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**The Antecedents and Outcomes of Dyadic Coping in Close Personal Relationships:
A Systematic Review and Narrative Synthesis**

Helen R. Staff, Faye F. Didymus, and Susan H. Backhouse

Leeds Beckett University, United Kingdom

Author Note

Helen R. Staff, Faye F. Didymus, and Susan H. Backhouse are with the Institute for Sport, Physical Activity and Leisure; Leeds Beckett University; Headingley Campus; Leeds; LS6 3QS; United Kingdom.

Correspondence concerning this article should be sent to Helen R. Staff, Institute for Sport, Physical Activity and Leisure; Leeds Beckett University; Headingley Campus; Leeds; LS6 3QS; United Kingdom. Telephone: +44(0)113-812-3246. Email:

H.R.Staff@leedsbeckett.ac.uk

Abstract

Background and objectives: Theories of dyadic coping and empirical literature have intermittently and inconsistently highlighted antecedents and outcomes of dyadic coping. The purpose of this review was to systematically identify the antecedents and outcomes of dyadic coping in close personal relationships.

Design: A PRISMA-guided systematic review and narrative synthesis.

Methods: Literature searches were conducted using CINAHL, PubMed, PsycINFO, and citation pearl growing to identify studies that were relevant to the aim of the review. The search strategy and exclusion criteria led to a final sample of 46 studies that each highlighted antecedents and outcomes of dyadic coping among married couples. Each study was critically appraised and analyzed using narrative synthesis.

Results: The narrative synthesis highlighted five antecedents (learning, gender, relationship characteristics, relationship role, and cultural influences) and two outcomes (relationship functioning and personal health) of dyadic coping.

Conclusion: The review exposes inconsistencies in the conceptualization of dyadic coping, highlights a range of antecedents that influence dyadic coping, and suggests that dyadic coping can have positive benefits for relationship functioning and personal health. The findings have implications for future research and practice (e.g. when working with couples to improve relationship functioning).

Keywords: communal coping, developmental-contextual coping model, dyads, systemic-transactional model, tabulation

The Antecedents and Outcomes of Dyadic Coping in Close Personal Relationships: A Systematic Review and Narrative Synthesis

Coping research has evolved over the past few decades following a surge of interest in stress transactions (see, e.g. Berg & Upchurch, 2007; Bodenmann, 1995; Folkman, 2010; Frydenberg, 2014; Lazarus & Folkman, 1984) and how individuals manage stressors (see, for a review, Skinner, Edge, Altman, & Sherwood, 2003). From a transactional perspective, coping is commonly defined as “constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984, p. 141). The theory on which this definition is based (i.e. transactional stress theory; Lazarus & Folkman, 1984) provides a useful framework for research that focuses on individuals but may not be appropriate when exploring coping in the context of close personal relationships (e.g. between two people). Some relationship theorists (e.g. Bodenmann, 1995; Coyne & Smith, 1991) advocate a conceptualization of coping as dynamic and reciprocal processes whereby the coping of one partner influences the coping of the other partner. Bodenmann (1997) refers to this dynamic concept as dyadic coping and defines it as “the process in which stress signals of one partner and the coping reactions of the other partner to these signals are taken in to account...thus both partners should be motivated to help one another deal with stressful encounters” (p.138). This interpersonal perspective of coping has allowed more contemporary lines of evidence to emerge that explore coping as an interpersonal concept (see, e.g. Berg & Upchurch, 2007; Didymus, 2017) and, in doing so, have developed coping research beyond that which focusses on individuals’ stress transactions.

Various models of interpersonal coping have been developed since the 1990s (e.g. Berg & Upchurch, 2007; Bodenmann, 1995; Coyne & Smith, 1991; Revenson, 1994). Revenson’s (1994) model focused on the congruence or discrepancy of couples’ coping

strategies. This model has been critiqued by some researchers (see, e.g. Falconier, Jackson, Hilpert, & Bodenmann, 2015) because it focuses on individuals as the unit of analysis and, thus, does not explore coping as a “true” dyadic concept. In contrast, the relationship-focused coping model (RFCM; Coyne & Smith, 1991) suggests that, when a couple experiences stress, each person engages in individual and combined coping processes to protect and manage the relationship. Other conceptualizations, such as the systemic transactional model (STM; Bodenmann, 1995) explain the mutual communication of stress, identify the support provided by each member of the dyad, and highlight joint strategies that are used to cope with common stressors. The STM also identifies positive (e.g. stress communication) and negative (e.g. hostile) ways of dyadic coping (Bodenmann, 1995). Positive dyadic coping is thought to be a way of restoring homeostasis for the partner and the couple while negative dyadic coping is viewed as maladaptive to relationship functioning and is thought to prevent or decrease reasonable adjustment to a stressor (Falconier et al., 2015). The STM frames positive and negative forms of dyadic coping as a secondary coping pathway that individuals engage with when individual coping efforts have been exhausted. From this perspective, a dyadic unit is co-created when both individuals reframe their coping efforts as an interpersonal process (Donato, Iafrate, Bradbury, & Scabini, 2012) and, together, expand their coping resources. In contrast to the STM, the developmental-contextual coping model (DCCM; Berg & Upchurch, 2007) suggests that dyadic coping is the first coping pathway used by couples when managing a chronic stressor. Thus, while the theoretical orientation of the most recent models of dyadic coping differ (i.e. the STM takes a transactional perspective while the DCCM adopts a socio-contextual perspective), similarities can be observed in their focus on coping as an interpersonal concept. To better understand the complex dyadic coping phenomenon, it is important that researchers explore the factors that lead to (i.e. antecedents) and occur as a result of (i.e. outcomes) dyadic coping episodes.

The DCCM suggests that sociocultural factors (e.g. gender) and contextual factors (e.g. chronic illness) may precede dyadic coping in couples. Further, the STM, the RFCM, and the DCCM each highlight potential outcomes of dyadic coping on relationships and personal well-being (Berg & Upchurch, 2007; Bodenmann, 1997; Coyne & Smith, 1991). Some published reviews of dyadic coping have also focused on the associations between dyadic coping and outcomes. For example, Falconier et al. (2015) conducted a meta-analysis of dyadic coping and relationship satisfaction and Traa, De Vries, Bodenmann, and Den Oudsten (2015) published a systematic review of dyadic coping and relationship functioning in couples who were coping with cancer. These two reviews and supporting empirical literature (e.g. Regan et al., 2014; Zeidner, Kloda, & Matthews, 2013) highlight the potential important outcomes of dyadic coping and suggest that research focusing more broadly on antecedents and outcomes, rather than on one outcome (e.g. relationship satisfaction) in one particular context (e.g. coping with cancer) is warranted.

Published literature on dyadic coping has often focused on theory building (e.g. Berg & Upchurch, 2007; Bodenmann, 1995), the strategies used during dyadic coping episodes (e.g. Körner et al., 2013), or on the antecedents (e.g. Badr, 2004) or outcomes of dyadic coping (e.g. Chow, Buhrmester, & Tan, 2014). While such research has contributed to a body of knowledge on dyadic coping in various contexts, a systematic review that thoroughly and comprehensively reviews research on antecedents and outcomes of dyadic coping is absent. Research of this nature is important because understanding what precedes and the potential outcomes of dyadic coping will contribute to better understanding of coping as an interpersonal concept. In addition, the findings of such work may be used to inform dyadic stress management interventions. Close personal relationships are the vehicle through which dyadic coping can occur and, thus, it is surprising that many contexts (e.g. health psychology, Agnew & South, 2014; marital relationships, Gottman, 2014; sport psychology, Jowett &

Shanmugam, 2016; occupational psychology, Sias, 2012) where dyadic coping could manifest have been excluded a priori during previous systematic reviews and meta-analyses. To advance understanding and draw on a broader knowledge base than has been used in previous reviews of the literature, the aim of this study was to systematically identify and explore peer-reviewed studies that have focused on antecedents and outcomes of dyadic coping in close personal relationships.

