response. (Spaces between questions in later sequences denote waiting for responses.)
- Listen with empathic neutrality to problem talk but show interest and curiosity in response to narrative elements about adaptive coping.
- If any challenges have become less difficult or disappeared, ask, *How do you explain that? How did that happen?*
- Encourage elaboration as above, inviting perspectives from both partners: *Is this how you see it, John?*
- Indirectly reinforce approximations of a communal coping narrative, as above.

Of all the challenges we’ve discussed, which would you say has been most difficult for you as a couple?

Which next?

And which challenges would you say you’ve dealt with most effectively as a couple?

[How do (or did) you do that? What does (or did) each of you do to help this happen?]

[Can you describe a recent example?]

[What did John do that gave you a sense of working together in this? What did Mary do?]

[What is different about times when this kind of teamwork occurs?]

- Wait for responses after each question

- Allow partners to describe the same or different challenges, as they prefer: *What would you say about this, Mary*
- If opportunities to reinforce communal coping do not arise (i.e., if partners do not describe a challenge they dealt with effectively), save the bracketed questions for later.

Module 3 – Illness as External Invader

Rationale: This module employs the narrative technique of *externalization*, framing the chronic illness as a separable alien influence on the patient and the couple's relationship. The externalization narrative then creates a basis for identifying and reinforcing efforts by the couple to take collaborative action against this "invader."

Questions and guidelines:

Now a few questions about the diabetes itself:

For some couples, diabetes can feel like an unwelcome or foreign invader in their relationship – something that may not always be present, but comes and goes in ways that make life difficult.

What is this like for you? How does the diabetes invade your relationship as a couple? How does it interfere with what you'd like to do or what you'd like to experience together?

What are some warning signs that let you know the diabetes invasion is beginning to happen?

Have you thought or talked about what you as a couple might do to thwart or repel this invasion?

[Have there been times when you did this? How did it go?]

- Wait for responses to each question, responding with brief probes to clarify or elaborate as appropriate.
- Allow partners to describe the same or different invasion patterns, as they prefer.
- If partners have taken action against the invader, reinforce communal themes in their narrative by showing interest and asking questions such as those bracketed above or listed below.

Module 4 – You as a Couple

Rationale: The idea here is to step back briefly from focusing on the patient's illness and reinforce strengths of the couple. The techniques come from vintage solution-focused therapy and in our experience can be especially helpful with disengaged or high-conflict couples.

Questions and guidelines:

Leaving the diabetes aside for a moment, I'd like to know more about you as a couple. What phrases would you say capture the strength of your relationship? How do other people describe you as a couple?

What do you do for fun as a couple?

What about your relationship or each other would you most like to preserve or hold onto and not see change as time goes on?

Can you think of times in the past when you made an important life decision and followed through?

- Again invite perspectives from both partners.
- Reinforce communal themes as above.

Module 5 – Past Teamwork: Overcoming Adversity

Rationale: This module moves to the heart of the intervention by identifying and reinforcing the couple's collaborative efforts in dealing with past adversities. Historical particulars of this nature serve to bolster an agentic narrative about what "we" as a couple have accomplished in the past and, by implication, what may be possible in the future.

Questions and guidelines:

Now here's a harder question: Tell me about some adversity or difficult life situation in the past that you managed to deal with effectively as a couple. For example, this could involve an important loss, a stressful illness or life event, a disappointment at work, or any other difficult past circumstance one or both of you encountered.

- After giving partners time to ponder the question, ask: *What comes to mind?*
- Allow partners to describe the same or different adversities, as they prefer.
- Follow up with questions about teamwork:

How did you know you were on the same team in dealing with this?

What did each of you do to help this happen? Mary, what did John do? John, what did Mary do?

Who else noticed how you worked together in this way? What did they notice? How did they let you know?

- Punctuate communal responses to these queries with intense interest and reflective summary comments: *So when John says (or does) X, this let's you know he's really in tune with you, Mary? Do I have that right?*

Module 6 – Present and Future Teamwork

Rationale: Building on previous modules, solution-focused scaling questions make concrete what improved communal coping will look like, both in general and in relation to the most difficult aspects of the patient's illness. Follow-on questions aim to solidify and make explicit behavioral pathways that can make this happen.

Questions and guidelines:

In general, how would you rate your present teamwork on a scale from 1 to 10, where 1 = almost no teamwork, we're hardly ever on the same page; and 10 = almost perfect teamwork, we work very well together to solve problems and cope with whatever difficulties arise?

