

Intimate Relationships and Chronic Illness: A literature review for counsellors and couple therapists

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Introduction

This paper reports on findings from a scoping literature review conducted on chronic physical illness and intimate relationships, with a view to presenting a set of clinical implications for counsellors and couple therapists. Of course, working with counselling and couple therapy clients in ways that account for their physical health and wellbeing is not a new idea. A Holistic approach, for example, incorporates clients' physical, emotional, psychological and spiritual aspects, a concept which has gained increasing momentum in the past twenty years. Authors have also suggested factoring social relationships into health policy (Umberson & Montez, 2010). Empirical research for the health sector indicates improved health outcomes for clients, when this multi-factorial approach is adopted (Anglemyer, Horvath & Rutherford, 2013; Badr & Krebs, 2013; Maller, Townsend, Pryor, Brown, & St Leger, 2005; McGill & Felton, 2007). Some research, for example, has explored the relationship between family functioning and health (Garcia-Huidobro, Puschel & Soto, 2012). It is also a recommended approach when working with culturally diverse communities, such as, refugees (Watters, 2001), migrants (Ogunsiji, 2009) and people from South East Asian countries (Chou, 2009). When working with Indigenous communities, both within Australia and internationally, it is considered particularly appropriate, as it aligns with traditional ways of understanding health and wellbeing, and best clinical practice accordingly (Adrian, 2009; Couzos & Murray, 2008; Hunter, Logan, Barton & Goulet, 2004). Indeed, the co-involvement of partners and family members in the care of the affected person is proven to improve health-related outcomes (Myer, et al., 2014; Remien, et al., 2005).

Despite these advances, the extent to which Australian counsellors and couple therapists are adopting a more holistic approach is unreported, as is their level of awareness for clients' physical health issues, and how these affect their clients' intimate relationships. In contrast to the health and medical literature, publications which target counselling and therapy include very little to guide professionals working with clients affected by chronic physical illness. The need to collate and summarise what is known is pressing. This paper outlines the findings of our review which informed a three year, multi-state, cross-

agency study, and explored the interplay between relationships and chronic pain, and then relationships and chronic illness more broadly. The findings of the study were used to develop a set of freely available resources for those with a chronic illness, their partners, and their counsellors or couple therapists (www.humankind-relationships.com.au). In what follows, we describe the background to the literature review, review methods and key findings, in order to discuss the potential role of counsellors and couple therapists working with clients affected by chronic illness.

Background

This review is the product of a three-phase study. Phase One, explored the interplay between chronic pain and relationship function; Phase Two, explored the interplay between chronic illness and relationship function, more broadly; and the final phase, explored the relationship dynamics between couples attending RANSW and affected by chronic pain. This background aims to contextualise our review findings.

Phase One: In 2012, Relationships Australia New South Wales was approached by Dr Toby Newton-John, a Clinical Psychologist specialising in chronic pain, to collaborate on research about intimate relationships and chronic pain. Dr. Newton-John has more than twenty years' experience working in pain clinics and has become increasingly interested in the interplay of pain management and intimate relationships, having observed the dynamics between his clients and their partners. He noted that the clients' relationship style affects their treatment adherence.

Pain is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or experienced in terms of such damage (Merskey & Bogduk, 1994; Treede et al., 2015). Chronic pain refers to pain that has persisted for longer than three months (Merskey & Bogduk, 1994). This form of pain is now considered a disease in its own right (Tracey & Bushnell, 2009), rather than just being a symptom of some other condition, as it is often experienced for many months or years despite attempts to treat it with medications and other therapies. While the majority of people affected by chronic pain manage their pain, a minority (10%) are severely affected and even disabled by their condition (Nahin, 2012).

The propensity of the person to manage their pain can be influenced by the style of their intimate relationship (Leonard, Cano & Johansen, 2006; Meredith, Ownsworth & Strong, 2008). A happy union has been correlated with improved coping (Taylor, Davis & Zautra, 2013). Moreover, recent research conceptualises pain expressions as behaviours which aim to elicit empathy and assistance from the caregiver. As such, pain management is undertaken through communal coping, rather than working with the individual sufferer in isolation (Burns et al., 2015). Given this correlation, Dr. Newton-John was interested in the prevalence of chronic pain among the relationship counselling client cohort, as well as the nature of their relationships, and how this is associated with chronic pain and treatment adherence. In developing this collaborative study, we started with the

questions: how many relationship counselling clients attending RANSW services are affected by chronic pain? And how might pain specialists and relationships counsellors work together to improve the health and wellbeing of couples affected by chronic pain?

