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Anxiety disorders and marital satisfaction

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Abstract

OBJECTIVES: Anxiety disorders can be a burden for the patient and his family. They affect the family everyday functioning, require greater demands on adaptation and re-evaluation of the existing habits of family members and consequently may result in family dysfunction due to anxiety disorders, especially in marital relationship or partnership. However, the knowledge about the impact of anxiety disorders on one or both partners in marital or partner life is still limited.

METHOD: The relevant studies were identified through the Web of Science, PubMed, and Scopus databases, within the period 1990–2017. Additional references were found using reviews of relevant articles. The search terms included "anxiety disorders,""marital problems," "marital conflicts," "partnership," "family functioning," and "communication."

RESULTS: Dissatisfaction in a relationship can act as a trigger for the development of anxiety disorders and could also be responsible for the modulation and maintenance of these disorders. However, this dissatisfaction may also be the consequence of manifestation of the anxiety disorders. The individuals with the anxiety may feel guilty about their partners because of the tolerance and help (does not matter what kind and quality of the help he/she provides), sometimes they are submissively grateful because of the support, they may feel inferior, tend to serve him /her. On the other hand, he/she begins to rebuke partner's supposed negative attitudes; the patient may start to use his psychological problems as an excuse and expects others to help him and solve the situation. Consequently, he /she starts to check and criticize the partner and this tense situation may lead to problems in marriage and disturbs family functioning.

CONCLUSION: Distress elements that contribute to the development of anxiety disorders can be diverse and sometimes it is not easy to identify so-called precipitating factors. The link between anxiety disorders and family relationships is bi-directional: psychological problems adversely affect patient relationships and attitudes of the partner towards the patient significantly affect his/her anxiety.

ORIGINAL ARTICLE

INTRODUCTION

Anxiety disorders belong to the most common psychological disorders in children and adults (Wittchen & Jacobi 2005; Lecrubier 2007). They are often debilitating not only for individuals who suffer from the disorder but also for their partners who have a close relationship with them. The results of many studies indicate that anxiety disorders have an adverse impact on the social functioning of the patient, including partner life (Machell *et al.* 2016). However, our knowledge of the impact of anxiety disorders on one or both partners in marital or partner life is still limited (Diamond & Siqueland 2001). People with the psychiatric disorder have problems in interpersonal relationships, especially with the closest persons (McLeod 1994; Zaider *et al.* 2010; Malary *et al.* 2015; Machell *et al.* 2016). The relationship between anxiety disorders and family relationships is bi-directional: psychological problems negatively affect patient relationships and attitudes of the partner towards the patient significantly affect his anxiety (Kessler *et al.* 1998; Zaider *et al.* 2010; Scott *et al.* 2010; Pilkington *et al.* 2015).

Marriage satisfaction surveys rarely appear in the psychiatric literature. However, it seems that marriage satisfaction and the quality of partnership plays an important role in the occurrence of psychiatric disorders and also affects the length of remission. These impacts are often underestimated and are not taken into account (Waring *et al.* 1986; Machell *et al.* 2016).

The fact that partner relationships and living together with a partner, most often in marriage, may be stressful for vulnerable individuals, and may also trigger an anxiety disorder, has not been fully understood yet. Also, the anxiety disorder, like any psychological disorder, may cause or be the consequence of marital disputes (Schless *et al.* 1977; Rao & Nambi 2009). Some personality disorders, but also personality traits that are highly comorbid with anxiety disorders are associated with a high incidence of partner conflicts (Schless *et al.* 1977; Dominian 1979).

Compared to well-functioning couples, psychiatric morbidity is high in divorcing couples, especially in individuals with anxiety spectrum problems (Schless *et al.* 1977; Rao *et al.* 2009). A study of patients with anxiety spectrum disorders has shown that the woman's inability to leave a partner with persistent neurotic behavior contributes significantly to the couple tension (Ovenstone 1973). Also, the expectation of relationship break-up can lead to independent and autonomous actions, and further increases conflicts and progressively results in alienation (Ovenstone 1973; Kreitman *et al.* 1970). Psychological problems can be contributed by some other problematic situations associated with partner life, such as the discovery of extramarital affairs, problems with children, sexual problems (anorgasmia, impotence). Also, the proclamation of intent to break away may be the key trigger for psychological problems (Schless *et al.* 1977; Prasko *et al.* 2007). Married women are more anxious than married men. This may be related to many factors that lead to the psychological, social and biological burden of women. There could be more responsibility for family care, an effort to adapt to others, pregnancy, birth and maternity, and usually greater liability for child upbringing and health (Pilkington *et al.* 2015; Schless *et al.* 1977).