Method

Design

Preliminary literature searches highlighted that antecedents and outcomes of dyadic coping have been explored using a range of methods (e.g. qualitative, quantitative, mixed) and in a variety of contexts (e.g. marital, patient–carer, parent–child, coach–athlete). A systematic review was, therefore, deemed an appropriate method to address the aim of this research. This type of review collects and synthesizes research papers and allows the findings of a variety of studies to be utilized (Jones, 2004). A meta-analysis or a meta-synthesis would not have been appropriate because they fail to accommodate the heterogeneity of studies (Higgins & Green, 2011; Moher et al., 2015) that could have been retrieved during the current review. Given the heterogeneity of the studies that were likely to be retrieved, a narrative synthesis (Popay et al., 2006) was most appropriate for presenting the findings. This approach is often used during systematic reviews (e.g. Le Bouillier et al., 2015) because it offers a framework for synthesizing findings from multiple heterogeneous studies. The guidelines for conducting a narrative synthesis (Popay et al., 2006) were followed when analyzing the retrieved studies and PRISMA guidelines (see Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group, 2009) were followed throughout to ensure systematic and rigorous methods. Other seminal literature (e.g. Cook, Mulrow, & Haynes, 1997; Higgins & Green, 2011) provided further guidance and reference when conducting the review.

Search Strategy

The first stage of the search strategy involved the research team identifying and reviewing relevant search terms (e.g. dyadic coping, communal coping, collective coping, and relational coping) using published literature and a priori knowledge. Once a list of search terms had been generated, complimentary terms were added to describe contexts where close personal relationships may exist (e.g. health, relationships, sport, occupation, and workplace). The final list of search terms and Boolean operators is given in Table 1. The search strategy was based on well-established guidelines that have been used in various contexts (e.g. health, Regan et al., 2014; relationships, Falconier et al., 2015) and involved two distinct phases that were executed by the first named author to gather relevant peer-reviewed literature. First, full-text searches were conducted on CINAHL (1990 to present), PsycINFO (1990 to present), and PubMed (1990 to present) between 31 May 2015 and 20 October 2015. A total of 1016 articles were identified from this first phase of the search strategy. Each of these articles was recorded in a Microsoft Excel™ spreadsheet, which included information relating to the title, year of publication, authors, journal, methods of data collection, units of analysis, and key findings. The Microsoft Excel™ spreadsheet was shared with the research team for cross-referencing and research quality purposes. The second phase of the search strategy used citation pearl growing (Hartley, 1990) to search the reference lists of the articles that had been retrieved during the electronic database searches and during the authors' complementary research activity. An additional 35 articles were identified during this second phase of the search strategy and were included in the initial sample. Thus, the two-phase search strategy yielded an initial sample of 1051 articles.

[Table 1 near here]

[Figure 1 near here]

Exclusion Criteria (rules of inclusion)

Each of the studies that was identified during the search strategy was reviewed against a set of predefined exclusion criteria and those articles that met one or more of the criteria were rejected: (a) the research did not explore dyadic coping as a primary objective; (b) quantitative studies did not use a valid and reliable questionnaire (as demonstrated by acceptable Cronbach's alphas [$\geq .70$] and or other acceptable reliability coefficients) that is relevant to dyadic coping; (c) the research addressed three or more members of close personal relationships (i.e. family studies); (d) the research was a literature review; (e) the research explored a single participant's coping strategies or individual coping; (f) the research used the individual as the unit of analysis; (g) the research was not available in full in the English language; (h) the publication related to a book chapter, abstract, unpublished dissertation, or a conference proceeding; and (i) the research was not published in a peer-reviewed journal. No inclusion or exclusion criteria related to socio-demographics (e.g. age, health) were applied. This decision was made to maximize the breadth of relevant sources that could be retrieved.

Sifting of Retrieved Citations

Prior to sifting, duplicate articles, books, and unpublished works (n = 618) were removed from the Microsoft Excel™ spreadsheet. Sifting was then carried out in two stages following the PRISMA guidelines with the exclusion criteria being applied systematically at each stage (see Figure 1). First, articles (n = 398) were reviewed by the lead author at abstract level and 300 articles were removed at this stage due to meeting one or more of the exclusion criteria. Second, the remaining 98 articles were reviewed at the full-text level and 52 were excluded at this stage. The final sample consisted of 46 papers that were deemed appropriate for inclusion in this systematic review. To minimize bias, inter-rater reliability checks were conducted by the second named author who analyzed 10% of the retrieved abstracts and full texts. There were five disagreements during the sifting processes, which related to the units of

analysis in published works. These disagreements were recorded in a Microsoft Word™ document at each stage of the review and were discussed at length by the research team until a consensus that aligned with the exclusion criteria was reached.

Quality Assessment

The trustworthiness of a systematic review depends on the quality of evidence included and, therefore, it was deemed important to include rigorous quality assessment procedures within this review. To achieve this, the first named author reviewed each of the 46 articles that was in the final sample against a quality assessment checklist that we adopted from a standard quality scoring tool for systematic reviews (Kmet, Lee, & Cook, 2004). The retrieved quantitative studies were scored according to how well they met a list of 14 quality assessment items (e.g. the study design is described and appropriate, means of assessment are clearly reported) and qualitative studies were scored against a similar seven-item list (e.g. the data collection methods are clearly described, the conclusions are fully supported by the results). A standardized rating scale was used: a score of two indicated that the quality criteria had been fulfilled, one indicated partial fulfillment of the quality criteria, and zero indicated that the study had not fulfilled the criteria. If items were not applicable to the study design, they were marked “not applicable” and were excluded from the overall summary score. Each study received a summary score, which was then converted to a percentage for standardization purposes. Five articles (10%) were selected using a random number generator and quality assessed independently by the second named author. The two researchers provided identical quality scores for two of these articles (86% for article one, 71% for article two). For the third article, the first named author’s quality assessment was 82% while the second named author’s assessment was 95%. The first named author provided a quality score of 64% for the fourth article and the second named author provided a score of 79%. The first named author’s assessment of the fifth article led to a score of 64% while the second named

author provided a score of 82%. Discussions among the research team took place to explore these discrepancies until agreement was reached. The agreed quality scores were then studied against a quality related threshold ($\geq 60\%$) for inclusion in the systematic review (Kmet et al., 2004). Each of the 46 studies met this threshold and remained in the final sample.

Data Extraction and Data Synthesis

Once the final sample of 46 studies had been identified and quality assessed, data extraction and synthesis took place. This involved tabulation (Popay et al., 2006), thematic analyses (Braun & Clarke, 2006), and concept mapping (Popay et al., 2006) to systematically extract, record, and analyze relevant data. A narrative synthesis was then developed to present the findings (Pope, Mays, & Popay, 2007). Tabulation involved the construction of a table that illustrated relevant information that had been extracted from each study in the final sample (see Table 2). Tabulation was conducted independently by the first and second named authors to minimize bias in this part of the method. The second and third named authors then reviewed the final table and cross-referenced the extracted data with the original publications. Each of the authors agreed that all relevant data had been extracted and presented appropriately. One article had missing information and, thus, the first named author contacted the corresponding author to request additional information. This information was received and included in Table 2. Once tabulation was complete, thematic analyses (Braun & Clarke, 2006) were used to inductively identify antecedents and outcomes of dyadic coping. In line with other published systematic reviews (e.g. Le Boutillier et al., 2015), we chose thematic analyses because this approach complemented our choice of a narrative synthesis.

The first stage of thematic analysis involved indwelling by the first and second named authors to facilitate immersion in the retrieved articles (Maykut & Morehouse, 1994). To facilitate indwelling, hard copies of the papers in the final sample were printed, annotated, and coded. The codes were then collated in a Microsoft Excel™ spreadsheet by the first

named author. The codes were used by the research team to create sub-themes and, in turn, higher order themes from the extracted data. The final stages of the thematic analyses involved defining and naming each higher order theme (Braun & Clarke, 2006) and producing the narrative synthesis. Throughout the analyses, the codes, sub-themes, and higher order themes were shared and discussed with the research team to enhance trustworthiness, to expose and minimize biases, and to instigate concept mapping (Popay et al., 2006). During concept mapping, the researchers highlighted the themes that were most relevant to the aim of the review (see Table 3) and could be used as a basis for the narrative synthesis.