Phase two: Relationships Australia NSW, with the help of their colleagues at the Relationships Australia National office, gained funding from Medtronic Philanthropy via their Health Access Grant to support the study. This funding enabled us to undertake a prevalence survey of relationships counselling clients within New South Wales. Clients were invited by researchers, over a 12 month period, to take part in a brief telephone administered study which asked them about their pain levels, and treatment behaviours. Of the 985 who were invited, 329 took part. Preliminary analysis indicates that Relationships Australia NSW relationships counselling clients are affected by chronic pain at the same rate, or slightly more often, than the general population (Blyth et al., 2001). The findings of the prevalence study, and our research methods, will be reported more fully elsewhere (Ling, Gray, Newton-John & Huntingdon, *forthcoming*; Newton-John, Gray, Ling, Huntingdon, *forthcoming*).

More research is needed to establish the interplay between pain and relationship distress, and to verify these findings. However, the prevalence study provides some evidence of the need for a collaborative approach between couple therapists and health specialists. The funding body was interested in our findings, and requested that we expand the study to develop freely available resources to support chronic illness more generally. To support resource development, Relationships Australia South Australia and Relationships Australia Victoria were invited to join the NSW team, given their expertise in developing resources for allied health.

At that stage, we conducted a scoping literature review to ascertain published accounts of relationship function and chronic physical illness to inform resource development. We were able to confirm that, like people living with chronic pain, chronic illnesses generally present a unique range of challenges, and these challenges are often mediated by the quality of the person's intimate relationship. While there is an emerging body of research for health professionals on these issues, we noted a lack of published research to guide counsellors and couple therapists. Moreover, preliminary discussions with the Relationships Australia NSW workforce led us to believe that counsellors who had themselves experienced chronic illness were more likely to note it as a factor with their clients, but there was less awareness among counsellors who had not experienced a chronic physical illness. This review, then, outlines the findings that guided this study, and analyses recent published research to ascertain what is known about the ways in which chronic illness affects relationships, and how relationships affect the clients' ability to manage their illness, in order to discuss practice implications for counsellors and couple therapists.

Method: Scoping Literature Review

Literature searches were undertaken throughout the overarching studies, that is: 1) the pain prevalence study; 2) the chronic illness review stage, when developing the *Humankind* website; and 3) the relationship dynamics study. Therefore, reviews were periodic, iterative and ongoing. We conducted a search and review during each phase: to ascertain the knowledge about the topic at hand; to design the research project and inform the ethics application; to explore emerging themes from client and professional consultation; and to curate the information for this paper. This article draws upon all these searches, however, focuses primarily on the main scoping literature review we undertook in development of the website, and aims to provide an overview of current knowledge.

Unlike a meta-analysis or systematic literature review, which uses a chronological process that aims to categorise the sourced papers through quality criteria, a scoping literature review, as defined by Arksey & O'Malley (2005), is an iterative process that usually follows these steps:

- 1) Identify the research question;
- 2) Find relevant articles, through the usual means;
- 3) Select papers that are relevant to the questions;
- 4) Chart the data, (information on and from the relevant studies);
- 5) Collate, summarise and report on the results;
- 6) Consult stakeholders to verify the findings, or provide insights as to what the report failed

to highlight.

We chose this method because we wanted to examine the extent, range and nature of the research activity. It is particularly useful for mapping fields of study, and for summarising and disseminating research findings for practitioners and policy makers. In identifying gaps in the existing evidence base, we are also able to generate some conclusions as to the overall state of the research activity on this particular area (Arksey & O'Malley, 2005). This method is well suited to professionals needing to synthesise knowledge to inform exploratory research questions aimed at mapping key concepts and, like other literature review methods, identifying gaps in research (Colquhoun et al., 2014).

A wide and comprehensive search of academic and scientific databases (*Arts & Humanities Citation Index; BMJ Journals Online; Psychological and Behavioral Sciences Collection; PsycINFO; PubMed; Social Science Citation Index*) was undertaken using the key words: "chronic ill*"; "chronic condition"; "chronic pain"; "chronic disease"; "intimate"; "partner"; "spouse"; "relationship"; "intervention"; "treatment"; "couple therapy"; "marital therapy"; "marriage guidance"; and "counsel*", both singularly and in various combinations. The search was augmented by reviewing the bibliographies of related articles, and by following the "cited by" reference directions. This yielded a modest literature from which online abstract and bibliographic information was used to select

articles that met the inclusion criteria of: 1) those published within a 16 year timeframe from 2000 onwards; and 2) those directly exploring the impact according to one or more of the domains listed above. Key seminal texts meeting this criterion but published prior to 2000 were also included in this review, where the information was deemed relevant and pertinent, and not subject to an outdated paradigm.