Distress elements that contribute to the development of anxiety disorder can be diverse and sometimes it is not easy to identify so-called precipitating factors, i.e. the situation or factors that triggered the development of anxiety in a vulnerable person. However, clinically seen, one of the frequent precipitating factors, manifested in protracted stress, is the pair or marital conflict (Faller & Gossler 1998; Benson *et al.* 2013). The consequences of anxiety disorder often include changes in lifestyle, family and work situations, sometimes institutional solutions of problems, such as getting a disability pension, etc. The patient can desire for some of these social consequences, on the other hand, it has a negative impact on the others. Sometimes the secondary gains are important – the patient has profited from the symptoms of the anxiety disorder – such as rent, care of the others, protection from the stress, etc. Many therapists refuse the term secondary gains as a labeling because the patient usually has more losses than profits and this term stigmatizes the patient and reduces the care. Therefore, we prefer to speak about "positive consequences" and "negative consequences." Both the anxiety disorder and its social impact can disrupt the balance in the relationship; the patient may lose his or her position, and is not being treated as an equal partner and finally getting higher stigmatization of the partner.

Load elements that contribute to the development of anxiety disorder can be diverse. However, clinically seen, one of the frequent precipitating factors, manifested in protracted stress, is the inability to solve conflicts (Faller & Gossler 1998; Benson *et al.* 2013). The effects of anxiety disorder often include changes in lifestyle, family and work situations, sometimes institutional solutions such as getting a disability pension, etc. Some of these social consequences may help the patient; others have a negative impact. As a result, it reduces the view of the patient, and as a rule, it also restricts care.

The most common cause of recidivism after remittance in maintaining drug treatment are family conflicts. On the contrary, a quiet home environment and social support (size and quality of the social network) have a positive effect on the course of the disorder.

Studies from recent years claim that people with anxiety disorders experience a higher degree of stress in marriage, and their marriage is more susceptible to decay than marriages where none of the couples suffer from anxiety disorder. Patients with anxiety disorder perceive the quality of their marriage as worse compared to healthy individuals (Yoon & Zinbarg 2007; Scott *et al.* 2010).

Some investigation has addressed the issue of the impact of anxiety disorder on the quality of marital relationships in women. It has been found that women suffering from the anxiety disorder evaluate their marriage worse than women without an anxiety disorder (Yoon & Zinbarg 2007). The men described their marriage as dissatisfied only with the condition that a female also suffers from the anxiety disorder. Women thus play a fundamental role in creating a quality of the relationship and also play a supportive role if their partner has an anxiety disorder (Whisman *et al.* 1997). In literature, there is described the term partnering effect, where the marital satisfaction is determined both by anxiety and depression levels of one partner and by the degree of depression of the second. In the first degree relatives, it was also observed that anxiety could be transmitted to other members of the household, including partners (Crowe *et al.* 1983).

METHOD

Studies used in this review were identified through the Web of Science, PubMed, and Scopus databases, including resources within the period 1990–2017. Additional references were found using reviews of the relevant papers. The search terms included "anxiety disorders, "marital problems," "marital conflicts," "self-stigma," "communication." The search was completed by repeated use of the words in different combinations without language and time constraints. The articles were collected, organized by their importance, and key articles itemized in reference lists were investigated. Reference lists of publications recognized by these procedures were enriched by manually tracing the relevant citations. The report also includes information from books referred to by other reviews.

TYPICAL ISSUES THAT CAN BE SEEN IN THE PARTNERSHIP/ MARITAL RELATIONSHIP

Disturbed attachment

Although the theory of attachment was originally developed to explain the behavior of the child, Hazan and Shaver (Hazan & Shaver 1987) used it to understand the behavior in the adult romantic relationships. They understand attachment as a globally functioning model or internal setting that helps manage the family behaviors. In their definition of the attachment styles, they demonstrate that it is essentially a stable and global scheme that works across all the relationships of an individual in different close ties (Hazan & Shaver 1987). Several studies have also shown that changes in the attachment style are related to the changes in relationship patterns, which may differ significantly from previous relationships (Cobb *et al.* 2001; Davila & Bradbury 2001; Saavedra *et al.* 2010). Several decades of research have shown that the attachment style in adulthood can be influenced by anxieties, which are connected to the fears of abandoning and harm avoidance linked to the closeness itself (Fraley & Shaver 2000; Ravitz *et al.* 2010).

