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RELATIONAL BENEFITS: THE POSITIVE EFFECT OF DYADIC COPING ON ALCOHOL CONSUMPTION

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RELATIONAL BENEFITS: THE POSITIVE EFFECT OF DYADIC COPING ON ALCOHOL CONSUMPTION

By

KIMBERLY GAIL GOULD

A Thesis Submitted to The Honors College
In Partial Fulfillment of the Bachelors Degree with Honors in Psychology

THE UNIVERSITY OF ARIZONA

MAY 2014

Professor Emily A. Butler

Approved by:

[Signature]

Dr. Emily A. Butler

Department of Family Studies and Human Development
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Dyadic Coping, Stress, and Alcohol Consumption

Abstract

Objective. Dyadic coping is one way in which partners support one another and share coping responsibility in response to a stressor (Bodenmann, 2005). While there is some literature on the positive effects of dyadic coping in romantic relationships on health behaviors, less is known about the way in which it can moderate alcohol consumption. Furthermore, virtually nothing is known about dyadic coping as a positive moderator for alcohol consumption in response to relational stress. To investigate this, frequency of dyadic coping and drinking in response to relational stress were assessed in couples.

Method. Participant sample included a total of 91 couples (N=182), ranging in age from 18 to 69 years old (M=26.8); participants must have been over the age of 18, in the first year of their relationship, and cohabitating. Participants answered questions regarding dyadic coping, relationship stress, and alcohol consumption. Results. Significant differences were found in levels of drinking when couples practiced dyadic coping in response to relational stress, as opposed to when couples did not. Specifically: Couples who did practice dyadic coping exhibited lower alcohol consumption when faced with relational stress than couples who did not. Results from this study may have clinical implications relating to couples therapy.

Keywords: Dyadic coping, relational stress, alcohol consumption
Relational Benefits: The Positive Effect of Dyadic Coping on Alcohol Consumption

Dyadic coping involves two partners in a relationship, and occurs when the stress signals of one partner influence the coping reactions of the other. Ultimately dyadic coping is the way in which partners support one another and share coping responsibility (Bodenmann, 2005). It can be expressed through every day activities such as communication, conflict resolution, joint problem solving, and emotional support to deal with stressors. Three types of dyadic coping exist: common dyadic coping (both partners are exposed to a stressful event), supportive coping (only one partner is affected by said event; the other serves as support), and delegated coping (one partner uses problem-solving in order to relieve stress for the other) (Bodenmann, 2008). Existing research shows that dyadic coping is associated with numerous variables such as marital quality, marital satisfaction, cortisol levels, and various health risks such as diabetes and life-threatening illnesses. However, less is known about the effect of dyadic coping on stress responses that subsequently influence health behaviors, specifically consuming alcohol. As reported below, supportive coping is most frequently studied when observing responses to stressful events.

Benefits of Dyadic Coping

A two-year longitudinal study revealed that dyadic coping was significantly associated with marital quality (Bodenmann, Pihet, & Kayser, 2006). While for women, both their own dyadic coping and that of their partner were significant predictors; dyadic coping was the only significant predictor for men. The results from this study provide
evidence that practicing dyadic coping within a marriage can promote the prevention of marital distress.

Another study followed a couple where one of the individuals was suffering from, but both were coping with, a chronic illness (Berg & Upchurch, 2007). The developmental model stresses that dyadic coping may be different at various stages of one’s lifespan, changing temporally when dealing with different stages of the illness, as well as when spouses interact with dyadic stressors. This model provides evidence for understanding how couples coping with chronic illness may face and manage it during adulthood, and determine when spousal involvement is beneficial or harmful to both patient and spousal adjustment to the illness.

**Acute Stress**

Known as the most common form of stress, acute stress comes from recent past and anticipated demands of the near future (Miller & Smith, 2014). While short doses can be exhilarating and exciting, repeated acute stress is taxing and can lead to psychological distress, tension headaches, and other negative physiological symptoms. However, acute stress does not last a long enough duration to do as much damage as long-term stress, and is highly treatable and manageable. Unfortunately, acute stress can also manifest itself into repeated stress, and has even manifested itself into a type of personality known as “Type A” by many cardiologists (Miller & Smith, 2014). This is known as episodic acute stress, and afflicted individuals suffer acute stress quite frequently and live in rushed chaos. These people worry constantly, and see the world as dangerous and unrewarding, continually waiting for negative events to happen.