A Note on Language

Throughout published reports, terms for intimate relationships, such as 'spouse' and 'partner', are used interchangeably. We note the heteronormative implications of using 'spouse', where marriage equality is currently denied to people in same sex relationships in Australia and many of the countries where research has been undertaken, as indicated below. We also note the assumptions placed on binary relationship constellations. We have adopted the term 'partner' throughout, as this does not affect the findings of the review.

Findings

There are five main areas of published research on chronic physical illness and intimate relationship dynamics, and these are: 1) the various ways in which health status is affected by intimate relationships; 2) the ways in which caring for someone with a chronic illness affects the partner; 3) how the style of the intimate relationship affects the management of a chronic illness; 4) recommendations for potential programs and interventions that address this issue; and 5) suggestions for future interventions and research.

Theme One: The Interplay of Intimate Relationships and Health Status

Health related research shows that negative aspects of relationship functioning have indirect influences on health, through depression and compromised health behaviours, and direct influences on physiological mechanisms, such as, cardiovascular, endocrine and immune function (Martire, Schulz, Helgeson, Small & Saghafi, 2010). There are particular implications for those individuals living with chronic illness (Kiecolt-Glaser & Newton, 2001; Martire et al., 2010). For example, relationship strain puts women with heart disease at greater risk of recurrent coronary events (Orth-Gomer et al., 2000), or increased risk of mortality in end-stage renal disease (Kimmel et al., 2000). Conversely, relationship quality has been linked to a whole set of positive health outcomes, such as, lower blood pressure in clients with hypertension (Baker et al., 1999); improved survival rates for those with congestive heart failure (Rohrbaugh, Shoham & Coyne, 2006), and breast cancer (Weihs, Enright & Simmens, 2008).

The general quality of the relationship may affect the client's interpretation of their partner's behaviours, and therefore the impact of those behaviours on health (Kiecolt-Glaser & Newton, 2001). Indeed, there are many factors associated with relationship style and health status, and recurring themes in the research literature highlights links with gender. In studies of cardiovascular disease, for example, female clients show stronger linkages between relationship distress and outcomes such as hospital stays or survival

rates, than male clients (Coyne et al., 2001; Kulik & Mahler, 2006). Therefore, it may be useful to examine gender-linked traits, such as unmitigated agency or communion (Hegeleson & Lepore, 2004) as moderators. Unmitigated agency is a focus on the self to the exclusion of others, and unmitigated communion is an inclusion of others to the exclusion of the self, both of which have been connected to poor health behaviour (Hegelson & Fritz, 2000). Including such considerations could help us to examine this moderator with all diseases, and to include both opposite sex and same sex couples (Martire, 2013).

Research indicates the detrimental impact of poor relationship function on health and mental health, for women in particular. Some research exploring levels of agency and communion within couples has shown that relationship difficulties correlate with problem behaviour related to poor health outcomes. Health status, then, is connected to relationship function, and so improving intimate relationships has the potential to improve health and mental health.

Theme Two: How Chronic Illness Affects Intimate Relationships

Chronic illness impacts the partner of the person living with a chronic illness (Schulz et al., 2009). While chronic illness is known to impact the whole family, including children and extended family members, the partner is thought to be most affected, and this may influence 'patient' adjustment (Merz et al., 2011). For example, partner support behaviour and relationship satisfaction are moderating effects for diabetes treatment (Schokker, 2010). Partners often experience poorer psychological wellbeing, decreased satisfaction in their relationship with the person living with a chronic illness, and burden associated with providing physical assistance (Martire & Schulz, 2011). Indeed, partners' own physical health and self-care may be compromised over time (Fredman, Betrand, Martire, Hochberg, & Harris, 2006; Lee, Colditz, Berkman, & Kawachi, 2003; Schulz et al., 2009), relationship satisfaction is affected (Geisser, Cano, & Leonard, 2005) and intimacy disrupted (Boylstein & Hayes, 2012). Over and above the physical burden of providing care, the negative effects for the partner make sense in light of the various other implications of living with chronic illness. Examples include: social and leisure activities are often curtailed, there can be increased financial burden due to the costs of medical treatment and/or a loss of income due to the inability to maintain occupational functioning, physical intimacy and sexual activity may cease, sleep can be disrupted for both parties.