And using the same scale, how would you rate your teamwork in coping with the most difficult challenges related to the diabetes? [Refer to challenges the partners cited earlier, getting separate ratings from each partner for each “most challenging situation” they indicated.]

How will you know when your teamwork is at level X for this challenge? Select a number 2-4 points higher than rating, but less than 10. What will be happening or not happening to let you know teamwork is at X?

How will your day go differently (or how will your lives be different) when teamwork is high in this way?

What will each of you have to do differently for this to occur?

Are there times now when pieces of this occur? What is different about those times? Who does what? How do you do that?

- Allow partners to proceed on different tracks if they prefer, but persistently request consensual validation of what each says.
- If partner disagreement seems strong, ask: *Would more agreement in your answers to my questions also be an indicator of better teamwork? When this happens, how will more agreement affect the ratings you gave earlier?*

Module 7 – Obstacles to Teamwork

Rationale: The questions here invite consideration of a crucial and often neglected source of impediments to successful communal coping – third-party participation in the couple’s relationship. Although the consultant may not be in a position to deal with triadic dynamics directly, incorporating such obstacles in the couple’s emerging coping narrative can pay dividends down the road.

Questions and guidelines:

What would you say are the main obstacles to your working together as a team? What gets in the way?

Are there other important people in your lives – relatives or friends – who make the teamwork we’ve been discussing any more or less difficult? How do they do this?

What signals might they read as an invitation to get involved?

- If a clear triadic pattern of interference emerges, incorporate this as an obstacle in pursuing the questions below

Can you think of a time in the past when [obstacle X] did NOT occur?

What is different about the times when [obstacle X] doesn’t occur?

How will the two of you get this to happen more often?

- Pursue these and similar questions for each significant obstacle the partners mention.
- Again, punctuate communal responses with interest and reflective summary comments.

Module 8 – Wrap-up

Rationale: The final module serves simply to conclude the interventive interview on a positive note, with the consultant's final (sole) declarative statement offering cautiously direct encouragement.

Questions and guidelines:

Well, this concludes the questions I have for you today. Do you have any questions for me?

Come to think of it, I do have one or two more questions for you:

Out of curiosity, what rating would you give for your sense of teamwork right now?

And in the future, what would you like that number to be?

Well, for what it's worth, I think you might get there!

[If rating of current teamwork is 9 or 10, say *I agree with you!*]

Logistical Considerations

For clinical-logistical purposes it is reasonable to ask who can most efficiently administer this intervention under what conditions and in what setting(s). Because the full communal coping interview can take at least 60 minutes to conduct, it may not be practical in primary care settings where health professionals routinely manage diabetes and other chronic illnesses in clinical encounters lasting 15-20 minutes. On the other hand, when other approaches have been unsuccessful due to non-adherence or other factors, a stepped-care framework justifies investment of additional time and resources by primary care providers, behavioral health consultants, or even outside professional specialists in referral programs. For that matter, including a spouse or partner in management of treatment-resistant chronic illness is itself a crucial feature of systemically informed stepped-care (Rohrbaugh, Lebensohn-Chialvo & Methvin, 2020; Rohrbaugh & Shoham, 2011).

As for clinician qualifications and training, we see the main requisites as basic familiarity with couple/family work and solid skills in empathic interviewing and active listening. Because the intervention protocol is highly structured, specialized training in narrative therapy per se is probably not necessary for competent implementation. Skilled narrative therapists will find little new in this intervention and, ironically, may even feel put off by the constraints it imposes.

Although one might hypothesize greater synergistic impact with the full communal coping protocol, piecemeal implementation of the component modules is certainly feasible depending on the clinical situation. So, too, are applications to chronic illnesses and health problems other than diabetes, with variations following from different illness-specific coping challenges elicited in the first module of the interview.

Regardless of problem type, most of our experience with the modules and full package has been in the framework of FAMCON's assessment phase. While this can facilitate later pattern interruption, clinicians can also implement some or all of the narrative protocol as a stand-alone intervention, or even integrate it with follow-on

psycho-educational, cognitive-behavioral, or coaching interventions based on different theories of change. Just as motivational interviewing can enhance the effectiveness of subsequent, individually focused cognitive-behavior therapy (Arkowitz, Westra, Miller & Rollnick, 2008), so might the communal coping interview facilitate a direct couple-focused intervention that follows.