**Chronic Stress**
Chronic stress is much more long-term than acute stress, and has been linked to dysfunctional families, unhappy marriages, and empty careers (Miller & Smith, 2014). Individuals suffering from chronic stress are unable to see the good in a situation, perpetually focusing on the negative and seeing life as an endless list of demands and issues. Chronic stress can arise from traumatic childhood experiences from which the individual never recovers, and profoundly affects their future worldview (Miller & Smith, 2014). Unlike acute stress events, which can be brushed off, chronic stress has ultimately proven fatal. After an elapsed period of time, the bodies of chronic stress sufferers are worn down both physically and mentally, and they may commit suicide, violence, endure a stroke, or develop cancer (Miller & Smith, 2014).

**Stress and Health Behaviors**

Stress has been linked to negative effects on health behaviors when individuals are faced with stressful situations. One study showed that, among university students anticipating exams, increased stress was associated with a substantial decrease in physical activity and an increase in smoking. This study on the effects of perceived stress on health behaviors in students investigated whether anticipating examinations would lead to decreases in physical activity, and subsequently showed the adverse effects of stress of levels of physical activity (Steptoe, Wardle, Pollard, & Canaan, 1996). Students were divided into exam-stress and control groups, and the levels of stress were assessed by a questionnaire and an interview. The exam-stress group anticipated the examinations; the control group was not. The exam-stress group reported significant increases in emotional and perceived stress, and these students showed a substantial decrease in physical activity, as well as women showing a significant increase in smoking behaviors while men remained
relatively stable. This study provides good evidence that increased stress levels are associated with decreased levels of physical activity as well as an increase in smoking.

Stress has been known to affect both physical activity levels and eating behaviors as well. Not only quantity, but also quality can be compromised when faced with stressful situations. When exposed to stressful situations, snacking behaviors increased in students regardless of gender or dieting status (Oliver & Wardle, 1999). Unfortunately, during this time the intake of “real meal” foods (fruit, vegetables, meat, and fish) during stressful events decreased, showing that students are more likely to reach for a less healthy options when stressed as well. A study was also conducted to assess the potential for increased food consumption when stress is increased (Epel, Lapidus, McEwen, & Brownell, 2001). Women in good health were placed in both a stress session and a control session on different days. Women who showed high cortisol responses consumed more calories as opposed to low cortisol reactors; they also consumed a higher quantity of sweeter foods during the span of the study. Women that showed negative responses to stressors were also observed to have significantly higher food consumption. The evidence provided from this study suggests that a psychophysiological response to stress has the potential to influence eating behaviors, and over time, may impact both weight and health.

Increased vulnerability to threatening or chronic stress has also been related to adult alcohol relapse following alcoholism treatment (Brown, Vik, Patterson, Grant, & Schuckit, 1995). A group of abstinent male alcoholics who had experienced previous life diversity or chronic threat completed a psychosocial assessment first as an inpatient in treatment for alcohol dependence, and then again at 3 months, then 1 year following discharge from the facility. The results provided evidence that amongst alcoholic men exposed to severe
psychosocial stressors, those with higher psychosocial vulnerability scores from the assessments were more likely to relapse than those with lower vulnerability scores. Additionally, men who improved in psychosocial functioning following treatment had better outcomes than those who had increased vulnerability. Results from this study provide evidence that increase vulnerability to stress have a higher risk for alcohol relapse than those who have an enhanced ability to remain abstinent, regardless of stress.

Stress has also been related to increased alcohol consumption in police officers that experience extreme job demands (Violanti, Marshall & Howe, 1985). Several hundred police officers were administered a questionnaire measuring their job demands, coping responses, and experienced stress. Results from this questionnaire indicated that stress had a significant effect on alcohol use; however, results suggest that stress and alcohol use do not develop apart from occupation. The occupational structure often forbids coping strategies that are consistent with the individual’s occupational goals. This suggests that the police structure may impede certain techniques to deal with stress, therefore leading the individuals to look for other methods, such as alcohol use, as a way to cope.