Another unfortunate consequence of an ongoing illness is that the partner's ability to be supportive may erode over time, and their critical and controlling behaviours may increase (Stephens, Martire, Cremeans-Smith, Druley, & Wojno, 2006). These findings have been observed across the most common chronic conditions affecting adults including heart disease, chronic pain, rheumatic disease, cancer and diabetes (Fisher, Chesla, Skaff, Mullan, & Kanter, 2002; Schmalings & Sher, 2000). A developmental-contextual model provides a framework for understanding how couples coping with chronic illness may together appraise and cope with illness, and for determining when partner involvement is beneficial or harmful to both the person living with a chronic illness and partner adjustment (Berg & Upchurch, 2007).

As such, Martire (2013) suggests developing physical health interventions which account for intimate relationship dynamics, and suggests identifying and targeting moderators of relationship health linkages. For example, in some couples, the client's symptoms have little negative impact on the partner, whereas in other couples the partner's emotional wellbeing is essentially a barometer for how the client is feeling. In research conducted on pain manifestations and relationship dynamics, Cano and Williams (2010) reconceptualise pain as an emotional disclosure, and suggest that both partners' distress is implicated in the disclosure and response patterns (Cano, Leong, Williams, May & Lutz, 2012). More specifically, moderators may tell us who would benefit most from an intervention. Indeed, individuals with low marital satisfaction may experience greater benefits from an intervention than those with high levels of relationship satisfaction (Martire, 2013).

Published reports, then, indicate that chronic illness has a negative impact on the well partner. As pointed out by Martire and colleagues (2010), while there is a known link between partner behaviours and patient illness management, more rigorous research is needed to understand the partners' role. Given that the ability of the carer to care can be eroded over time, it is possible that supporting the carer to manage this work would also be of benefit to the person living with a chronic illness, as well as the carer themselves. While not all partners will be adversely affected by their partner's illness, identifying these cases could enable a more effective and client-centred response. Research aimed at identifying factors that explain these between-couple differences could be used to tailor interventions.

Theme Three: How the Style of Intimate Relationships Affect Illness Management

Long-term outcomes, such as recurrent health events, hospitalisations and survival, are also affected by the quality of the person's relationship (Kimmel et al., 2000; Orth-Gomer et al., 2000; Rohrbaugh, Shoham, & Coyne, 2006). Other couple characteristics, with consistent effects on the management of chronic illness, include conflict, criticism, and a lack of congruence between client and partner in disease beliefs and expectations (Fisher, 2006).

While there is a known link between partner behaviours and client illness management (Johnson et al., 2013), more research is needed to understand the partners' role. Johansson and colleagues, for example, provided a detailed account of couples affected by dementia, and how mealtimes were managed, and how this progressed over time as the disease worsened (Johansson, Björklund, Sidenvall & Christensson, 2014). More detailed information like this is needed about what people living with a chronic illness and their partners do, and how this plays out in clients' daily lives and practices. Another relatively unexplored factor is parasympathetic activation. This is when interactions affect *heart rate variability* (HRV), and is believed to reflect an individual's efforts to regulate emotion. Over time, negative interactions may reduce resting HRV, an indicator of self-regulatory capacity, and increase the risk of cardiovascular morbidity and mortality (Butler, Wilhelm & Gross, 2006).

Authors suggest that associations be studied with repeated measures designs, in which both partners are assessed daily or throughout the day. This would allow for addressing questions regarding the within-couple variability. For example, one hypothesis that needs testing: is the client *less* physically active on days when the partner is more critical? Or, *more* physically active? It also extends previous research on couples and chronic illness that has taken a between-couple approach to analysis. Intensive repeated measurement studies could reveal the effects of client symptoms on partner mood, support behaviours and physiological responses (Monin et al., 2010).

