Quality of intimate relationships, dyadic coping, and psychological health in women with endometriosis: results from an online survey

Running head: Endometriosis and intimate relationships

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ABSTRACT

OBJECTIVE: To explore the associations between intimate relationships, psychological health, and endometriosis-related variables such as pelvic pain and infertility.

METHODS: In this cross-sectional study, data were collected with an online survey delivered through Qualtrics and posted on the Facebook page and website of a patient association (Associazione Progetto Endometriosi—APE) in August 2020. The survey was composed of a researcher-made questionnaire and four validated questionnaires assessing relational satisfaction (adapted Quality of Marriage Index), dyadic coping (Dyadic Coping Questionnaire), and psychological health (Hospital Anxiety and Depression Scale and Rosenberg Self-Esteem Scale).

RESULTS: Participants were 316 women (age: 35.9 ± 6.7) with endometriosis, who reported being in an intimate relationship from at least one year. A greater perceived negative impact of the disease on past and current intimate relationships was associated with poorer psychological health, lower relational satisfaction and worse dyadic coping. Women who perceived their partner as more informed about endometriosis, more informed about and interested in their health conditions, and more likely to accompany them to the medical appointments, showed greater relational satisfaction and dyadic coping. Relational satisfaction and dyadic coping were associated with psychological health. A greater perceived negative impact of endometriosis on intimate relationships was associated with more severe pelvic pain (especially dyspareunia).

CONCLUSION: Endometriosis has a negative impact on intimate relationships, which is associated with poorer psychological health. For the women with the disease, partner's support is important, and our findings suggest that effort should be made to involve both members of the couple in multidisciplinary treatment.

KEYWORDS: Dyadic coping; Endometriosis; Intimate relationships; Online survey; Psychological health; Self-esteem

1. Introduction

Endometriosis is a menstrual cycle-dependent, chronic, inflammatory, systemic disease that affects approximately 8-10% of women of reproductive age and 30-50% of women with infertility, and is characterized by lesions of endometrial-like tissue outside of the uterus [1-4]. This condition, especially when painful, may have a pervasive impact on women's daily life due its emotional and economic costs, leading to impaired psychological health [5-8]. Intimate relationships are also affected, considering not only the association between endometriosis and infertility (which involves revising the couple's expectations and future plans, including having children), but also its negative consequences on social and working lives, intimacy and sexuality [9]. In this regard, there is evidence that endometriosis-related dyspareunia (i.e., pain at intercourse) is an important cause of sexual dysfunction [10-12], which may lead to reduced or even non-existent sexual activity, with negative consequences on women's self-esteem and intimate relationships [13,14]. In a study by De Graaff *et al.* [15], 468 women (50% of the total) reported that endometriosis affected their relationships. Of these, 312 (67%) reported endometriosis-related problems with their partner, and 90 (19%) considered endometriosis associated with relationship breakup. In an online survey conducted by Armour *et al.* [16] using the World Endometriosis Research Foundation EndoCost tool [17] (see also De Graaff *et al.* [15]) and including 340 women with endometriosis, the disease was linked to significant problems with partner by 120 participants (59%) and to relationship breakdown by 31 women (15%).

The negative systemic (rather than merely individual) effects of the disease have been recently underlined by Facchin *et al.* [18], who summarized the evidence provided by a small body of literature showing that endometriosis represents a source of stress for both women and their partners. In addition, partners are often scarcely informed about endometriosis by physicians, with limited involvement in healthcare decisions that may affect the organization of the whole family [13,19].