While the classic attachment theory is one of the key models explaining the origin of anxiety, contemporary attachment theories have the potential to integrate neurobiological and behavioral knowledge into a common framework (Nolte *et al.* 2011). Recent research highlighted the relationship between the development of anxiety disorder and the ability of an individual to regulate stress. These factors interact with each other, result in a certain capacity to manage interpersonal stress and the ability for mentalization (capacity to feel, grasp and understand, and respond to the thoughts and feelings of the other). Everything is linked to an early bond to the caregiver (especially the mother). Children who have developed a good relationship with a mother and have experienced a sensitive mother to their needs, are later able to mentalize better than children who have had a mother anxious or depressed. From this point of view, anxiety disorder appears to be the result of the interaction of genetic factors, environmental factors, and epigenetic factors (Nolte *et al.* 2011). Figure 1 shows the model of "tree" showing how the problems with a partner have developed from childhood to the present.

Many researchers have confirmed the importance of attachment and its effect on the occurrence of depressive symptoms in adulthood. Numerous researchers have examined the effect of depressive symptoms and conflict resolution (conflict and compromise) on marriage satisfaction (Marchand 2004)· A study of 64 pairs showed that unlike their wives, husbands had the ability to resolve conflicts for both the depressive symptoms and also for personal marriage satisfaction. Problem-solving ability influences the quality of the relationship, which affects negatively or positively marital satisfaction (Marchand 2004). It seems therefore that the quality of the partner relationship is crucial mainly for a woman.

Unfulfilled expectations

Conflicts in a partnership are most often related to unfulfilled expectations from a partner, but also by oneself when a partner is being blamed for it. Lack of security, acceptance, and appreciation that has not been saturated in childhood in a variety of ways usually leads to the patient´s unconscious endeavor to engage in a relationship (Young *et al.* 2003). Often, these needs are so substantial that the partner is unable to fulfill them. At the time of further external stress, to which the family approaches from time to time, high tension or the conflict in the relationship are triggered. Thus the couple finds itself in a situation where the probability of the pair disintegration increases (Praško *et al.* 2015). The uncertain attachment is replicated in an adult partnership. The anxiety develops, as a rule, in a more dependent person in a couple who is more concerned with the separation (Fraley & Shaver 2000).

Satisfaction in a relationship is influenced by four factors: sociability, reliability, ability to agree and make the compromises, and also reciprocity (McNulty & Widman 2014). Among the most common causes of a breakup are low skills in problem-solving, personality accentuation or personality disorder, family conflicts, infertility, partner abuse, and infidelity (McNulty & Widman 2014). People suffering from anxiety disorders, through safety, avoidance or compensatory behavior, easily fill the factors that are related to the causes