Narrative synthesis of the findings

The final sample for this review consisted of 46 empirical studies that adopted quantitative ($n = 40$), qualitative ($n = 5$), and mixed methods ($n = 1$) study designs (see Table 2). A cross-sectional research design was used in the majority of the studies (67%, $n = 31$), which suggests that researchers are yet to fully explore the development of dyadic coping within close personal relationships. A longitudinal design was, however, used to explore changes in dyadic coping over time in ten (22%) studies. The number of dyads in each study ranged from five to 663 ($M_{dyads} = 132.56$) and the mean age of the participants ranged from 20.65 to 67.95 years ($M_{age} = 45.23$ years). Each of the studies sampled heterosexual couples who were in romantic relationships and, therefore, the gender divide in each study was 50% male and 50% female. Nineteen studies explored dyadic coping and health-related outcomes, with the remaining 27 studies focusing on relationships more broadly. No studies were identified in alternative contexts that exhibit close personal relationships (e.g. sport, the workplace). Fifty-four percent ($n = 25$) of the studies in the final sample focused on daily hassles (e.g. finances; Falconier, 2015) among romantic and marital couples while other studies ($n = 21$; e.g. Berg, Wiebe, & Butner, 2011; Bergstraesser, Inglin, Hornung, &

Landolt, 2015) focused on major life events (e.g. death of a relative, chronic illness). The findings identify that dyadic coping exists following acute stressful experiences (e.g. daily hassles) as well as major life events (e.g. cancer diagnosis). With reference to the geographical locations of the articles, 54% were conducted in Europe, 37% took place in North America, 7% in Asia and Australasia, and 2% (n = 1) compared couples in China, India, and the United States of America. The thematic analyses resulted in two higher order themes: antecedents dyadic coping and outcomes of dyadic coping. During the tabulation processes, interesting insight to the theoretical framework adopted by published works was also illuminated. Thus, the following narrative synthesis focuses on theoretical frameworks, antecedents of, and outcome of dyadic coping.

[Table 2 near here]

Theoretical Frameworks

A range of dyadic coping theories were used in the included studies. Bodenmann's STM was used to guide 85% (n = 39) of studies in the final sample. Thus, the STM (Bodenmann, 1995, 1997) is most commonly used when exploring the antecedents and outcomes of dyadic coping among marital couples. The more recent DCCM (Berg & Upchurch, 2007) was used to inform 7% (n = 3) of the studies (Berg et al., 2008, 2011; Herzberg, 2013), each of which was conducted in the health domain. Revenson's (1994) coping congruence model was referred to in one (Bodenmann, Meuwly, & Kayser, 2011) of the 46 studies (2%). One other study (Badr, 2004) used the RFCM (Coyne & Smith, 1991) and focused on the joint coping strategies that couples used to protect and maintain their relationship. Lyons, Mickelson, Sullivan, and Coyne's (1998) communal coping model was discussed in one study (Rohrbaugh, Mehl, Shoham, Reilly, & Ewy, 2008). The remaining three studies either did not specify a theoretical framework (Hamama-Raz, Hemmendinger, & Buchbinder, 2010; Wise, Schatell, Klicko, Burdan, & Showers, 2010) or conducted a

grounded theory (Fergus, 2011) and was not informed by one theory in particular.

Antecedents of dyadic coping

The findings suggest that contextual and personal antecedents provide a platform for the utilization of dyadic coping strategies. The high-order theme named “antecedents of dyadic coping” was defined as “concepts that precede dyadic coping in close personal relationships” (see Table 3). Sub-themes relating to contextual antecedents were (i) learning; (ii) relationship characteristics; (iii) roles within the relationship; and (iv) cultural influences. The one sub-theme related to personal antecedents was gender.

Learning

The thematic analyses highlighted learning as a contextual antecedent of dyadic coping. To expand, the findings of eight (17%) studies that were included in the final sample highlight that learning about dyadic coping, either via directed learning (Bodenmann, Bradbury, & Pihet, 2008; Bodenmann, Hilpert, Nussbeck, & Bradbury, 2014; Bodenmann, Pihet, Shantinath, Cina, & Widmer, 2006; Bodenmann, Plancherel, et al., 2008; Falconier, 2015; Heinrichs et al., 2012; Ledermann, Bodenmann, & Cina, 2007) or vicarious experience (Donato et al., 2012), promoted the utilization of dyadic coping in heterosexual relationships. These eight studies referred to various methods of learning about dyadic coping: five studies referred to couples’ coping enhancement training (CCET; Bodenmann, Bradbury, et al., 2008; Bodenmann et al., 2014; Bodenmann, Pihet, Shantinath, et al., 2006; Falconier, 2015; Ledermann et al., 2007), one study referred to coping-oriented couples therapy (COCT, Bodenmann, Plancherel, et al., 2008), one focused on side-by-side learning (Heinrichs et al., 2012), and one other study referred to learning via vicarious experiences of parents and partners (Donato et al., 2012).

The majority of the eight studies (88%) that reported findings related to learning highlighted significant increases in positive dyadic coping following learning. However, one

study (Bodenmann, Plancherel, et al., 2008) explored dyadic coping among couples who were coping with depression and had engaged with either COCT, cognitive-behavioral therapy, or interpersonal psychotherapy. They reported no significant differences in post-intervention dyadic coping between intervention groups. The findings of studies within this theme reported gender differences 88% of the time. Significant effects by gender were reported in 63% of studies (e.g. Ledermann et al., 2007) and, collectively, the findings suggest that learning about dyadic coping provides longer lasting effects among women. In sum, it appears that learning about dyadic coping bolsters the use of dyadic strategies when managing stressors and that the effects of learning last longer for women.

Relationship characteristics

Thematic analyses revealed that relationship characteristics were highlighted in 35% (n = 16) of the studies in the final sample. The codes within this theme were as follows: relationship length (Bodenmann, Pihet, & Kayser, 2006; Herzberg, 2013; Papp & Witt, 2010; Wunderer & Schneewind, 2008), coping similarities (Bergstraesser et al., 2015; Donato et al., 2015; Kayser, Watson, & Andrade, 2007; Untas, Koleck, Bonnaire, & Idier, 2015), and pre-existing dyadic foundations (Berg et al., 2011; Bodenmann, Bradbury, et al., 2008; Bodenmann & Cina, 2006; Bodenmann, Gottman, & Backman, 1997; Fergus, 2011; Kayser et al., 2007; Landis et al., 2014; Ruffieux, Nussbeck, & Bodenmann, 2014; Wise et al., 2010; Wunderer & Schneewind, 2008). The findings within this theme suggest that relationship length influenced dyadic coping in 9% (n = 4) of the studies in the final sample. Three of these studies (Herzberg, 2013; Papp & Witt, 2010; Wunderer & Schneewind, 2008) highlighted that participants who were in longer relationships had a tendency to foster a stronger dyadic focus and use dyadic coping strategies more so than those in shorter relationships. The other study (Bodenmann, Pihet, & Kayser, 2006) that focused on relationship length as an antecedent to dyadic coping found that female participants' perceptions of relationship

quality negatively correlated with relationship length, which impeded positive dyadic coping.

Turning to the second code within this theme, coping similarities were identified in 9% (n = 4) of studies as an antecedent to dyadic coping. These studies highlighted that dyadic coping was preceded by couples' use of similar individual coping strategies (Bergstraesser et al., 2015); perceptions of dyadic coping by an individual's partner (Donato et al., 2015); couple's, but not individual's, alexithymia (Untas et al., 2015); and perceptions of relationship mutuality (Kayser et al., 2007). With reference to the third code within this theme, pre-existing dyadic foundations were discussed in 20% (n = 9) of the studies in the final sample. Pre-existing dyadic foundations related to reciprocal embrace (Fergus, 2011; Wunderer & Schneewind, 2008), relationship stability (Bodenmann & Cina, 2006), relationship satisfaction (Bodenmann, Bradbury, et al., 2008; Berg et al., 2011; Landis et al., 2014; Ruffieux et al., 2014), and relationship quality (Bergstraesser et al., 2015; Bodenmann et al., 1997; Wise et al., 2010). Each of the studies that addressed pre-existing dyadic foundations highlighted that these characteristics increased the opportunity for dyadic coping strategies to be implemented by couples who were coping with stressors. For example, studies that explored relationship satisfaction as an antecedent to dyadic coping (44%, n = 4) demonstrated a positive association with dyadic coping (Bodenmann, Bradbury, et al., 2008; Berg et al., 2011; Landis et al., 2014; Ruffieux et al., 2014). Similarly, 22% (n = 2) of studies which explored pre-existing dyadic foundations found that couples who reported poor relationship quality reduced their stress communication (e.g. Bergstraesser et al., 2015) and common dyadic coping (e.g. Bodenmann et al., 1997). Thus, couples who are in long-term relationships, share common approaches to coping, and have higher relationship satisfaction, appear to use dyadic coping strategies more so than those who are in short-term relationships, have limited coping similarities, and lower perceptions of relationship satisfaction.