1.1. Coping with chronic illness: the notion of dyadic coping

Managing a chronic condition like endometriosis is a relational process that involves the couple and requires taking multiple actions related to the illness (e.g., attending medical appointments together, discussing treatment options), to everyday life (e.g., housework and childcare), to revising plans for the future (for instance as a consequence of infertility) and dealing with the emotional burden of the disease [20,21]. In the context of diseases other than endometriosis, coping with chronic illness has been conceptualized as a transactional process (referred to as dyadic coping) in which partners mutually influence each other while coping with a shared stressor [22,23]. Communicating one's stress to one's partner is an important component of dyadic coping, and positive dyadic coping involves: supportive dyadic coping (i.e., providing listening and understanding, information and practical advice, to help the other deal with the stressor); delegated dyadic coping (i.e., taking over the other's daily tasks to reduce the other's stress); common dyadic coping (i.e., making efforts to cope with the stressor as a couple, for instance by talking and relaxing together). On the other hand, negative dyadic coping occurs when one partner is bothered by the other's stress and shows lack of motivation and engagement, ambivalence, or even hostility while providing support. Depression and chronic illness are associated with negative dyadic coping [24,25]. Greater positive dyadic coping and lower negative dyadic coping are associated with better relational and psychological outcomes in patients with cancer [26] and other types of chronic disease such as chronic obstructive pulmonary disease [25], dementia [27], and diabetes [28].

1.2. The current study

Although the importance of intimate relationships and partner's support is well known in the context of other chronic diseases, in most studies the impact of endometriosis on women's mental health was examined with an exclusive focus on the association between several aspects of the disease (including pelvic pain) and psychological symptoms (especially anxiety and depression). Little attention has been devoted to the role played by intimate relationships in shaping women's subjective experience of endometriosis. Therefore, we conducted the current study to provide

102 further insights into the association between women's experiences of intimate relationships
103 (including relational satisfaction and dyadic coping) and psychological health. We expected to find
104 better psychological conditions in women who (1) reported a lower negative impact of
105 endometriosis in their past and current love life, (2) perceived their partner as interested in and
106 informed about their condition, (3) were more satisfied with their relationship, and (4) had better
107 dyadic coping. In addition, we explored the correlation between women's subjective experiences of
108 intimate relationships and some important aspects of endometriosis, such as pelvic pain and
109 infertility.

110 **2. Methods**

111 In this cross-sectional study, data were collected from 10 to 13 August 2020 with an
112 anonymous online survey hosted on Qualtrics (Qualtrics Ltd.). Participants were recruited using a
113 snowballing sampling strategy that involved posting the invitation to participate in the study (with a
114 direct link to the survey) on the Facebook page and the website of the largest endometriosis patient
115 association in Italy (Associazione Progetto Endometriosi [Endometriosis Project Association]—
116 APE). APE is a volunteer organization founded in 2005 by a group of women with endometriosis
117 and is currently committed to supporting other women with the disease and their families, providing
118 correct information about endometriosis, and sensitizing in order to enhance early diagnosis and
119 quality of care. Inclusion criteria were: (1) age ≥ 18 years, (2) surgical or clinical (gynecological
120 examination, transvaginal ultrasound, magnetic resonance imaging) diagnosis of endometriosis (as
121 regards to the importance of clinical diagnosis of endometriosis, see Agarwal *et al.* [29]), and (3)
122 being in a relationship for at least one year (as done in other studies exploring dyadic coping in
123 couples, see for instance Breitenstein *et al.* [30]). Women who completed the survey, but reported
124 being in a romantic relationship for less than one year, were excluded from the analyses. Detailed
125 information regarding the research, including aims and procedures, were reported in an online
126 consent form that women had to read and approve (anonymously) to be able to continue the survey.

The research was approved by the Ethics Commission of the Department of Psychology, Catholic University of the Sacred Heart (protocol number: 21-20; approval date: 10 July 2020).

2.1. Measures

The online survey was composed of a researcher-made questionnaire, along with the Italian version of 4 validated questionnaires focused on relational satisfaction, dyadic coping, and psychological health (symptoms of anxiety/depression and self-esteem). The researcher-made questionnaire was divided in three parts aimed at collecting (1) socio-demographic data such as age, level of education, employment, and marital status, (2) endometriosis-related information, including type of endometriosis, type of diagnosis, hormonal treatment, current infertility and IVF, comorbidities, pelvic pain severity (rated on a 0-10 numerical rating scale, with 0 = "no pain at all", and 10 = "the worst imaginable pain", with a separate score for chronic pelvic pain, dysmenorrhea, dyspareunia, and dyschezia), and age at diagnosis, and (3) details regarding the couple relationship (e.g., gender of partner, length of relationship, presence of children). The third section also included a set of 5-point Likert scales to assess women's perceptions regarding the negative impact of endometriosis on intimate relationships ("To what extent do you think endometriosis had a negative impact on your past love life / on your current intimate relationship" [1 = "not at all", 5 = "very much"]) and partner attitudes and behaviors towards endometriosis and women's health status ("To what extent do you think your partner is informed about endometriosis / informed about your health status / interested in being informed about your health status" [1 = "not at all", 5 = "very much"]; "How often does you partner accompany you to medical appointments" [1 = "never", 5 = "always"]).