Similarly, while the interview is explicitly for couples, parts of it may also be relevant for other relationship units involved in caregiving for chronic illness. In particular, when a chronically ill patient has no partner or spouse, or when the primary caretaker is another family member or friend, it can be helpful to build the potential for communal coping with the patient and another person. The first challenge is to find and recruit that person (e.g., a parent, adult child, or close friend), a good rule of thumb being that he or she have a past and future with the patient. To pursue this we sometimes engage the patient in a social network interview that includes questions about network members' involvement with the patient's illness and potential for constructive teamwork. Another rule of thumb is for the clinician to contact the prospective communal coping partner directly, and in advance, to explain the purpose of the conjoint interview. With appropriate modifications, the protocol conversation can then proceed through most of the same modules, although some (e.g., couple identity) will probably not apply.

Brief Case Example

Linda and Brad, a married couple in their late '50s, participated in a primary care consultation interview focused on Linda's worsening diabetes. Linda, a full time elementary school teacher, was moderately overweight, did not exercise, and enjoyed preparing (and sharing) elaborate but unhealthy meals with Brad, toward whom she felt protective because of his unsatisfactory job situation. Brad also appreciated these meals and the sense of connection they afforded, but unlike Linda he went to the gym regularly and was able to stay fit. In module 1 of the coping interview Brad cited diet and exercise as especially difficult challenges for Linda and expressed regret he could not do more to help her with this. Module 3 elicited a shared view that the diabetes had invaded their relationship by undermining enthusiasm for activities like biking, hiking, and camping that had been important earlier and which Linda had sometimes initiated. Most pivotal was the couple's recollection in module 5 of how they had worked together to facilitate their adolescent son's physical rehabilitation following a serious accident several decades earlier, when crucial pieces of teamwork included establishing daily routines and being direct with each other about worries and obstacles along the way. Module 6 then brought these and other elements into the conversation about coping with the diabetes, as Linda and Brad began to develop and elaborate a vision of how they, as a team, might change their dietary and exercise routines.

Discussion

As noted at the outset, we as yet have little hard evidence that this communal coping intervention is effective. The closest approximations come from FAMCON studies (Rohrbaugh & Shoham, 2017; Shoham et al., 2006), where communal coping elements were only part of a larger package, and Rentscher's (2017) more focused demonstration that these same elements led to observable within-session change in couples coping with

chronic illnesses other than diabetes. We constructed the intervention based mainly on clinical theory, qualitative observations, and indirectly relevant quantitative findings, yet in a manual-like manner amenable to replicable empirical research that for narrative interventions has been in short supply. In this sense, the intervention's heuristic value may be its greatest virtue.

An important clinical and theoretical issue is whether the conceptual unit for understanding and promoting communal coping should be individual or relational, involving more than one person. Despite its dyadic emphasis, research in this area suggests that active ingredients of communal coping operate at least partly at an individual level. For example, *we-talk* and self-report communal coping scores from the patient and spouse tend not to correlate very highly between partners, and several studies suggest that spouse *we-talk* predicts patient health outcomes better than the patient's own *we-talk* (Helgeson et al., 2018; Rohrbaugh et al., 2008). This raises the possibility that a unilateral intervention targeting shared appraisal by only one partner – say the spouse (“this is *our* problem, not his or hers alone”) – could have positive therapeutic effects. Although we have tried this only occasionally (usually when a patient is reluctant to participate), it is certainly possible for one partner to answer many of the protocol questions without the other partner being physically present – and whether this alone could be therapeutic for the patient or couple is an empirical question. Interestingly, the shared appraisal component of communal coping is an inherently individualistic construct, unlike the dyadic collaboration component that by definition requires joint action by two people.

Another definitional issue is whether communal coping applies only to situations where one partner has a stressful illness or whether it can also encompass stressors that the partners share. Following Lyons et al. (1998), Helgeson et al. (2018) distinguish “communal” from “collectivist” coping, reserving the former for attempts to help the patient adjust to stressful illness while collectivist coping addresses shared stressors and aims to enhance the couple's relationship. Thus, even though both patient and partner are likely to benefit from communal coping, its primary goal is the health of the patient. From our perspective, however, the communal-collectivist distinction is easier to maintain in theory than in practice. For example, it is not uncommon for both partners in a couple to face significant, health compromising stressors, including caregiver burden, and there are situations where both partners have a debilitating chronic illness – or even the same illness, like diabetes. The line between individual and shared stressors can be rather blurry, and in our experience the relationship-focused communal coping modules concerned with teamwork and “you as a couple” can be particularly helpful when this is the case. In fact, it is difficult to imagine how an effective communal coping intervention would *not* have relationship-enhancing consequences for a couple.