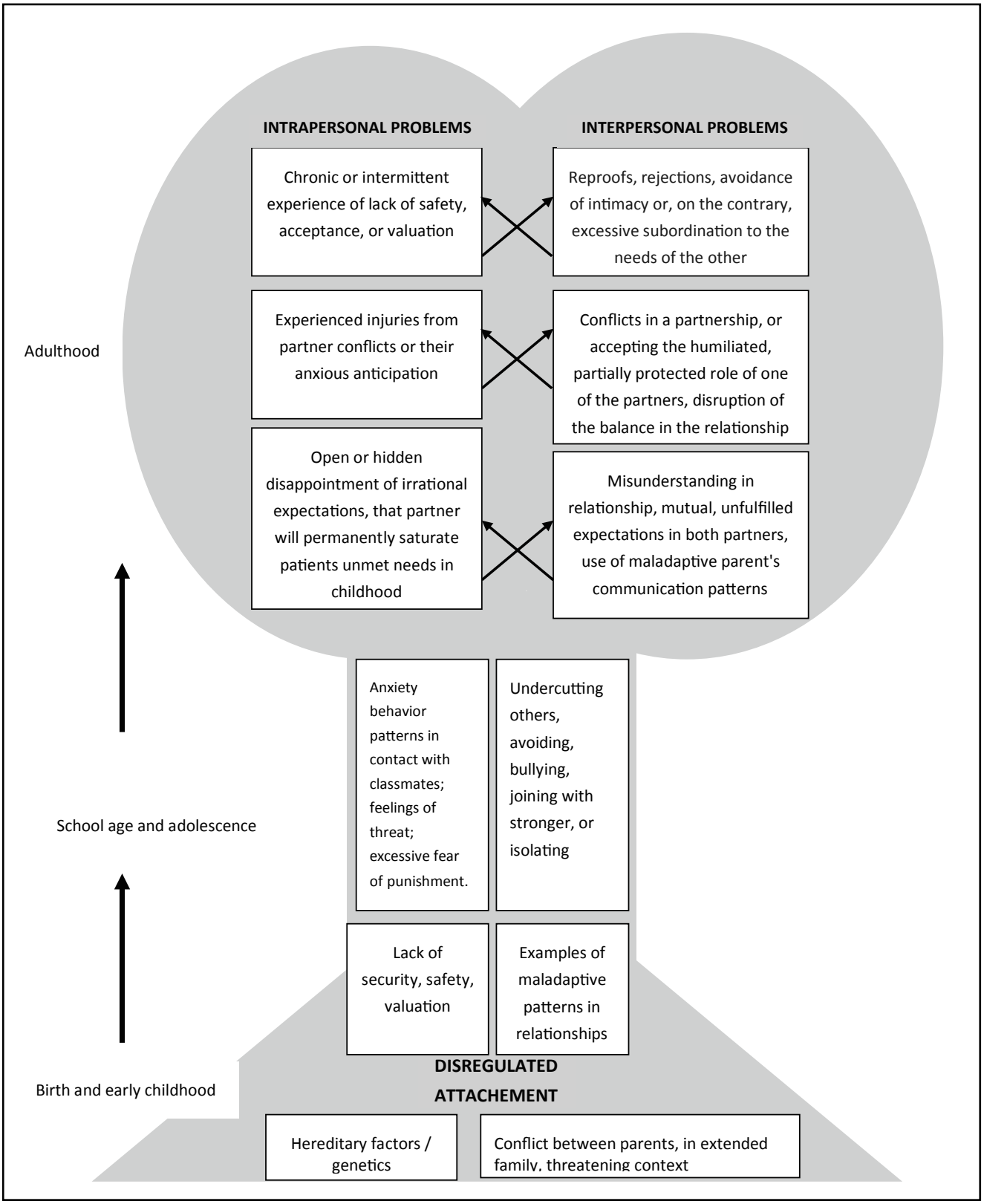

Fig. 1. Developmental "tree" of partner problems in individuals suffering from anxiety disorders.

of the breakup. Because of their lack of inside security feelings, they demand excessive external security, but they cannot provide the partner with the same thing they want themselves. Similarly, most of them have a high need for acceptance and appreciation from the partner, but they have not done the same for him/her. In their anxiety, they often do not realize that the partner lacks reciprocity (Ravitz *et al.* 2010).

Disruption of the still stable balance in the relationship

The manifestations of psychological disorder and its consequences can irritate the partner, force him/her to change the behaviors, to change attitudes towards the sick partner, to be part of the manipulation of control in the relationship. The consequences of a mental disorder that lead to a limitation in the functioning of a sick partner may result in increased demands on a healthy partner, often without a reciprocal reward back (Boisvert & Beaudry 1991; Daiuto *et al.* 1998). The disorder may disturb the symmetry in a relationship, increasing the dominance of an either of the partners, who, through his illness, "keeps a partner in check."

Lack of intimacy in the relationship

A substantial part of the development of anxiety disorders is played by the degree of intimacy in the relationship. Intimacy as a concept refers to different meanings that are related to age, gender, education, and culture. Researchers have no consensus about the sense of this concept, which makes it difficult to define (Martin & Tardif 2014; Mitchell 2007; Kardan-Souraki *et al.* 2015). Bagarozzi (2001) defines intimacy as proximity, similarity, and personal romantic or emotional communication that requires knowledge and understanding of others to express ideas and feelings. Intimacy is firmly linked to the quality of life of couples, and it is frequently referred to an elementary psychological need and one of the main characteristics of family communication that affects satisfaction in marriage and influences the mental health. It reduces the risk of depression, anxiety disorders, increases feelings of happiness and well-being and provides a satisfying feeling of a person in his life (Soltani *et al.* 2013). It is also a strong predictor of physical health (Boden *et al.* 2010; Dandurand & Lafontaine 2013; Moreira *et al.* 2010). All of these factors are matched with marital satisfaction (Greeff *et al.* 2001; Kim 2013). Intimacy acts as a bumper between the influence of everyday stress and the relationship between partners (Harper *et al.* 2000). Intimacy positively correlates with sexual satisfaction in a relationship. In contrast, lack of intimacy is one of the most common causes of anxiety, and it has an adverse impact on the relationship. It leads to mismatches and increases stress; it is a precipitator of depressive and anxiety states or decompensation of personality (Whisman *et al.* 1997; Duffey *et al.* 2004; Kim 2013; Yoo *et al.* 2014). Lack of intimacy in the couple is the most important indicator of divorce among elderly patients (Weinberger *et al.* 2008).