Relational satisfaction was assessed using the Quality of Marriage Index [31,32], adapted to be administered to either unmarried or married couples (in this article, the adapted version of the QMI is referred to as "Quality of Relationship Index" [QRI]). The QRI is composed of 6 items measuring relational satisfaction on a 7-point scale (the first 5 items, e.g., "We have a good relationship"; 1 = "strongly disagree", 7 = "strongly agree") and on a 10-point scale (the last item,

153 which measures participants' overall level of happiness in their relationship; 1 = "extremely
154 unhappy", 10 = "extremely happy"). The scores of the six items are summed to obtain a global
155 score, with higher scores indicating greater relational satisfaction. In this study, the QRI had good
156 internal consistency (Cronbach's α = .95).

157 Dyadic coping was assessed with the Dyadic Coping Questionnaire (DCQ) [33,34], a 41-
158 item questionnaire assessing dyadic coping, with responses scored on a 1-5 Likert scale (1 =
159 "Never", 5 = "Very often"). Thirty-nine items measure stress communication, supportive and
160 delegated dyadic coping, common dyadic coping, and negative dyadic coping. Specifically, the
161 DCQ measures: (1) the respondent's perception of their own dyadic coping strategies (e.g., "I show
162 my partner that I'm stressed and I am not feeling well" [own stress communication]; "When my
163 partner feels he/she has too much to do, I help him/her out" [own delegated dyadic coping]); (2) the
164 respondent's perception of their partner's dyadic coping (e.g., "My partner shows me that he/she is
165 stressed and is not feeling well" [partner stress communication]; "When I am too busy and I have
166 too much to do, my partner helps me out" [partner delegated dyadic coping]); (3) common dyadic
167 coping (e.g., "We try to cope with the problem together and search for practical solutions"); (4) the
168 respondent's evaluation of the quality of dyadic coping, in terms of satisfaction with dyadic coping
169 (item 40) and the perceived efficacy of dyadic coping (item 41). Besides the scores of the 8
170 subscales related to the respondent's own and partner dyadic coping, common dyadic coping,
171 satisfaction and efficacy of dyadic coping, a global score (DCQ-Total) can be calculated as a sum of
172 items 1 through 39 (i.e., excluding evaluation), with higher scores indicating better dyadic coping.
173 The negative dyadic coping items were reversed to calculate DCQ-Total, whereas associations
174 between the negative dyadic coping subscales and other variables were examined using the original
175 negative dyadic coping scores (such that higher scores indicate more negative dyadic coping).
176 Overall evaluation of dyadic coping was calculated as the sum of items 40 and 41. In this study, the
177 values of Cronbach's α ranged from .66 for women's own negative dyadic coping to .94 for
178 evaluation of dyadic coping.

The Hospital Anxiety and Depression Scale (HADS) and the Rosenberg Self-Esteem Scale (RSES) were used to measure women's psychological health. The HADS [35,36] assesses symptoms of anxiety and depression on two 7-item subscales (HADS-Anxiety and HADS-Depression). The frequency of symptoms is scored on a 0-3 scale and a total score (HADS-Total) can also be calculated, with higher scores indicating poorer psychological conditions. The RSES [37,38] is a 10-item questionnaire that measures self-esteem, with responses scored on 4-point Likert scale (1 = "strongly disagree", 4 = "strongly agree"). Cronbach's α ranged from .78 for HADS-Depression to .90 for the RSES.