**Stress, Dyadic Coping, and Health Behaviors**

Support of partners within relationships can be quite beneficial to counteract negative effects of stress. In fact, evidence suggests that social support can be a method of “stress buffering” within an intimate relationship (Meuwly, Bodenmann, Germann, Bradbury, Ditzen & Heinrichs, 2012). One study investigating support and stress buffering looked at whether dyadic coping as a way to show support would affect cortisol levels during stress recovery, and if the stressed partner’s attachment and avoidance style altered these effects. The men and women had stress induced by having to do a public speaking
task, and researchers found that the more positive dyadic coping an individual received from his or her partner, the faster he or she recovered—the only moderator being women with high anxiety, who benefited less from the positive dyadic coping. This study provides evidence that dyadic coping can be a beneficial way to reduce stress, at least in certain situations and for some people.

Some evidence proposes that dyadic coping can impact health behaviors as well as stress. For example, one study provided evidence that common dyadic coping was associated with better “diabetes efficacy” for both a patient and their respective spouse was conducted in 2013 (Johnson, Anderson, Walker, Wilcox, Lewis & Robbins, 2013). That is, due to both the dyadic coping and its positive effects on the couple, the patient showed better dietary and exercise adherence overall. Thus this study shows the beneficial use of dyadic coping in relation to positive health behaviors, such as increased levels of physical activity and better eating behaviors. This study is important because we know that prior work as well that stress can negatively impact health behaviors such as eating behaviors (Epel, Lapidus, McEwen, & Brownell, 2001) and levels of physical activity (Steptoe, Wardle, Pollard & Canaan, 1996. While these demonstrated the adverse effects of stress on physical activity levels and eating behaviors, the study conducted with diabetic patients portrays the beneficial nature of dyadic coping when dealing with stress and adherence to good health behaviors.

A study describing levels of alcohol consumption when faced with stress most closely relates to my thesis. This study observed stressor vulnerability with stress-induced drinking, and was tested with a random sample of both African-American and Caucasian participants (Cooper, Russell, Skinner, Frone, Mudar, 1992). The stressors were highly
predictive of both alcohol used and substance abuse problems among the men who used 
avoidant forms of coping or strongly relied on alcohol’s positive effects. In contrast, 
stressors were negatively related to alcohol consumption among men who were low in both 
vulnerability factors, and were completely unrelated among women regardless of their 
coping. The findings of this study suggest that individual characteristics must be considered 
when accounting for the effects of stress on alcohol use and abuse.

The study using diabetic patients and their partners exhibited that increased health 
behaviors have an indirect link to dyadic coping; however, it did not focus on health 
behaviors of both partners—the majority of the results focused on the patient’s progress as 
opposed to including the partner’s resulting health behaviors as well. The study 
concentrating on stress-induced drinking behaviors in both women and men emphasized 
increased alcohol consumption when faced when stress, but did not focus on the effects of 
relational stress on drinking behaviors in romantic couples. Discovering the effects of 
dyadic coping on health behaviors of both partners in a relationship is imperative because it 
may be the essential factor in determining how to maintain a mentally and physically 
healthy relationship. My study both extends and contributes to knowledge about specific 
health behaviors exhibited by couples that practice dyadic coping versus those who do not, 
and investigates whether dyadic coping may most influence alcohol consumption, 
specifically, in a positive way.

**Research Question and Hypothesis**

Existing research shows that stress has the potential to negatively affect health 
behaviors, specifically in regard to alcohol use. Dyadic coping may reduce relational stress, 
subsequently benefiting drinking behaviors. The present study investigates two types of
relational stress (acute stress and chronic stress) within heterosexual relationships. It examines whether relational stress will have a significant effect on alcohol consumption for couples over time, and whether dyadic coping moderates those effects. The study addresses the following questions using data from a questionnaire:

(1) Do these two types of relational stress (acute stress and chronic stress) increase alcohol consumption? Based off of existing literature, which provides evidence that stress is associated with increased drinking behaviors, I hypothesize that an increase in relational stress will also increase alcohol consumption amongst couples.

(2) Does dyadic coping predict lower alcohol consumption? While there is less literature providing evidence of the effect of dyadic coping on drinking behaviors, I hypothesize that dyadic coping will result in lower alcohol consumption.

(3) Does dyadic coping lessen the association between relationship stress (acute and chronic) and alcohol consumption? Based upon existing data, I hypothesize that if a couple practices dyadic coping, then they will engage in less frequent drinking behaviors when faced with a stressor in the relationship. On the other hand, I predict that a couple that does not practice dyadic coping, presented with the same stressor, will exhibit increased alcohol consumption.