Roles within the relationship

Roles with the relationship was discussed an antecedent to dyadic coping in 22% ($n = 10$) of the final sample. The codes within this theme related to patients (Meier, Bodenmann, Mörgeli, & Jenewein, 2011; Rottmann et al., 2015), caregivers (Fife, Weaver, Cook, & Stump, 2013), patients and caregivers (Badr, 2004; Badr et al., 2010; Fergus, 2011; Johnson et al., 2013; Meier et al., 2012; Rohrbaugh et al., 2008), and marital roles (Kayser et al., 2014). Patients' stress communication, which refers to the ability to communicate one's stress to a partner, was higher than partner stress communication in 30% ($n = 3$) of these studies. However, one study identified that those in a caregiving role suffered more stress than patients with life-threatening illnesses (Fife et al., 2013). Patients reported higher levels of positive dyadic coping from caregivers in 70% of studies (e.g. Badr et al., 2010; Fergus, 2011) and partner delegate dyadic coping was reported as higher than patients' delegate dyadic coping in 30% of studies (e.g. Rottmann et al., 2015; Meier et al., 2011). This appears important because Bodenmann (1997) suggested that delegate dyadic coping can improve an individual's environment and, in turn, minimize stressors.

Some studies (60%, $n = 6$) explored roles with the relationship as an antecedent to negative dyadic coping. In 33% of these studies (Badr, 2004; Fergus, 2011), partner use of protective buffering, a negative dyadic coping strategy that is outlined in the RFCM, was higher than patients' use of this strategy. This finding suggests that caregivers attempt to hide their concerns about a stressor to support their patient. An increase in negative dyadic coping in patients was identified in 33% of studies (Badr et al., 2010; Meier et al., 2011). Meier et al. (2012), for example, found that patients reported higher negative dyadic coping than healthy couples. Patients' individual coping orientations were identified in 20% of studies (Fergus, 2011; Rohrbaugh et al., 2008). For example, patients reported more "I" talk when referring to stressors and caregivers more "we" talk (Rohrbaugh et al., 2008). Collectively, these findings show that patients report more positive dyadic coping than partners (Badr et al., 2010;

Rottmann et al., 2015), that patients use more individual and negative dyadic coping strategies than partners or healthy couples, and that roles (e.g. patient, caregiver) act as an antecedent to dyadic coping.

Cultural influences

Cultural influences were discussed as a contextual antecedent of dyadic coping in 9% (n = 4) of studies in the final sample. Codes identified within this theme were collectivism (Kayser et al., 2014), family systems (Falconier, 2013), and spirituality (Austin & Falconier, 2013; Hamama-Raz et al., 2010). With reference to collectivism and family systems, a heightened traditional gender role orientation minimized supportive and common dyadic coping in couples of Asian (Kayser et al., 2014) and Latino heritage (Falconier, 2013). Additionally, although spirituality and faith have been explored as individual coping strategies in literature beyond the scope of this review (e.g. Pargament, Smith, Koenig, & Perez, 1998), spirituality also appears to act as an antecedent to couples' dyadic coping (Austin & Falconier, 2013; Hamama-Raz et al., 2010). Spirituality, which was addressed in 50% (n = 2) of studies that explored cultural influences on dyadic coping, was seen to enhance togetherness (Hamama-Raz et al., 2010), supportive, and common dyadic coping (Austin & Falconier, 2013). However, cultural values were also seen to have a positive association with negative dyadic coping (e.g. protective buffering) in males when managing chronic dyadic stressors (Hamama-Raz et al., 2010; Kayser et al., 2014). Consequently, cultural influences may be considered an antecedent for both positive and negative forms of dyadic coping.

Gender

Gender was discussed in 85% (n = 39) of the studies that were included in the final sample. However, only 33% (n = 15) of the studies specifically addressed and reported gender as an antecedent to dyadic coping. The two codes within this theme were: male effects

and female effects. Fifty-three percent ($n = 8$) of the studies that had a gender code attached illustrated that females communicated stress more often than males (e.g. Bodenmann & Cina, 2006; Körner et al., 2013) and offered higher levels of positive dyadic coping to their partners (Berg et al., 2008; Falconier, Nussbeck, & Bodenmann, 2013). All 15 studies which addressed gender as an antecedent, have suggested that males provide support to their female partners during stressful events while two studies (Bodenmann, Pihet, & Kayser, 2006; Falconier, 2013) have highlighted that females offer more supportive dyadic coping to their male partners than male partners offered to females. In another study, Hamama-Raz et al. (2010) found that males tried to overcome stressors using individual coping strategies so that they could offer support to their female partners. The research presented here suggests that gender may shape the dyadic coping strategies that are used in close personal relationships and that males use individual coping more often than females.

Outcomes of dyadic coping

This higher order theme was defined as “consequences of dyadic coping” and incorporates the relational (relationship functioning) and personal (health) outcomes of dyadic coping. These outcomes were reported in 87% ($n = 40$) of studies in the final sample.

Relationship functioning

Relationship functioning was considered an outcome of dyadic coping in 76% of studies ($n = 35$) in the final sample. The theme included the following codes: relationship quality (e.g. Bodenmann et al., 2011; Chow et al., 2014; Zeidner et al., 2013), relationship satisfaction (e.g. Bodenmann et al., 2014; Iafate, Bertoni, Margola, Cigoli, & Acitelli, 2012), relationship growth (e.g. Hamama-Raz et al., 2010), and relationship stability (e.g. Bodenmann & Cina, 2006). Relationship quality was explored in 29% ($n = 10$) of studies that reported outcomes of dyadic coping that were related to relationship functioning (Bodenmann et al., 2011; Bodenmann, Pihet, & Kayser, 2006; Bodenmann, Pihet, Shantinath, et al., 2006;

Bodenmann, Bradbury, et al., 2008; Chow et al., 2014; Lambert, Hasbun, Engh, & Holzer, 2015; Rohrbaugh et al., 2008; Rottmann et al., 2015; Wise et al., 2010; Zeidner et al., 2013). Positive dyadic coping from both members of the couple was identified in all of these studies as a means to enhance relationship quality. A total of three studies (30%) identified negative associations between negative dyadic coping and relationship quality (Bodenmann, Pihet, & Kayser, 2006; Bodenmann, Bradbury, et al., 2008; Rottmann et al., 2015). Turning to the second code, relationship satisfaction was explored in 49% of studies ($n = 17$). Each of these studies reported that positive dyadic coping improved relationship satisfaction (e.g. Landis, Peter-Wight, Martin, & Bodenmann, 2013). However, gender differences were observed in 47% ($n = 8$) of these studies, which collectively highlighted that dyadic coping had a significant impact on females' relationship satisfaction (Bodenmann et al., 2014; Donato et al., 2015; Falconier, 2013; Falconier et al., 2013; Herzberg, 2013; Iafrate et al., 2012; Papp & Witt, 2010; Wunderer & Schneewind, 2008). Negative dyadic coping was seen to reduce relationship satisfaction in two studies (Donato et al., 2012; Regan et al., 2014).

With reference to relationship growth, this was identified as an outcome of positive dyadic coping in 29% ($n = 10$) of studies that addressed relationship functioning. Relationship growth has been explored in relation to interdependence (Kayser et al., 2007; 2014), togetherness (Bergstraesser et al., 2015; Hamama-Raz et al., 2010; Körner et al., 2013), dyadic adjustment (Badr, 2004; Badr et al., 2010; Heinrichs et al., 2012; Fife et al., 2013) and the reduction of negative emotions (Austin & Falconier, 2013). Common dyadic coping was reported to enhance relationship growth in three (30%) studies (Austin & Falconier, 2013; Badr et al., 2010; Bergstraesser et al., 2015) but positive dyadic coping does not always show a direct positive association with relationship growth (Austin & Falconier, 2013; Kayser et al., 2014). Negative dyadic coping was shown to reduce tenderness and togetherness in one study (Körner et al., 2013). Turning to stability, the findings of two

studies (6%) suggest that dyadic coping enhances relationship stability in healthy couples (Bodenmann & Cina, 2006; Bergstraesser et al., 2015). To summarize, the research in this area suggests that individuals in close personal relationships use positive dyadic coping strategies to enhance relationship functioning in terms of quality, satisfaction, growth, and stability.