2.2. Statistical analyses

All statistical analyses were performed using the software SPSS version 25 (IBM Corporation). In this article, descriptive statistics were reported as means ± standard deviations for continuous variables, and numbers and percentages for categorical variables. Normality of distributions was assessed considering the values of skewness and kurtosis (-1/+1 was the acceptable range for normality [39,40]). Correlations between continuous variables were examined using Pearson or Spearman correlation, as appropriate. Group comparisons were performed using independent samples *t*-test or Mann-Whitney U test, according to the distribution of the dependent variables.

Sample size was determined using the software G*Power [41] and considering that, in a previous unpublished survey conducted by our group, Pearson correlation between DCQ-Total and HADS-Total, as reported by 143 women with endometriosis (who were in a relationship from at least 1 year), was -.276. Therefore, we calculated that, given $r = -.276$, $\alpha = .05$, and power = .90, a sample size of 133 participants was required. Considering that the overall reach of APE on Facebook was over 32 800 followers when the study was conducted, we established that the number of participants had to be ≥ 133 and we planned to stop data collection two days after reaching the required number of participants. Findings were considered statistically significant at $P < .01$. No

attempt was made to replace missing data, and in this article we reported the exact number of respondents (i.e., valid observations) for each variable of interest.

3. Results

A total of 345 women accessed the online survey. Twenty-seven participants provided remarkably incomplete responses (i.e., no data at all, or complete absence of information regarding the couple relationship) and 2 reported that the length of the intimate relationship was < 1 year. Three hundred and sixteen women aged 20-54 years (35.9 ± 6.7) responded to at least one question related to intimate relationships and were included in the statistical analyses. Most of them were Italian (308 [97.5%]), 132 (41.8%) had a high school diploma, 153 (48.4%) had a full-time job, and 166 (52.5%) were unmarried. In almost all cases, partners were males (304 [96.2%]). Only 6 women (1.9%) had a female partner and the remaining 6 participants (1.8%) did not answer the question. Relationship duration ranged from 1 to 35 years (10.7 ± 7.0). The majority of the women included in the study did not have children with the current partner (235 [74.4%]). Nine women (2.8%) had children from previous relationships and 8 participants (2.5%) were pregnant when the study was conducted.

Most women (223 [70.6%]) were diagnosed with endometriosis after the initiation of the current relationship. Age at diagnosis ranged from 13 to 44 years (28.5 ± 6.0). Complete information regarding endometriosis-related variables is reported in Table 1. Means and standard deviations of all the variables related to intimate relationships and women's psychological health are reported in Table 2.

3.1. Intimate relationships and psychological health

The majority of the respondents (192 [63.4%]) reported that endometriosis had a moderate to very negative impact on their past love life, as well as on their current relationship (114 [62.9%]). A higher perceived negative impact of the disease on intimate relationships (either past or present)

was significantly associated with poorer psychological health (see Table 3), as well as with lower relational satisfaction and worse dyadic coping, including evaluation of dyadic coping (see Table 4).

A minority of women perceived their partner as not or a little informed about endometriosis (84 [19.5%]) and about their health status (37 [11.8%]). Only 21 participants (6.7%) reported that their partner was not or a little interested in being informed about their health conditions, and 72 women (23.1%) reported that their partner never or rarely accompanied them to the medical visits. Women who perceived their partner as more informed about endometriosis (in general), informed about and interested in being informed about their health status, as well as women who reported that their partner used to accompany them to the medical visits, showed greater relational satisfaction and better dyadic coping (see Table 4).

As reported in Table 3, a greater relational satisfaction (measured with the QRI) was associated with lower anxiety and depression, and higher self-esteem. As regards dyadic coping (see Table 3), higher negative dyadic coping (considering either women's self-perceptions or perceptions of partner's negative dyadic coping) was associated with greater symptoms of anxiety and depression, and lower self-esteem, whereas more positive dyadic coping (especially common dyadic coping) and evaluation of dyadic coping were associated with better psychological conditions.