Methods

Recruitment

A community sample of heterosexual, committed romantic couples was recruited from the United States. Advertisements were posted on Craig’s list, University of Arizona listservs, flyers posted at churches, a county marriage license building, and local businesses, as well as by word of mouth.
All participants were required to meet the following criteria: 1) cohabiting in their first year of the relationship, 2) over 18 years of age, and 3) both partners were required to participate. Individuals who met the exclusion criteria for the study were as follows: couples with children, those that had mental or physical health problems, lifetime diagnosis of a psychiatric disorder (eating disorders), enrollment in a weight reduction program, or any intention to lose or gain weight either with medication or on a prescribed diet.

Interested individuals contacted a research assistant (RA) by email or phone and the RA arranged to conduct a telephone screening interview to make sure the participants did not possess exclusion criteria. The RA informed the participants of the study procedures, and then asked if the participant was still interested. The screening forms were kept for the duration of the recruiting period to track rates of enrollment and reasons for declining to enroll or ineligibility. Participants had to make sure their partner agreed to participate as well. Once the couple was in agreement to participate, they were given random ID numbers that identified them for the rest of the study (i.e. the female was 050, and the male was 550).

**Participants**

The sample included a total of 91 couples (N=182), ranging in age from 18 to 69 years old (M=26.8). Approximately 40.11% of the participants were European American, 31.87% non-Hispanic white, 20.33% identified as “other”, 3.30% were Asian American, 1.65% African American, and 0.55% Native Hawaiian or Pacific Islander. Around 67.59% of participants had an income between 0$-$25,000, 15.38% were between $25,000-$50,000, 11.54% were between $50,000- $75,000, 2.75% earned $75,000 - $100,000, 0.55% were between $100,000 - $150,000 and 1.10% earned over $150,000. About half
(46.15%) of the participants had some college education while 28.02% had undergraduate
degrees, 12.64% had a high school education, 1.65% had less than that, and 8.79% had
graduate degrees.

Procedures

Participants completed a baseline survey, baseline lab session, daily diaries, and a
follow-up interview. The measures for this study come from the baseline survey. The
survey was completed before the couple entered into the actual lab. Each participant logged
into a password protected website using their assigned ID number to complete the
questionnaire, which was preceded by a disclosure form (the Baseline Disclosure)
informing participants about the procedures as well as their rights to voluntary participation
and confidentiality. The questionnaire took around 1 hour to complete and the participants
were each compensated $10 for doing so (compensation was either given to the participants
at the lab session, or by mail if they decided to drop out of the study).

Measures

Stress. To assess relationship specific stress, I used the relational stress subscales from the
Multidimensional Stress Scale for Couples (Bodenmann & Gmelch, 2008). These scales
included 30 questions regarding the stresses and burdens the participants had experienced
during the past week and the past year. The raw alpha for relationship acute stress was .88,
and the raw alpha for relationship chronic stress was .94; however, I ultimately combined
acute and chronic stress into one scale due to similarity expressed in the questionnaire, and
the raw alpha for the combined relationship stress scales was .96. The correlation between
the two types of stress was .94. The questions ranged from no burden/stress (0) to
significant burden/stress (3), and assess stress within 7 days (acute stress) and 12 months
(chronic stress). Several specific questions that assessed varying stress levels at these specific times were the difference of opinion with his/her partner, different attitudes concerning relationship and life, and the disturbing habits of his/her partner.

**Average Alcohol Use.** The questionnaire had three specific questions that assessed alcohol consumption for each individual (Wadden & Phelan, 2002). It asked how often a person drank alcohol, how much alcohol was consumed per week, and if more than four alcoholic drinks were ever consumed per one occasion. I used these questions to assess overall how alcohol consumption increased or decreased based upon levels of stress and levels of dyadic coping, and combined the questions to create an overall drinking scale.

**Dyadic Coping.** To measure dyadic coping I used the Dyadic Coping inventory (Bodenmann, 2008) with 5 subsections. The first 4 questions asked how the participant communicated with their partner (I let my partner know that I appreciate his/her practical support, advice, or help). The next 11 questions were about what the participant’s partner did when they were stressed (My partner shows empathy and understanding). The third section of 4 questions asked about how the participant’s partner communicated when he/she was feeling stressed (My partner lets me know that he/she appreciates my practical support, advice, or help). The fourth section was composed of 9 questions that asked what the participant did when their partner was stressed (I show empathy and understanding). The fifth and final section asked what the participant and their partner did when they were both feeling stressed (We try to cope with the problem together and search for shared solutions). The mean was used from the combination of the items and the raw alpha score was .91.