Theme Four: Potential Programs and Interventions

An important meta-analysis of couple-oriented interventions for chronic illness found that chronic diseases, such as cardiac disease, obesity, and diabetes, which are the leading causes of morbidity and mortality, share common features, including: being behaviourally driven; influenced by social environment; and negatively impacting the intimate relationship (Martire, Schulz, Helgeson, Small & Saghafi, 2010). Reflecting these commonalities, couple oriented behavioural interventions for different conditions share many of the same features and goals and can, arguably, be evaluated as a group. Reviewed interventions tend to be multicomponent, with educational and cognitive-behavioural interventions commonly represented. Many went beyond treating the client and partner as individuals, and included relationship-focused content, such as those studies which directly explored the effects of relationship functioning on illness management (Martire, et al., 2010). Associated studies compared couple oriented interventions to usual care or a client-oriented, behavioural intervention. Meta-analyses of these studies require corroboration, but seem to show that interventions have a significant but small effect on client depressive symptoms, relationship functioning and pain. There is a lack of research which includes partner outcomes, but interventions had similar effects despite varying illness populations and intervention content (Martire, 2013).

In comparison to individual client-oriented approaches, couple interventions may have an advantage in long-term maintenance of behavioural changes, and addressing the partners' concerns may protect against the erosion of their support to the client (Martire, Schulz, Keefe, Rudy & Starz, 2007). Awareness of the reciprocal health effects in the intimate relationship has led researchers to develop psychosocial or behavioural interventions that include the partner. One example includes the *Integrative Behavioural Couple Therapy* model (IBCT) which aims to improve outcomes for clients presenting with chronic pain in health settings, by increasing partner's empathy and emotional acceptance (Cano & Leonard, 2006). The majority of tailored interventions for couples, however, provide couples with the same materials regardless of their specific needs (Martire, 2013). It is likely that interventions will be more impactful if tailored to the diverse needs of different couples (Martire, 2013; Pietromonaco, Uchino & Dunkel Schetter, 2013), and that reach will be increased where interventions work for multiple chronic conditions (Lorig et al., 1999). In a tailored approach, the amount of targeted support for chronic illness depends on couple characteristics and could also change over the duration of the interventions. The potential advantages of tailored interventions include

increased participant engagement and increased potency of the interventions. For example, FAMCON, the family consultation intervention, targets smoking cessation (Shoham, Rohrbaugh, Trost & Muramoto, 2006). Couples receive up to ten sessions that address the relationship dynamics which contribute to smoking, such as ironic processes (partners' inadvertent reinforcement of smoking) and help couples realign their relationship in ways that are not organised around tobacco use (Martire, 2013).

Another example, the *Ecological Momentary Intervention* (EMI), delivered interventions that were tailored in ways that helped couples practise new skills in their daily lives, thereby improving the chance of long term gains. EMI uses mobile technology to deliver interventions as clients go about their daily lives, and has been shown to be effective for a variety of health related behaviours, and psychological and physical symptoms (Heron & Smyth, 2010). When used for couple applications, it is based on within-couple associations observed through either pre-intervention *Ecological Momentary Assessment* (EMA) or a clinical interview with the couple, such as, data on couple communications and overt behaviours that precede changes in client physical activity. Dyadic EMI is ideally preceded by sessions with a professional to learn basic concepts and skills, and establish a working relationship (Martire, 2013).

Theme Five: Recommended Directions for Future Research

The reviewed studies include recommendations for future research, in order to develop a stronger evidence-base to understand relationship dynamics in chronic illness. For example, more rigorous research is needed to establish how various other intra- and inter-personal factors, and within couple variability influence, physical health outcomes (Martire et al., 2010), using larger sample sizes and greater standardisation across studies (Robles, Slatcher, Trombello & McGinn, 2014).

It is also clear, however, that studies often lack a strong foundation in conceptual models and are rarely designed to examine mechanisms of change.

Couple interventions. Future research on effective couple interventions needs to focus on the experience and outcomes for the partners of people living with a chronic physical illness, and examine mechanisms of change in couples. Interventions that modify relationship-related mechanisms (partner support) and then measure change in client functioning, would enhance understanding of how close relationships affect health (Martire, 2013). Moreover, these interventions could provide critical information about differences between diseases, such as unique or shared pathways leading to clinical outcomes (Miller, Chen & Cole, 2009; Uchino, 2006), thereby relationships related health research could also contribute information about diseases and health outcomes. It is important that future studies compare couple-oriented interventions to client-oriented interventions, rather than using usual care as the control condition, in order to collect evidence on whether improvements in patient health are due to changes in dyadic processes, and not only due to changes in patient psychological well-being or health behaviours (Martire et al., 2007). An additive treatment design could be used, where

couple components are added to a standard intervention. Alternatively, researchers could modify an evidence-based patient intervention for use with couples, and compare the relative efficacy of two approaches (Martire et al., 2007).