Personal health

Personal health was referred to as an outcome of dyadic coping in 28% (n = 13) of the 46 studies in the final sample. Codes within this theme were: mental health (Bodenmann et al., 2011), physical health (Meuwly et al., 2012), and quality of life (Berg et al., 2008; Meier et al., 2011). Mental health advantages were reported in 31% (n = 4) of these studies, which discussed the positive impact that dyadic coping can have on symptoms of depression (Bodenmann et al., 2011; Bodenmann, Plancherel, et al., 2008; Regan et al., 2014; Rottmann et al., 2015). Seventy-five percent (n = 3) of studies that explored mental health as an outcome of dyadic coping reported that negative dyadic coping increased depressive symptoms while positive dyadic coping decreased depressive symptoms (Bodenmann et al., 2011; Regan et al., 2014; Rottmann et al., 2015). One study found that delegate dyadic coping from a partner did not alleviate patients' depressive symptoms (Rottmann et al., 2015). Couples were reported to experience improved physical health in 31% (n = 4) of studies which reported health outcomes (Johnson et al., 2013; Körner et al., 2013; Meuwly et al., 2012; Rohrbaugh et al., 2008). In these studies, positive dyadic coping contributed to health-related outcomes, including a reduction in self-reported heart failure symptoms (Rohrbaugh et al., 2008), reduced cortisol levels (Meuwly et al., 2012), increased exercise adherence (Johnson et al., 2013), and enhanced metabolic control (Körner et al., 2013).

Turning to the final code within this theme, quality of life was assessed in 38% (n = 5) of studies that focused on personal health-related outcomes of dyadic coping. In three

studies (Badr et al., 2010; Heinrichs et al., 2012; Kayser et al., 2014), dyadic coping enhanced quality of life among patients who had been diagnosed with breast or gynecological cancer. One study (Meier et al., 2011) explored the impact of positive and negative dyadic coping on quality of life and found that positive dyadic coping increased quality of life while negative dyadic coping decreased quality of life in patients and partners. In the same study, partner delegate dyadic coping decreased patients' quality of life. To summarize, it appears that positive dyadic coping can reduce depressive symptoms, self-reported heart failure symptoms, and cortisol levels while increasing exercise adherence and overall quality of life.

Discussion

The aim of this review was to systematically identify and explore the antecedents and outcomes of dyadic coping in close personal relationships. The findings of the review have advanced understanding by drawing on a broader knowledge base than has been used in previous reviews of the literature and by focusing on antecedents and outcomes of dyadic coping. In doing so, we synthesized the findings of published works to move towards a better understanding of what precedes and occurs as a result of dyadic coping. The findings of the review acknowledge various theories of dyadic coping and suggest that antecedents of dyadic coping (e.g. cultural influences, relationship characteristics) lead to adaptive or maladaptive dyadic coping strategies. Relationship functioning and personal health were identified as outcomes of dyadic coping that are influenced by the dyadic coping strategies (e.g. positive and negative) that individuals in close personal relationships use. Given the prevalence and importance of close personal relationships in performance domains such as sport and occupational psychology, it is surprising that our rigorous searches did not identify relevant published works within these and other domains. While the search strategy allowed literature from all domains to be retrieved, the paucity of research in such aforementioned domains

means that the findings of this review are limited to the antecedents and outcomes of dyadic coping that have been reported in health and relationship literature. Given that some researchers have noted that broader terms (e.g. social support, communal coping) have erroneously been used interchangeably with the term dyadic coping (Coyne, Ellard, & Smith, 1990), it may be that our search strategy excluded research that has indirectly explored the ways that dyads cope with stressors in performance environments.

Although the number of published studies that were deemed suitable for inclusion in this review was relatively low ($n = 46$), the research spans 26 years and is dominated by theory-informed research. This has allowed scholars to develop a strong foundation of knowledge about complex dyadic coping processes (Folkman, 2010) and the factors that antecede and occur as a result of dyadic coping. Despite this knowledge, research on dyadic coping in close personal relationships remains in its infancy and the slow growth of the field across various disciplines has led to the development of multiple theoretical frameworks (e.g. DCCM, STM, and RFCM). While these frameworks have allowed empirical research to focus on important and relevant concepts, they have contributed to conceptual ambiguity in the dyadic coping literature. It is, therefore, not surprising that there is a dualistic divide within coping literature (i.e. researchers mostly study either individual or dyadic coping; Wolf, 2015). Nevertheless, dyadic coping is a fortunate new insight to psychological stress research (Folkman, 2010) that warrants further attention to theory building and refinement.

The findings of this review highlight antecedents of dyadic coping that appear to be important for those in close personal relationships. Learning, for example, was acknowledged as a contextual antecedent to dyadic coping. Indeed, a number of studies retrieved during this review (e.g. Bodenmann, Bradbury, et al., 2008; Bodenmann et al., 2014; Bodenmann, Pihet, Shantinath, et al., 2006); Bodenmann, Plancherel, et al., 2008; Falconier, 2015; Heinrichs, et al., 2012; Ledermann et al., 2007) demonstrated that dyadic coping interventions promote the

use of dyadic strategies to overcome the stressors that couples experience. Other researchers have suggested that enhancing couples' communication and problem-solving skills is not sufficient and, as such, that specific education about effective dyadic coping is needed to promote the use of dyadic coping strategies (Bodenmann & Shantinath, 2004). Relationship characteristics was another factor that appeared to antecede dyadic coping among couples in close personal relationships. The findings within this theme suggest that couples who use dyadic coping view stressors as "ours," rather than viewing them as "mine" or "yours." Of particular note within relationship characteristics was relationship length, which was shown to influence the use of dyadic coping strategies (Herzberg, 2013; Papp & Witt, 2010; Wunderer & Schneewind, 2008). Specifically, those in longer relationships appear to use dyadic coping more so than those in shorter relationships. Interdependence theory (Kelley & Thibaut, 1978) may be helpful when explaining this finding because it acknowledges relationship length as a contextual factor that is needed to promote interdependence. This theory suggests that independent motivations are minimized once an individual enters a committed relationship and engages with dyadic processes and, thus, that dyadic coping may develop and change as time in a relationship increases.

Turning to roles within the relationship, relationship psychology researchers have suggested that context-specific attachment figures can provide real or perceived sources of support when managing demands (Mikulincer & Shaver, 2007). This is comparable to our findings that identify roles within relationships as an antecedent of dyadic coping. To expand briefly, the findings of this review suggest that the role that an individual has in a close personal relationship (e.g. patient or partner) influences both dyadic coping episodes and subsequent outcomes. Another situational antecedent that was identified by this review was cultural influences. Cultural influences was defined in this study as a group's way of life that considers individuals' values, beliefs, and social organization that are meaningful to all group

members (see also Aranda & Knight, 1997). The findings of other research on stress and coping have identified that cultural influences (e.g. individualism or collectivism) can affect coping strategies employed in close personal relationships (Berg & Upchurch, 2007; Chun, Moos, & Cronkite, 2006; Hobfoll, 2001). Others (e.g. Lazarus, 1999), however, have argued that exploring culture and coping poses a risk of assuming that all people within a particular culture utilize similar ways of coping. Therefore, our findings indicate a need for further investigation into the effect of culture as a stimulus for dyadic coping.

The last antecedent of dyadic coping that was highlighted in this review was gender, which is categorized as a personal antecedent that influences the dyadic coping strategies used. To expand, our findings indicate that females communicate stress more often than males (e.g. Körner et al., 2013), that males use individual coping more often than females (e.g. Hamama-Raz et al., 2010), and that females offer more supportive dyadic coping than males (e.g. Falconier, 2013). One explanation for these findings may relate to the different coping strategies that males and females are thought to prefer (Tamres, Janicki, & Helgeson, 2002) or the different appraisal processes that men and women engage with (Santacana, Kirchner, Abad, & Amador, 2012). It should be noted that, while we explored gender as an antecedent to dyadic coping, gender may also play a part in moderating dyadic coping.

It is now apparent that dyadic coping can have adaptive outcomes for those in close personal relationships (see, e.g. Bodenmann, 1997; Coyne & Smith, 1991; Falconier et al., 2015). Our findings suggest more specifically that relationship functioning (e.g. enhanced relationship quality) can occur when couples pool together their resources to cope with a shared stressor. One explanation for this may relate to the role of dyadic coping in fostering less threatening appraisals of stressors and increasing available coping resources (Bodenmann, 1995; Berg & Upchurch, 2007). In line with assumptions of theoretical frameworks (e.g. STM; Bodenmann, 1995), dyadic coping was seen in this review to enhance

relationship functioning. This suggests that dyadic coping is a predictor of relationship satisfaction for those in heterosexual relationships (Falconier et al., 2015). The results presented here also suggest that relationship satisfaction may have a dual role by acting as an antecedent and an outcome of dyadic coping in close personal relationships (Landis et al., 2014).