3.2. Intimate relationships and endometriosis-related variables

A greater perceived negative impact of the disease on the current relationship was associated with more severe pain symptoms, especially as regards to dyspareunia (chronic pelvic pain: $r = .249$, $P = .001$; dysmenorrhea: $r = .238$, $P = .002$; dyspareunia: $r = .433$, $P < .001$; dyschezia: $r_s = .389$, $P < .001$). The perceived negative impact of endometriosis on past love life was also associated with pain, and specifically with dyspareunia ($r = .275$; $P < .001$) and dyschezia ($r_s = .188$, $P = .001$). The perceived negative impact of endometriosis on intimate relationships (either in the past or in the present) was not significantly correlated with any other endometriosis-related variable (*Ps* >.01).

253 However, of the 36 women who were undergoing IVF, 32 (88.9%) reported a moderate to severe
254 impact of the treatment on the couple relationship.

255 The association between relational satisfaction and dyspareunia was very close to the pre-
256 planned level of statistical significance (r_s = -.153, P = .011). Women who reported higher negative
257 dyadic coping of partner had more severe chronic pelvic pain (r_s = .190, P = .002) and dyschezia (r_s
258 = .182, P = .003). No other significant associations were found between relational satisfaction,
259 dyadic coping, and endometriosis-related variables (*Ps* >.01).

260 **4. Discussion**

261 At least to our knowledge, this is one of the very few studies examining the association
262 between the perceived quality of intimate relationships and the psychological health (in terms of
263 symptoms of anxiety/depression and self-esteem) of women with endometriosis. Overall, the
264 responses provided by the 316 participants included in the study confirmed that the disease has a
265 negative impact on women's love life, as suggested in previous research [6,14-16]. In our study, a
266 greater perceived negative impact of the disease on intimate relationships was associated with
267 poorer psychological health.

268 We also found that higher satisfaction with the current relationship and better dyadic coping
269 were associated with greater psychological health. Specifically, our findings highlighted the
270 correlation between positive dyadic coping – especially common dyadic coping (which occurs when
271 both partners make efforts to cope together with a shared stressor) – and the mental health of
272 women with endometriosis. The role played by common dyadic coping strategies in the context of
273 clinical samples (including couples coping with diabetes, cancer, or psychological disorders such as
274 depression) and its positive outcomes for couples, in terms of decreased distress and greater
275 relational satisfaction, have been highlighted in previous studies [26,45-47]. On the other hand, our
276 study confirmed that negative dyadic coping (which entails responding with hostility, sarcasm,
277 distancing, superficiality, or ambivalence to the partner's signals of stress) is associated with poorer

psychological health in people with chronic illness, as previously demonstrated by other authors [25].

In our study, women who perceived their partner as more interested and actively involved in the management of endometriosis (for instance by accompanying them to the medical visits) reported greater relational satisfaction and better dyadic coping. Taken together, these findings highlighted the importance of coping strategies based on mutuality and we-ness ("we are in this together" [47]), which seem to be particularly helpful for women coping with different types of stressors (such as breast cancer [49]), as recently underlined by Rusu *et al.* [50].

Our results showed that a greater perceived negative impact of endometriosis on women's love life was also associated with lower relational satisfaction and worse dyadic coping (along with poorer psychological health). Most importantly, our findings highlighted the correlation between the perceived negative impact of endometriosis on intimate relationships and pelvic pain, especially dyspareunia. The negative effects of this form of endometriosis-related pain on women's sexual quality of life are well known [42,43]. In addition, introital dyspareunia is associated with greater concerns related to infertility in women with endometriosis [44].

4.1. Limitations

Our study presents several limitations, especially in relation to the methodology used to collect the data. Some caution should be taken with the interpretation of our findings due to the self-reported nature of the data (including medical information, for instance regarding the type of diagnosis) and the risk of selection bias, also considering that the invitation to participate in the online survey was posted on the social media of a patient association. Specifically, this type of recruitment strategy may have resulted in the selection of women with more severe physical and psychological symptoms. As underlined by De Graaff *et al.* [51], quality of life outcomes (including the impact of endometriosis on relationships) are influenced by settings and recruitment strategies.