**Data Analysis**
I used a model in which there was a predictor, outcome, and moderating variable (relationship stress, drinking behaviors, and dyadic coping). Broken down, I observed how the predictor variable affected the outcome variable, and how the moderator then altered this effect.

The statistical analysis program R was used to analyze my data. I tested my hypotheses and analyzed my data by looking for interactions and using a dyadic version of a regression model, because men and women are in couples and therefore not independent of one another. After reading the data into R and creating individual scales for each variable, I checked for outliers and to make sure distributions appeared normal, as well as ran each scale for reliability. In order to confirm outliers and distributions, I used histograms and boxplots to check for a bell-shaped curve in my outcome variables. I originally separated the data file into men and women, and then ran a reliability analysis for each measure; however, there were no significant differences between the two sexes. The reliability analysis tested whether all the items for a given scale correlated highly with one another and each measured what they were “supposed” to be measuring. I then looked for a raw alpha of .8 or greater, meaning that each measure was reliable. If there had been a measure of less than .8, I would have dropped that from my analysis. Of my three variables (once I combined acute and chronic stress into one scale), eight items in the dyadic coping scale needed to be reverse coded.

Once I combined the items into a mean-score for that scale, those became the variables used in my analyses. I ran correlations to determine if the variables I used in my hypothesis were significantly correlated, and then determined in which direction. Once this
Dyadic Coping, Stress, and Alcohol Consumption

was confirmed, I used a regular linear model to determine if relational stress predicted increased drinking behaviors, and if dyadic coping moderated this effect.

I centered both the moderator (dyadic coping) and the predictor variable (relational stress) at their own respective first and third quartiles. Then, I ran the model with four combinations of the predictor and moderator variables: HH (high relational stress and high dyadic coping), HL (high relational stress and low dyadic coping), LH (low relational stress and high dyadic coping), and LL (low relational stress and low dyadic coping). I used dyadic regression to run the model four times with the respective changes in order to see how dyadic coping moderated relational stress in regard to drinking. The intercepts of these analyses were then used to create graphs of the interactions.

Results

Table 1 provides descriptive statistics (both means and standard deviations) for all variables separated by sex:

<table>
<thead>
<tr>
<th>Variable</th>
<th>Men (Mean, SD)</th>
<th>Women (Mean, SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship Acute Stress</td>
<td>.6 (.5)</td>
<td>.6 (.4)</td>
</tr>
<tr>
<td>Relationship Chronic Stress</td>
<td>.6 (.5)</td>
<td>.5 (.9)</td>
</tr>
<tr>
<td>Combined Relationship Stress</td>
<td>.6 (.5)</td>
<td>.6 (.4)</td>
</tr>
<tr>
<td>Dyadic Coping</td>
<td>2.3 (.5)</td>
<td>2.3 (.5)</td>
</tr>
<tr>
<td>Alcohol Consumption</td>
<td>1.3 (1.0)</td>
<td>1.0 (.8)</td>
</tr>
</tbody>
</table>

As seen in Table 1, both men and women tended to have similar descriptive statistics, providing evidence that sex does not differ significantly in determining whether relational stress will predict drinking behaviors. Both the means and standard deviations for
each variable were quite similar; providing evidence that for each variable, there was not much difference between men and women overall in their responses in the baseline questionnaire (E.g. men and woman both reported mean scores of .6 for relationship acute stress, and there was only a .5 standard deviation for men, while there was a slightly smaller .4 standard deviation for women).

**Relationship Stress and Alcohol Consumption**

H1 addressed the association between relationship stress and its effect on levels of alcohol consumption. When testing the effect of relationship stress on alcohol consumption, there was no main effect, \( p = .20 \). My first hypothesis was not supported with the related model.

**Dyadic Coping and Alcohol Consumption**

H2 predicted that dyadic coping would decrease alcohol consumption among couples. This hypothesis was supported, \( F(1, 166)= 4.7, p= .03 \); as dyadic coping increased by one point, alcohol consumption decreased by -2.19 points, \( p=. 03 \).