A brief battery of client and partner outcome measures for use across chronic illness populations would promote greater synthesis of the intervention literature. Important outcome domains include: psychological well-being, health behaviours, relationship functioning, physiological functioning, quality of life measures, and client illness symptoms. Specific measures tapping these domains should be identified for inclusion in an outcomes battery. A cross-disease assessment approach has been adopted with success in the *Patient-Reported Outcomes Measurement Information System* (PROMIS; Cella et al., 2007) and the *NIH Toolbox* (Gershon et al., 2010). These projects have yielded brief measures of psychological, physical, and social health functioning for use in clinical trial research, and are useful for developing cross-disease outcomes battery for couple oriented interventions (Martire, 2013). Similarly, measures which examine clients' quality of life, such as the *SF 36* and the *Euroqol 5* (Picavet & Hoeymans, 2004) have been informative for tracking bidirectional effect of pain, health status and quality of life.

Discussion

Findings indicate that chronic physical illness places a strain on the majority of intimate relationships. The interplay between chronic illness and relationship function is dynamic and bi-directional, and poor relationships have a negative effect on health and mental health, in general. For those clients living with a chronic illness, poor relationship function makes it harder to manage the illness, and the treatment regime. Research also indicates that many people living with an existing and chronic physical condition can expect to see their illness worsen, as the negative affect of their relationship intensifies their poor health status. While more research is needed, it seems that counselling and couple therapy has a role to play in improving health and mental health conditions, by improving relationship function, especially for those living with a chronic illness. Measuring this will enhance the knowledge base, and provide more information that can be used to benefit clients and their carers.

The research exploring unmitigated communion and unmitigated agency suggests there is potential for couple therapists to use their systemic knowledge and expertise to reduce enmeshment between patients and their partners. Differentiation might help to counter the detrimental effects on the partners' physical health, as well as the couples' mental health. The research reviewed for this article provides an evidence base for recommending that chronic illness management be complemented with systemic interventions. This also has the potential to improve treatment adherence, and the quality of the sufferers' engagement in their treatment. Given that health status is affected by relationship function, it is probable that counselling and couple therapy should play a greater role in allied health services. Counselling and couple therapy may reduce poor health outcomes—where avoidable—thereby saving health expenditure on treatment costs. This and other savings should be better articulated in reports of counselling client outcomes for

both funding purposes and professional recognition. In conducting this review, we found little recognition of the ways in which counselling or couple therapy could better contribute to the health sector.

Couple therapists could also better measure the outcomes of chronic illness interventions using health outcome measures, and by conducting case analyses to establish changes in treatment adherence. Gaps in research include partner outcomes, and this is a recommended focus for future research. Incorporating health measures within couple therapy settings, and collating findings across agencies, will help to establish whether couple therapy improves health outcomes for partners and carers of people living with a chronic illness. Studies collating outcome measures and responses across agencies will contribute to the research literature on relationship dynamics and chronic illness, and increase knowledge at a sector level. This has the potential to help overcome the limitations of previous research, which was hampered by small samples.

Significantly, published research has not yet accounted for different types of intimate relationship. The literature tends to describe long term, married, heterosexual relationships and does not account for differences relating to de facto arrangements, polyamorous constellations, or same sex couples, where gender differences might be less pronounced. There is also a lack of information on couples where both are affected by chronic illness. Having said this, an emerging body of work describes the ways in which chronic illness and health management interfaces with intimate relationships, and vice versa. Such knowledge has the potential to support counsellors and couple therapists in raising awareness of chronic illness as a factor for relationship dissatisfaction or distress, as well as the support needs of partners living with someone affected by a chronic illness.

In conclusion, it is likely that people with an existing and chronic condition, can expect to see their illness worsen, as the negative affect of their dysfunctional relationship intensifies their poor health status. While there is a known link between partner behaviours and patient illness management, more research is needed to understand the partners' role. In the meantime, counsellors and couple therapists would be wise to ask their clients questions about the presence of chronic illness, and establish their role in supporting clients to prevent the illness worsening, so that the relationship can become a site for mutual support and healing. In improving the relationship dynamics, and therefore health status of the sufferer, couple therapists might also have greater scope to improve the quality of life of carers.

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