In their study, the authors found that affected relationships were more prevalent in women recruited via the Dutch patient association vs. secondary and tertiary care populations.

It should also be considered that important aspects, such as impact of endometriosis on women's love life and partner's engagement, were assessed using researcher-made items (rather than validated questionnaires). In addition, although we examined dyadic coping, we did not perform an actual dyadic study, since we considered only women's perspective. Moreover, the associations between intimate relationships and psychological health were conceptualized and explored in terms of correlation, which does not imply causation. Therefore, no causal inferences can be drawn from our findings, also considering the cross-sectional research design.

4.2. Suggestions for future research and clinical practice

Future studies should include partners as participants to explore the impact of endometriosis on couples in a more systematic fashion. Longitudinal studies are encouraged to describe adjustment trajectories and predictors of psychological health in couples dealing with endometriosis, and to further clarify the effectiveness of specific coping strategies. Dyadic research (see for example Van Niekerk *et al.* [52]) can be particularly helpful to examine how couples deal with endometriosis as a shared stressor, as also underlined by Hudson *et al.* [53].

Endometriosis should be investigated and treated considering its pervasive detrimental effects on women's romantic relationships. Our findings suggest that multidisciplinary clinical practice with endometriosis patients may improve their psychological health (including self-esteem) by helping them find effective strategies to reduce pelvic pain and enjoy sexuality, as well as by enhancing partners' engagement in the management of the disease. Psychological counseling with couples may encourage common dyadic coping strategies, based on the idea that any chronic disease is a shared stressor. In this regard, providing partners with detailed information about endometriosis and its consequences on intimate relationships, including sexuality, may increase their awareness of women's sufferance and thus decrease negative dyadic coping.

5. Conclusions

Combined with the small body of evidence highlighting the negative impact of endometriosis on women's partners [18], our findings suggest that endometriosis significantly affects couple relationships. Over the past decades, diseases other than endometriosis (such as breast cancer [54]) have been investigated and treated as a "we-stress" that affects both partners. In this regard, we believe that a broader conceptualization of endometriosis as a "we-disease" may contribute to expand our perspectives as researchers and clinicians, and benefit women.

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493

Variables			Respondents (N)
Type of diagnosis (N, %)	Surgical	81 (25.8%)	314
	Clinical	233 (74.2%)	
Pelvic pain (M ± SD)	Chronic pain	5.3 ± 2.7	302
	Dysmenorrhea	6.5 ± 3.3	290
	Dyspareunia	5.5 ± 2.9	298
	Dyschezia	4.1 ± 3.2	297
Hormonal treatment (N, %)	Yes	206 (66.2%)	311
	No	105 (33.8%)	
Type of hormonal treatment (N, %)	Estroprogestins	70 (34.5%)	203
	Progestins	126 (62.1%)	
	GnRH analogues	7 (3.4%)	
Comorbidities	Yes	124 (40.9%)	303
	No	179 (59.1%)	
Current infertility	Yes	157 (52.2%)	301
	No	144 (47.8%)	
Assisted reproduction	Yes	36 (23.1%)	156
	No	120 (76.9%)	

Table 1. Endometriosis-related variables

498

Variables		Respondents (N)	Mean ± SD
Perceived negative impact of endometriosis	--on the current relationship	181	2.9 ± 1.1
	--on past love life	303	2.9 ± 1.2
Women's perceptions about partner attitudes and behaviors	Partner informed about endometriosis	312	3.1 ± 0.9
	Partner informed about the woman's health status	312	3.7 ± 1.0
	Partner interested in being informed about the woman's health status	312	4.1 ± 0.9
	Partner accompanies the woman to medical visits	311	3.5 ± 1.3
Relational satisfaction (QRI)		282	36.4 ± 9.3
Dyadic Coping (DCQ)	Own stress communication	270	14.6 ± 3.1
	Partner stress communication	268	12.7 ± 3.3
	Own supportive dyadic coping	266	20.1 ± 2.9
	Partner supportive dyadic coping	267	18.4 ± 4.4
	Own delegated dyadic coping	269	7.1 ± 1.4
	Partner delegated dyadic coping	270	6.8 ± 1.9
	Own negative dyadic coping	267	7.5 ± 2.5
	Partner negative dyadic coping	269	8.3 ± 3.5
	Common dyadic coping	267	24.2 ± 5.6
	Evaluation of dyadic coping	269	7.2 ± 2.1
	DCQ-Total	253	148.0 ± 19.9
Psychological health	HADS-A	272	9.3 ± 4.2
	HADS-D	272	8.4 ± 4.1
	HADS-Total	271	17.7 ± 7.6
	RSES	261	28.5 ± 6.1