**The Moderating Effect of Dyadic Coping on Relationship Stress and Drinking**

As seen in Figure 1, in the test of the interaction for the outcome variable *drinking behaviors*, there was a significant interaction effect of *relational stress and dyadic coping*, \( F(1, 163)= 4.20, and p= .041 \). As I predicted, I discovered that at low levels of dyadic coping, relational stress increased the frequency of drinking behaviors, but stress was not related to drinking when the couple used high levels of dyadic coping. There were no significant sex differences for these effects. While I also looked at the three-way interaction and differences between men and women, neither was significant. In fact, models that did not include sex showed even more significance when sex was taken out of the equation
Summary

In summary, only two of my three hypotheses were confirmed. While there was no main effect for relationship stress on alcohol consumption, dyadic coping does have a significant effect on drinking, and because there was a significant interaction for H3, dyadic coping does moderate the effects of relationship stress on alcohol consumption. In regard to my second hypothesis, dyadic coping did decrease the frequency of drinking behaviors, once again; sex was not a significant contributing factor. Lastly, my third
hypothesis was confirmed when we discovered that couples who practiced dyadic coping most frequently exhibited less drinking behaviors in response to relational stress.

**Discussion**

The study began by asking the question, could dyadic coping moderate alcohol consumption in response to stress? To address this, I posed three specific hypotheses: (1) Relational stress will increase alcohol consumption within a relationship, (2) Dyadic coping will reduce alcohol consumption within a relationship, and (3) Dyadic coping will moderate the effect of relational stress on drinking behaviors. While not all of my hypotheses were all supported by my results, the following sections contain more nuanced responses to each of these questions.

**Will relational stress increase alcohol consumption?**

Based upon existing literature, I predicted that relational stress would increase alcohol consumption for both men and women. Though there was relatively little evidence supporting the idea that relational stress specifically would increase drinking behaviors, and certainly not much literature on the idea of stress produced within a relationship increasing drinking behaviors, I remained certain that the outcome of relational stress would be increased drinking. Because stress in general is a powerful predictor for poorer health behaviors (i.e. lower levels of physical activity, increased smoking behaviors, and higher fat consumption) I was surprised to find that there was no significant main effect for relationship stress and alcohol consumption. When couples experience stressors within their relationship, or with one another, they frequently turn to ways to cope. Often those coping mechanisms involve harmful health behaviors (such as those stated above), and are less effective in creating a solution to the relational stressor because each individual within
the relationship may cope with stress differently. Because alcohol is known as a way to “escape” from the responsibilities and stressors of everyday life, I expected this to be an explanation for why alcohol consumption would increase in response to relational stress. Ultimately, there may be other contributing factors that may promote alcohol consumption within a relationship, and relationship stress may not be at the top of that list. Stressful jobs, an affinity for alcohol, and social functions are all reasons why couples turn to alcohol throughout their relationship. Based off of these factors, it is not constructive to determine that relational stress is the only catalyst for drinking.

**Why will dyadic coping have a positive effect on drinking behaviors?**

Unfortunately, while there was a decent amount of evidence in the literature to support dyadic coping as a way to positively moderate health behaviors, such as sticking to healthy eating and physical exercise regimes, there was less literature on dyadic coping in regard to drinking behaviors. However, results from this study provide evidence that not only does dyadic coping promote more beneficial health behaviors, it also helps in counteracting negative ones in response to stress. Instead of each person within the relationship coping separately in regard to an individual or shared stressor, withdrawing and becoming isolated from the situation to handle it themselves, dyadic coping will promote the support and genuine sharing of the stressor. By learning how to practice dyadic coping, the couple will feel an increased level of support from their partner respectively; this will ultimately raise both self-esteem and lower the necessity for coping separately, as well as lower the original desire to drink in response to the stressor and lack of partner support.
Why will dyadic coping moderate the association between relationship stress and alcohol consumption?

While relational stress may play a significant role in increasing drinking behaviors within a couple, this study provided evidence that dyadic coping can moderate these effects. As stated in the above discussion, couples who practiced dyadic coping were less likely to engage in detrimental drinking behaviors when faced with same relational stressors than those that did not. Without the feelings of isolation and loneliness each partner may have originally felt, drinking is no longer a necessity. While at first the relational stressor may have induced a desire to reach for alcohol to cope, dyadic coping promotes the support essential to develop positive health behaviors. With this information, it is probable to deduce that dyadic coping serves as a way to lessen the association between relationship stress and alcohol consumption.