The findings of this review identified personal health as another outcome of dyadic coping. This theme encapsulated both physical and psychological health implications of dyadic coping, which adds to previous reviews that have focused solely on the psychological health outcomes of this type of coping (Berg & Upchurch, 2007). This provides support for the assertion that dyadic coping has noteworthy implications beyond simply coping together with another individual. Our personal health-related findings also highlight the potentially double-edged sword of dyadic coping because negative dyadic coping can have a negative impact on mental health by increasing depressive symptoms while positive dyadic coping can have a positive impact. One explanation for these findings is emotional contagion, which suggests an individual's perception of their partner's emotional state automatically causes the individual to covertly replicate the partner's behavior and share their emotional state (Dezecache, Jacob, & Grèzes, 2015). As noted by other researchers (e.g. Falconier et al., 2015), there remains a requirement for explorations of how dyadic coping relates to various physical and psychological health outcomes. Outcomes relating to both health and relationship functioning were observed during this review in a range of studies but the majority of these used cross-sectional research designs that capture a snapshot of dyadic coping episodes. While cross-sectional research contributes to knowledge development, we suggest that the extant literature falls short of fully exploring dynamic dyadic coping processes in close personal relationships.

When bringing the findings on antecedents and outcomes of dyadic coping together, it

should be noted that positive and negative types of dyadic coping appear to be anteceded by different factors and that these types of coping have different outcomes for individuals and relationships. For example, it appears that the role of a caregiver can antecede delegate dyadic coping and that negative dyadic coping contributes to increased distress and poorer quality of life (Meier et al., 2011). On the other hand, positive dyadic coping has been shown to be anteceded by relationship characteristics and to lead to both adaptive (e.g. increased exercise adherence; Johnson et al., 2013) and maladaptive (e.g. increased patient anxiety; Rottmann et al., 2015) outcomes for individuals and relationships. Thus, antecedents of dyadic coping (i.e. learning, relationship characteristics, roles within the relationship, cultural influences, and gender) may be important for determining the types of coping used and the subsequent outcomes for individuals and relationships.

The findings of this review should be considered in light of some limitations. For example, the thematic analyses and narrative synthesis that were used to analyze and report the findings have inherent limitations (e.g. the subjective nature of the themes), which are particularly relevant when considering that some of our findings are based on one or two published articles. While the narrative synthesis was based on theory (see, e.g. Popay et al., 2006) and was the most appropriate approach for our review that aimed to synthesize heterogeneous studies, meta-analyses and meta-syntheses should be considered for future complementary reviews. In addition, the search strategy that we adopted may have excluded some literature that met one or more of the exclusion criteria but may have been relevant to the aim of the study. It is worth noting at this stage, however, that the exclusion criteria were developed and applied rigorously to allow the exploration of quality peer-reviewed studies from a range of disciplines that have explored dyadic coping. A large proportion of the studies in our final sample focused on middle-class participants of Western European descent. This may have been due to our decision to exclude studies that were not available in

the English language, which was made in accordance with PRISMA and Cochrane guidelines.

The findings of this review suggest that longitudinal research is needed to explore how dyadic coping evolves and changes over time. Research of this nature will help to develop more advanced understanding of complex and dynamic coping processes in close personal relationships. Various conceptualizations of dyadic coping have been developed and explored, which has led to a lack of coherence in the literature. Researchers would do well to work towards a consensual definition of dyadic coping that will help to advance knowledge in a logical and uniform fashion. Future research should also explore how gender acts as both an antecedent and moderator of dyadic coping to better understand the role of gender during dyadic coping episodes. One clear void in current knowledge relates to performance environments where dyads are known to experience shared stressors. Further research in sport and the workplace, for example, will help to address this shortcoming and better understand how dyadic coping manifests in different contexts. This is important because researchers and applied practitioners require knowledge of dyadic coping processes to be able to support and nurture environments that facilitate adaptation and, potentially, performance.

Conclusion

The findings of 46 empirical studies highlight the complexity of dyadic coping in close personal relationships. A range of antecedents were highlighted that have nuanced influences on dyadic coping and it appears that dyadic coping has consequences for relationship functioning and personal health. The findings have implications for future research and practice. For example, knowledge of antecedents and outcomes of dyadic coping can help to inform practitioners who are seeking to enhance positive dyadic coping via stress management interventions with dyads in a range of contexts. In terms of theory building, the review exposes inconsistencies in the conceptualization of dyadic coping and suggests that

further uniformity is required to make logical progression. Complementary and somewhat uniform development of dyadic coping literature will ensure that researchers work toward a better understanding of complex stress processes and will contribute to the development of effective interventions to enhance relationship functioning and individual health and well-being.

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1 Table 1

2 *Search Terms Used to Conduct the Database Searches*

Discipline	Keyword(s)	Boolean operator(s)	Searches
Health	Dyadic cop*	AND	Dyadic cop* AND Health
	Communal cop*	AND	Communal cop* AND Health
	Collective cop*	AND	Collective cop* AND Health
	Relational cop*	AND	Relational cop* AND Health
Relationship	Dyadic cop*	AND	Dyadic cop* AND Relationship*
	Communal cop*	AND	Communal cop* AND Relationship*
	Collective cop*	AND	Collective cop* AND Relationship*
	Relational cop*	AND	Relational cop* AND Relationship*
Occupation	Dyadic cop*	AND/OR	Dyadic cop* AND Occupation* or Workplace
	Communal cop*	AND/OR	Communal cop* AND Occupation* or Workplace
	Collective cop*	AND/OR	Collective cop* AND Occupation* or Workplace
	Relational cop*	AND/OR	Relational cop* AND Occupation* or Workplace
Sport	Dyadic cop*	AND	Dyadic cop* AND Sport
	Communal cop*	AND	Communal cop* AND Sport
	Collective cop*	AND	Collective cop* AND Sport
	Relational cop*	AND	Relational cop* AND Sport

3

4 *Note.* All searches were conducted at the “TX all text” level.

5 Table 2

6 *Tabulation of Extracted Data From the Final Sample*

	Author(s), year	Sample in dyads, body of literature	Study design	Quality score (%)	Guiding theory	Dyadic coping measure	Themes	Significant findings
1	Austin & Falconier (2012)	104 ($M_{age}=40$), relationship	QT, CS	77	STM	DCI	CI, G, RF	Aggression impacted positive forms of DC. Spirituality had indirect effects on aggression via increased CDC in males ($r=-.36$) and females ($r=-.32$).
2	Badr (2004)	182 ($M_{age}=44$), health	QT, CS	86	RFCM	RFCS	RWR, G, RF	Coping styles varied by gender ($p=.05$) and health ($p=.05$). Coping congruence led to greater marital adjustment ($p=.02$).
3	Badr et al. (2010)	191 ($M_{age}=53$), health	QT, Lo	68	DCCM	FDCT-N	RWR, RF, PH	Following cancer-related distress, positive CDC had differing effects on patients and their partners ($r=.09$). Negative CDC resulted in greater distress for both members of the dyad ($r=.17$).
4	Berg et al. (2008)	57 ($M_{age}=66$), health	QT, Lo	82	DCCM	Diary	G, PH	Marital satisfaction was higher in couples who reported greater collaborative coping ($r=.38$). Collaborative coping increased positive same day mood in both partners ($p<.01$) and less negative same day mood in wives ($p<.001$).
5	Berg et al. (2011)	59 ($M_{age}=66$), health	QT, CS	64	DCCM	Diary	RC	Wives perceived more frequent coping collaboration than their husbands, moderated by negative covariation. Males ($SE=.10$) and females ($SE=.14$) in close personal relationships experienced similar negative affect when managing a major life event.
6	Bergstaesser et al. (2015)	23 ($M_{age}=45$), relationship	MM, CS	64	STM	DCI, IV	RC, G, RF	CDC helped couples manage individual and dyad grief following the death of a child. A well-functioning partnership prior to stressor stimulated DC strategies.
7	Bodenmann, Bradbury et al. (2008)	122 ($M_{age}=41$), relationship	QT, I	64	STM	DCI	Le, RC, G, RF	Improvements in positive communication were significantly correlated with changes in positive DC in couples ($r=.46$). Wives' increases in positive DC and decreases in negative