What about future research? Because the literature now includes a number of reliable self-report and observational measures of communal coping in addition to the pronoun (*we-talk*) indices that have been a staple of research in this area (Helgeson et al., 2018), it should be possible to evaluate short-term effects of the intervention by comparing pre-post assessments to, say, a didactic control intervention. Going further, it should also be possible to test hypotheses about how the communal coping construct operates. For example, Helgeson et al. (2018) have proposed that the appraisal component is

foundational to the action (collaboration) component, in which case one might predict that experimental modification of shared appraisals would lead to later changes in teamwork and collaborative behavior more than vice versa. This would fit nicely with the NIH “experimental medicine” paradigm for intervention development research (Nielsen, Riddle, King et al., 2018), where investigators first seek to demonstrate “target engagement” by showing that a new intervention modifies some hypothesized mechanism construct (e.g., communal coping appraisals), with follow-on “target validation” verifying that target engagement leads to downstream clinical improvement.

Several other facets of communal coping deserve comment. One is that the theme of *we-ness* goes well beyond health concerns and has a central place in theory, research, and practice concerned with relationship quality and enrichment (Aron, Aron & Smollan, 1992; Buehlman, Gottman & Katz, 1992; Skerret, 2016). In fact, some narrative therapists have made innovative use of “*we-ness*” stories to promote relationship quality in ways similar to what transpires in our communal coping interview (Singer & Skerrett, 2014; Strong, Rogers-de Jong & Merritt, 2014). A difference is that these stories do not focus on helping one of the partners cope with a chronic illness and thus are more in the realm of “collectivist coping” as mentioned above. In any case, the narrative intervention modules we developed borrow heavily from techniques clinicians have applied with couples and families experiencing a variety of problems, including but not limited to chronic illness. The most central of these techniques come from solution-focused therapy (Berg & Miller, 1992; DeShazer, 1985; O’Hanlon & Weiner-Davis, 1989) but other approaches such as Steinglass’ (1998) application of the external invader metaphor in multiple family groups for chronic illness were influential as well.

Another consideration is that communal coping is not always adaptive. In the *we-talk* literature, for example, there are indications that partner pronoun use predicts health outcomes better than the patient’s own pronoun use, which sometimes has no prognostic significance at all (Rohrbaugh et al., 2008; Helgeson, et al., 2018). Also, in a study comparing dual- and single-smoker couples coping with chronic illness, *we-talk* increased when both partners actually smoked together in the laboratory (Rohrbaugh, Shoham, Skoyen, Jensen & Mehl, 2012). Dual but not single-smoker couples showed increased positive affect and affective synchrony during active smoking as well, suggesting a systemic pattern of “symptom system fit” where smoking and relational cohesion (marked by communal *we-talk*) were mutually maintaining (Rohrbaugh, Shoham, Butler, Hasler & Berman, 2009). Yet another likely boundary condition for adaptive communal coping is when partners are highly discrepant in their shared (*we-ness*) appraisals. Thus, Rentscher, Rohrbaugh, Shoham and Mehl (2013) studied couple-level *we-talk* discrepancy scores, calculated by subtracting patient *we-talk* from spouse *we-talk* in a combined sample of couples from our FAMCON smoking and alcohol projects. This index of skewed communal appraisal was concurrently associated with observer ratings of demand-withdraw interaction – a pattern that itself correlates highly with couple distress and dysfunction (Christensen & Shenk, 1991). This implies the possibility of too much communal coping, as when a spouse takes on the problem to the extent that it feels intrusive and controlling.

Needless to say, the effectiveness of this formulaic communal coping protocol will depend greatly on the non-formulaic clinical interviewing skills of the consultant who

administers it. Of particular importance is skillful follow-up inquiry and avoiding the temptation to make educational observations or give therapeutic suggestions – and our bulleted guidelines offer only general guidance for this at best. Another challenge is the clinical complexity of dynamics beyond the dyad. We have tried to anticipate this in the *Obstacles to Teamwork* module (#6), where the consultant's questions invite reflection on specific third-party influences in the couple's relationship (e.g., an over-involved parent or problematic child). Still, it can be difficult to resolve such situations without directly engaging other people in the consultation.

Finally, it is fair to acknowledge that the constraining structure of the narrative interview protocol is in some ways antithetical to the kind of open-ended, collaborative conversation favored by narrative therapists. Nevertheless, if the specificity of what we propose helps to stimulate further clinical adaptation or research, this contribution will have served its purpose.

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