Implications of the Research

This study is one of the first to examine whether dyadic coping lessens the association between relationship stress and alcohol consumption. The results of this research provided findings useful to the advancement of coping strategies in relationships, coping to moderate positive health behaviors, and ways to combat the detrimental effects of relational stress. This study’s findings revealed how both dyadic coping and relational stress are associated with varying levels of alcohol consumption. This is significant because according to research done by Meuwly, Bodenmann, Germann, Bradbury, Ditzen & Heinrichs (2012), support of partners within relationships, specifically dyadic coping, can be quite beneficial to counteract negative effects of stress. According to Brown, Vik, Patterson, Grant, & Schuckit (1995), increased vulnerability to threatening or chronic stress
has also been related to adult alcohol relapse following alcoholism treatment. While dyadic coping promotes beneficial health behaviors among couples, various types of stress induce disadvantageous health behaviors among individuals. Understanding how relational coping can adequately benefit health behaviors among couples can begin to give researchers and clinicians a better sense of how couples therapy should be adjusted and specialized, and how it would be most constructive to begin focusing on dyadic coping in response to relational stress.

Limitations and Future Research

A limitation with the self-report questionnaires used by this study may be that it was difficult to determine full validity, because some individuals may have rushed to complete them or be compelled to answer untruthfully. Take-home self-report questionnaires are beneficial in helping researchers understand the dynamic of a couple in their “natural” environment, but they can also induce error into a study. Researchers are unable to control the way a participant answers the questionnaire, and do not know with certainty whether participants have answered the questionnaires truthfully and correctly. Participants may answer the way they think would make them look like a better, more supportive partner, and this would skew the results of the dyadic coping portion of the survey. They may also fail to fill out necessary information, skip over questions they do not wish to respond to, and provide dishonest answers. Understandably, people want to look good in regard to problem solving and how they cope with stressors within their relationship; many may not truthfully expose how often they actually drink in response to relational stress. Fortunately, enough couples were truthful about their drinking behaviors in response to relational stress that the results were both significant and informative.
Another limitation of the study was the age of the participants that qualified. Participants must be 18 years and older; older adults from a “different” generation may be less compelled to turn to alcohol when they are stressed, due to understanding the detrimental implication of increased drinking in response to stress. Furthermore, younger adults in a collegiate or academic setting have a greater access to alcohol (i.e. parties and social functions), accessing alcohol when faced with relational distress may prove far more easy for a certain age range, such as the younger generation, than that of an older one. However, older adults may have more money, and therefore may be more prone to buying alcohol when faced with the same stressors as younger adults. Overall, it would seem that variance in age will result in different outcomes.

Potential Future Studies

Due to a lack of generalizability in this study (particular set of people, specific place, specific time), it would be interesting to determine whether the results concluded in this study would be significant for relationships nationwide; would various cultures differ in their drinking frequency in response to relational stress? Would race or ethnicity alter the results? The study focused upon heterosexual couples cohabitating within the first year of their relationship, so it would be beneficial to be able to generalize the results even worldwide and to test in future research whether the very specific participant criteria for the present study were what helped in determining the final results. Changing the amount of time the individuals were living together, the length of the couples’ relationship, and the sexual orientation of the couples would all be ways to expand upon the existing research. In accord with this, children in other countries such as Europe or Asia are allowed to drink at a younger age. The criteria for this study determined that participants must be over the age
of 18 to participate; however, if this study was conducted in a different country with different laws and criteria (i.e. age, culture, ethnicity), there may be cross-cultural variations in results.

By educating couples nationwide, even worldwide, about the benefits of using dyadic coping when faced with relational stress, it may be possible to decrease the amount of alcohol consumed amongst couples when they experience stress. Not only will dyadic coping benefit their relationship emotionally by providing access on how and when to use successful partner-support, decreasing alcohol consumption in response to relational stress will also improve physical health. Future studies have the potential to expand upon this research by changing participant criteria and health outcome variables. By discovering these effects, it may be possible to strengthen the bond between couples by promoting the proper coping strategies to combat relational stress.
Works Cited