8	Bodenmann & Cina (2005)	62 ($M_{age}=33$), relationship	QT, Lo	86	STM	FDCT-N	RC, G, RF	DC improved marital satisfaction when learned strategies were used in daily lives. DC and individual coping correctly predicted relationship status five years later (62.1%). Stable-satisfied marriages were categorized as low stress and reported engaging in more positive DC than distressed or separated/divorced couples ($p<.10$).
9	Bodenmann et al. (1997)	40 ($M_{age}=35$), relationship	QT, CS	77	STM	FDCT-N	RC	No significant differences between four types of satisfied couples and the total score of DC. Avoider couples were significantly different ($p<.05$) to the other three typologies in emotion-focused stress communication and CDC.
10	Bodenmann et al. (2014)	330 ($M_{age}=41$), relationship	QT, RCT	82	STM	DCI	Le, RF	A relationship enhancing intervention increased DC in women six months after the intervention ($.15 \leq d \leq .47$). After the intervention couples reported improvements in relationship satisfaction ($.23 \leq d \leq .47$).
11	Bodenmann et al. (2011)	443 ($M_{age}=34$), relationship	QT, CS	68	STM & CCM	DCI	RF, PH	Positive DC was related to relationship quality for males ($\beta=.48$) and females ($\beta=.47$) and was a negative predictor of anxiety, social dysfunction, and depression in females ($\beta=.10$). Negative DC was a significant predictor of anxiety and depression in female ($\beta \geq .16$). In men, negative DC was associated with physical symptoms ($\beta=.10$), and higher anxiety ($\beta=.11$) and depression ($\beta=.13$).
12	Bodenmann, Pihet, & Kayser (2006)	90 ($M_{age}=43$), relationship	QT, Lo	77	STM	FDCT-N	RC, RF	Positive DC was significantly associated with marital quality ($p<.001$). Gender differences were apparent when addressing negative DC and marital quality. The association between positive DC and marital quality was predicted by the duration of the relationship ($\beta=-.002$, $p<.001$).
13	Bodenmann, Pihet, Shantinath, et al. (2006)	118 ($M_{age}=41$), relationship	QT, QE	82	STM	FDCT-N	Le, RF	An intervention aimed to enhance marital competencies through DC shows that DC improved marital quality ($\eta^2=.05$) and stability ($\eta^2=.07$) in couples compared to a matched comparison group.
14	Bodenmann,	60	QT, RCT	68	STM	DCI	Le, PH	An intervention used to enhance DC in couples suggested

22	Fife et al. (2013)	health 193 ($M_{age}=51$), health	QT, Lo	68	STM	Modified RWR, WCCL RF	an important contributor to connectedness. Partner-related coping had positive effects on dyadic adjustment for patients at time 2 ($r=.316$), time 3 ($r=.269$), time 4 ($r=.464$), and themselves at time 4 ($r=.282$).
23	Hamama-Raz et al. (2010)	health 5 ($M_{age}=31$), relationship	QL, CS	71	None	IV CI, G, RF	Gender differences in coping strategy use. Males supported females' coping, which enhanced perceptions of dyadic cohesion and togetherness. Cultural influences can inhibit DC.
24	Heinrichs et al. (2012)	72 ($M_{age}=52$), health	QT, RCT	64	STM	DCI Le, RF, PH	A relationship skills program enhanced couples' DC with short term effects. A significant large positive relationship was established between communication and DC ($r=.77$). DC had a significant negative relationship with fear of cancer progression in both partners ($r=-.25$). Post-traumatic growth was seen in couples who engaged with the program.
25	Herzberg (2013)	240 ($M_{age}=39$), relationship	QT, CS	73	STM & DCCM	DCI RC, RF	DC was a stronger predictor of relationship satisfaction in males ($\beta=.44$) and females ($\beta=.52$) than individual coping. Relationship length had a negative effect on females' DC ($r=-.11$ and $-.22$) and males' emotion focused DC ($r=-.16$).
26	Iafrate et al. (2012)	281 ($M_{age}=34$), relationship	QT, CS	68	STM	FDCT-N RF	Perceived similarity in DC strategies predicted relationship satisfaction for both males ($\beta=.37$) and females ($\beta=.18$). Once all of the variables were adjusted for stereotype effects, none of the variables predicted males' relationship satisfaction.
27	Johnson et al. (2013)	117 ($M_{age}=57$), health	QT, CS	77	STM	DCI RWR, PH	CDC was associated with greater health benefits (e.g., diabetes efficacy) for both patients ($\beta=.19$) and partners ($\beta=.43$). Relationship satisfaction was associated with higher CDC in both patients ($\beta=.45$) and their partners ($\beta=.52$).
28	Kayser et al. (2007)	10 ($M_{age}=51$), health	QL, CS	64	STM	IV RC, RF	Two patterns of relational coping were identified: mutually responsiveness and disengaged avoidance. Relationship qualities (e.g., relationship authenticity) were seen as important for DC.
29	Kayser et al.	28	QL, CS	64	STM	IV RWR,	Culture influenced marital roles and DC strategies. Higher

	(2014)	($M_{age}=45$), health				CI, RF, PH	levels of interdependence were observed in Asian couples compared to a focus on independence in Western couples. The stressor itself was seen to enhance interdependence in Western couples.	
30	Körner et al. (2013)	38 ($M_{age}=39$), health	QT, CS	64	STM	FDCT-N	G, RF, PH	Couples utilizing negative DC reported lower levels of tenderness and togetherness ($p \leq .01$). Although not significant, parents who used positive DC showed greater health benefits (e.g., regulation of blood glucose) in their children, compared to those using negative DC styles.
31	Lambert et al. (2015)	56 ($M_{age}=29$), health	QT, CS	77	STM	DCI	RF	SDC ($\beta=.11$, $SE=.03$) and CDC ($\beta=.11$, $SE=.03$) mediated the association between veteran PTSS and relationship quality. CDC predicted spousal relationship quality ($b=1.61$, $p=.017$).
32	Landis et al. (2013)	132 ($M_{age}=68$), relationship	QT, CS	64	STM	DCI	RF	Husbands' ($r=.41$) and wives' ($r=.36$) perceptions of partner SDC was more important for their relationship satisfaction than their own DC.
33	Landis et al. (2014)	201 ($M_{age}=59$), relationship	QT, CS	68	STM	DCI	RC, G, RF	Relationship satisfaction significantly mediated the effect of commitment ($r=.76$) on DC ($r=.88$). Gender differences were found: women's satisfaction significantly mediated the effects between partners' commitment ($r=.17$) and partners' DC ($r=.24$).
34	Ledermann et al. (2007)	100 ($M_{age}=38$), relationship	QT, RCT	64	STM	DCI	Le, G	A couple's coping enhancement training intervention increased DC over time ($\eta^2 p=.298$). Gender differences were observed: women displayed higher levels of negative DC ($\eta^2 p=.078$).
35	Meier et al. (2011)	43 ($M_{age}=67$), health	QT, CS	72	STM	DCI	RWR, PH	Patients' own stress communication correlated negatively with their overall QoL ($r=-.33$). Partners' own negative DC was significantly associated with poorer QoL ($r=.40$).
36	Meier et al. (2012)	181 ($M_{age}=54$), health	QT, CS	68	STM	DCI	RWR, G	Patients received more delegate DC from their partners ($p<.001$). In couples managing a clinical stressor, patients reported lower assessment of own DC ($p<.001$), partner DC ($p<.05$), and overall DC ($p<.01$) than the comparison group.

37	Meuwly et al. (2012)	123 ($M_{age}=27$), relationship	QT, CS	77	STM	DCI	G, PH	Significant main effects for gender and stress communication ($p<.05$). Stress recovery was faster when more positive DC was received from the partner in females ($B<.000$, $SE<.000$) and males ($B= -.002$, $SE=.001$). Males provided more positive ($p=.021$) and negative ($p=.033$) DC than females.
38	Papp & Witt (2010)	100 ($M_{age}=21$), relationship	QT, CS	64	STM	DCI	RC, RF	Positive DC influenced relationship functioning more so than individual coping strategies for males ($p<.05$) and females ($p<.01$). Negative DC was a stronger predictor of relationship satisfaction than individual coping in males and females ($p<.001$).
39	Regan et al. (2014)	42 ($M_{age}=62$), health	QT, CS	64	STM	DCI	RF, PH	Patients depression was significantly associated with oneself SDC ($r=-.35$), negative DC from partner ($r=.32$) and CDC ($r=-.35$). Relationship satisfaction was significantly correlated with CDC ($r=.51$). Spousal anxiety was significantly correlated with one's negative DC ($r=-.32$) and partner negative DC ($r=.34$). Couples' use of SDC and CDC was associated with relationship satisfaction.
40	Rohrbaugh et al. (2008)	60 ($M_{age}=66$), health	QT, CS	68	CC	IV	RWR, RF, PH	"We talk" by the partner predicted positive changes in patients' health ($\beta=.23$, $p=.014$). Use of we talk correlated with marital quality scores of both partners ($rs= .28$ and $.26$, $p<.05$)
41	Rottmann et al. (2015)	538 ($M_{age}=59$), health	QT, Lo	77	STM	DCI	RWR, RF, PH	Patient negative DC was adversely associated with their own ($SE=.09$) and their partner's ($SE=.09$) relationship quality. Patient negative DC was positively associated with their own depressive symptoms ($SE=.41$). CDC resulted in higher relationship quality for patients ($SE=.10$) and partners ($SE=.09$) and fewer depressive symptoms among patients ($SE=.40$) and partners ($SE=.40$). Relationship roles influenced depressive symptoms.
42	Ruffieux et al. (2014)	162 ($M_{age}=42$),	QT, Lo	64	STM	DCI	RC, G, RF	Positive communication was correlated with DC for men ($r=.57$). DC was significantly correlated with initial