499

500 **Table 2.** Intimate relationships and psychological health: means and standard deviations

501

Intimate relationships		Psychological health			
		HADS-A	HADS-D	HADS-Total	RSES
Perceived negative impact of endometriosis	--on the current relationship	.381**	.404**	.430**	-.337**
	--on past love life	.162*	.180*	.186*	-.201*
Women's perceptions about partner attitudes and behaviors	Partner informed about endometriosis	-.002	-.039	-.024	.123
	Partner informed about the woman's health status	-.084	-.078	-.091	.126
	Partner interested in being informed about the woman's health status	-.076	-.084	-.086	.091
	Partner accompanies the woman to medical visits	.000	.027	.014	.058
Relational satisfaction (QRI)		-.262**	-.337**	-.333**	.250**
Dyadic Coping (DCQ)	Own stress communication	-.025	-.140*	-.090	.115
	Partner stress communication	.016	-.092	-.044	.031
	Own supportive dyadic coping	-.092	-.206*	-.166*	.178*
	Partner supportive dyadic coping	-.132	-.208*	-.187*	.215*
	Own delegated dyadic coping	.009	-.070	-.039	.080
	Partner delegated dyadic coping	-.109	-.130	-.132	.160
	Own negative dyadic coping	.250**	.304**	.305**	-.289**
	Partner negative dyadic coping	.203*	.235**	.242**	-.296**
	Common dyadic coping	-.215**	-.319**	-.293**	.291**
	Evaluation of dyadic coping	-.214**	-.305**	-.286**	.299**
	DCQ-Total	-.195*	-.316**	-.282**	.296**

Table 3. Intimate relationships and psychological health

The values reported in this table were derived from Spearman (for relational satisfaction and negative dyadic coping) and Pearson correlation analyses (for all the other variables).

*$P < .01$

**$P < .001$

	QRI			DCQ								
	Relational satisfaction	Own stress communication	Partner stress communication	Own supportive DC	Partner supportive DC	Own delegated DC	Partner delegated DC	Own negative DC	Partner negative DC	Common DC	Evaluation of DC	DCQ-Total
Perceived negative impact of endometriosis												
--on the current relationship	-.408**	-.053	-.117	-.248*	-.290**	-.042	-.199	.357**	.391**	-.375**	-.406**	-.354**
--on past love life	-.258**	-.051	.016	-.097	-.210*	.067	-.123	.129	.189*	-.248**	-.274**	-.203*
Women's perceptions about partner attitudes and behaviors												
Partner informed about endometriosis	.347**	.271**	.213**	.255**	.420**	.156	.339**	-.160*	-.319**	.387**	.384**	.441**
Partner informed about the woman's health status	.456**	.333**	.171*	.301**	.542**	.173*	.417**	-.251**	-.433**	.508**	.519**	.554**
Partner interested in being informed about the woman's health status	.302**	.275**	.046	.299**	.352**	.137	.324**	-.210**	-.352**	.348**	.296**	.406**
Partner accompanies the woman to medical visits	.309**	.200*	.146	.167*	.346**	.152	.340**	-.152	-.328**	.285**	.306**	.343**

Table 4. Women's perceptions, relational satisfaction, and dyadic coping (DC)

The values reported in this table were derived from Spearman (for relational satisfaction and negative DC) and Pearson correlation analyses (for all the other variables).
*Significant at $P < .01$
**Significant at $P < .001$