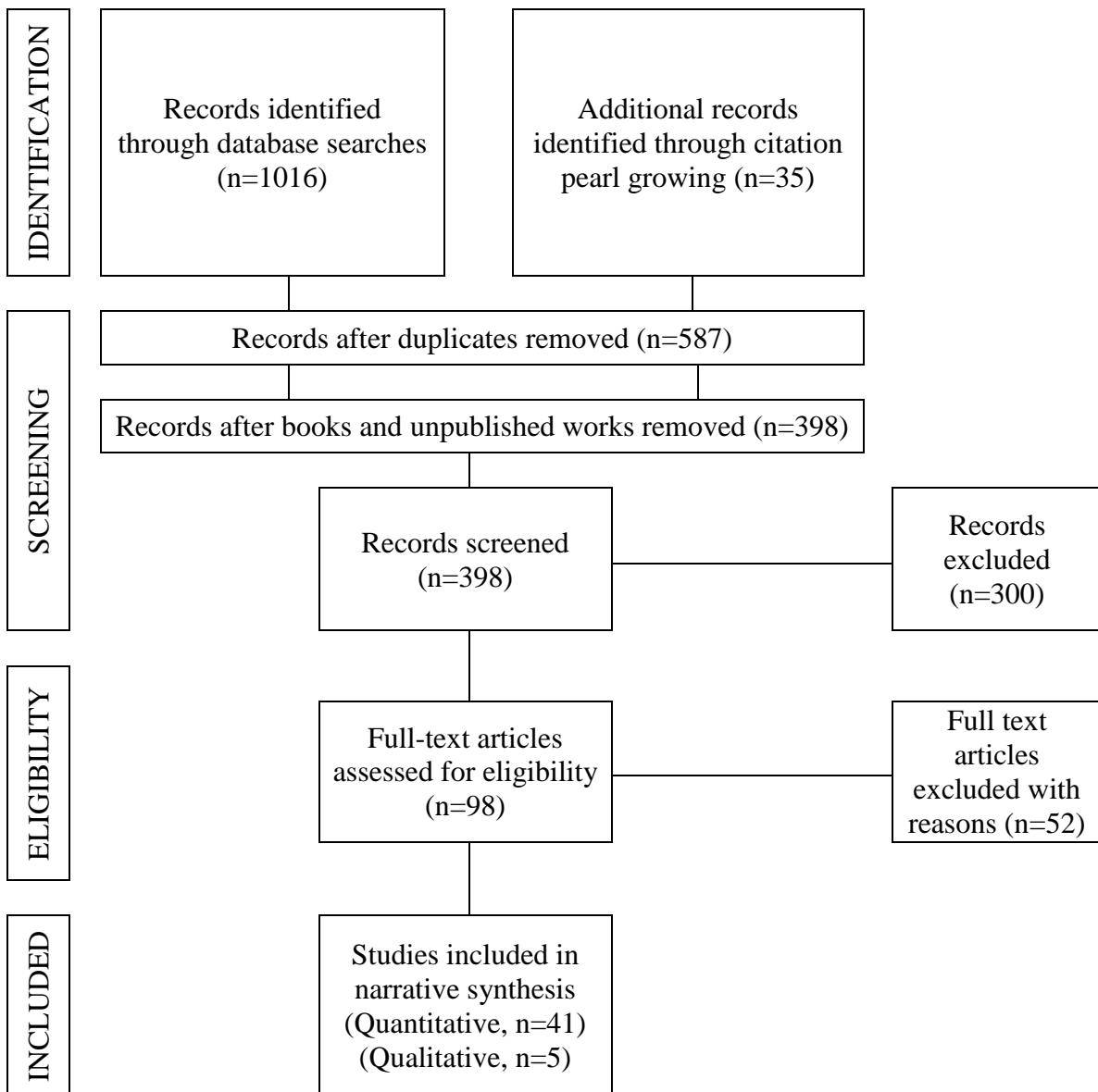
43	Untas et al. (2015)	relationship 112 ($M_{age}=35$), relationship	QT, CS	68	STM	DCI	RC	relationship satisfaction for men ($r=.67$) and women ($r=.64$). Individual high levels of alexithymia reduced an individual's positive DC for men ($r=-.90$) and women ($r=-.21$). Higher levels of couple alexithymia were significantly related with higher levels of DC in women ($r=1.20$).
44	Wise et al. (2010)	13 ($M_{age}=57$), health	QL, CS	64	None	IV	RC, RF,	Four profiles of DC emerged: thriving, surviving, martyrdom, and seeking another option. Pre-existing solid relationships were seen as antecedents to thriving couples who used more self-care methods of hemodialysis and the challenge of home care ensured strong relationships became stronger.
45	Wunderer & Schneewind (2008)	663 ($M_{age}=52$), relationship	QT, CS	73	STM	FDCT-N	RC, RF,	Significant positive correlations between relationship standards and DC in males ($r=.51$) and females ($r=.42$). Significant positive correlations were found between marital satisfaction and DC in males ($r=.53$) and females ($r=.53$).
46	Zeidner et al. (2013)	100 ($M_{age}=26$), relationship	QT, CS	77	STM	DCI	RF	Self-DC mediated the relationship between emotional intelligence and marital relationships ($p<.05$). Actor ($p=.20$) and partner ($p=.06$) effects of DC were seen on marital quality.

7

8 *Note.* All dyads were heterosexual couples and, therefore, the gender split in each sample was 50% male and 50% female. CC=communal
9 coping, CCM=coping congruence model, CDC=common dyadic coping, CI=cultural influences, CS=cross-sectional, DC=dyadic coping,
10 DCCM=developmental contextual coping model, DCI=dyadic coping inventory, FDCT-N=former dyadic coping questionnaire, G=gender,
11 GT=grounded theory, IV=interviews, Le=learning, Lo=longitudinal, MM=mixed methods, PH= personal health, PTSS=posttraumatic stress
12 symptoms, QL=qualitative, QoL=quality of life, QE=quasi-experimental, QT=quantitative, RC=relationship characteristics, RCT=randomized
13 controlled trial, RF=relationship functioning, RFCM=relationship-focused coping model, RFCS=relationship focused coping scale, RWR=roles
14 within the relationship, SDC=supportive dyadic coping, STM=systemic transactional model, WCCL=ways of coping checklist.

- 15 Table 3
- 16 *Codes, Sub-themes, and Higher-order Themes and Definitions Generated During the*
- 17 *Thematic Analyses.*

Codes	Sub-themes	Higher-order themes and definitions
Delivery Directed learning Experience knowledge Informing Intervention Teaching Support	Contextual: Learning	
Collaboration Communication Coping similarities Perceptions of dyadic coping Pre-existing dyadic foundations Reciprocal embrace Relationship length Relationship mutuality Relationship quality Relationship satisfaction Relationship stability	Contextual: Relationship characteristics	Antecedents: concepts that precede dyadic coping in close personal relationships
Caregiver roles Marital roles Patient roles	Contextual: Roles within the relationship	
Collectivism Family systems Spirituality	Contextual: Cultural influences	
Female effects Male effects	Personal: Gender	
Belonging Closeness Interdependence Marital tension Negative emotions Reduced conflict Relationship growth Relationship quality Relationship satisfaction Relationship stability Reduction of negative emotions Togetherness Unified	Relationship functioning	Outcomes: consequences of dyadic coping
Mental health Physical health Quality of life	Personal health	



19

20 *Figure 1.* PRISMA flow diagram summarizing the study selection criteria.