Longitudinal 7-year research in 102 pairs has shown that the imbalance of power and control on the part of husbands and the lack of support by the wives are particularly influenced by the development of psychological difficulties. The feeling of intimacy in the relationship on the wives' side is also greatly influenced (Brock & Lawrence 2011). The practice of psychotherapy shows considerable variance in the degree of intimacy among the partners. Women with anxiety disorders complain more often that they do not receive a close, confidential relationship with their partners, but they are obviously afraid to be open and free to talk about their experience. They want from the partners to do something they can not do reciprocally. They also typically have a problem to open themselves in therapy – the defense mechanism they can use is the externalization. They are not able to talk about their problems and complain about husband behavior. They also typically cannot accept themselves as they are, and paradoxically want from their partner to accept them. Instead, rather than intimacy about deep reciprocal openness, it is about fulfilling the basic need for security, acceptance, and appreciation. If the partner provides it, the women with an anxiety disorder are more satisfied in the relationship, but the problem with intimity does not change considerably, and the issue of lack of intimacy maintained. Men with anxiety disorders complain more often to themselves and are not able to confide or express their emotions to their partners because they do not know how. These men tend to be helpless because they do not know what to do, they do not understand what they should say. Anxious men often complain to the therapist about their problems with openness with the women partner, and inability to express their wishes, fear of conflict or feelings of helplessness ("It is not worth it"). They worry about criticism from a partner and rejection.

Conflicts between partners

Marital disagreements are closely linked to both depression and anxiety among partners. However, exactly how marriage is involved in the rise of these symptoms cannot be accurately determined. There are only limited tools, and no simple model has been developed yet. Marriage is such a complex type of relationship that is not easy to determine how precisely it might trigger or affect the psychological problems of partners. It is hard to identify processes that cause anxiety symptoms. Hafner & Spence (1988) surveyed 109 couples with psychological symptoms, personality, and marital adjustment. Both psychological symptoms and marital adaptation remained stable at the time of marriage. Wives, however, scored worse than spouses on most items. It has been found that the main negative predictors of marital satisfaction are the rate of psychological symptoms, especially phobic anxiety in women and depression in men, moreover, especially for short marriages. In middle-term marriages, the degree of hostility among spouses was the strongest negative

predictor. In long-term marriages, the most important factor was the personality characteristics of husbands, especially assertiveness in men and personality flexibility and adaptability in women. The spouse's anxiety level also plays an important role. Another important factor that determines the length of the marriage, i.e. the persistence of individuals in a long-term relationship, was the ability to solve problems constructively, no aggressive expression of dissatisfaction and also open but not destructive expression of anger toward the partner (Hafner & Spence 1988).

The link between the dysfunctional partnership and the anxiety of one or both partners may be a source of inadequate understanding of one's behavior not only the behavior of a partner (South *et al.* 2008). Problems in partnering are the consequences. One or both partners, in particular, cannot understand the causes of the negative emotions that occur in the couple's living together. Negative emotions either avoid, suppress or divert attention to the physical signs of anxiety. People with anxiety disorders may experience some misunderstandings, misinterpretations, poor communication, and if they suffer from a comorbid personality disorder, they are more alert to verbal and physical aggression (South *et al.* 2008).

The presence of violence in the relationship, in particular, violence against a woman, also affects the occurrence of depression and anxiety in a relationship. In the research of 373 women, it was found that if violence was present in a relationship, women were ten times more depressed and 17 times more anxious than controls without violence (Mapayi *et al.* 2013).

Dysfunctional communication

Communication of the people with the anxiety disorders can be dysfunctional in varying degrees and different ways, depending on the particular type of anxiety disorder and the individual equipment of the individual. Communication has two building blocks (Prasko 2005): (a) understanding the meaning what the partner communicates, (b) expression – how we react to partner´s statement. Anxiety can affect both components.

Therefore, the problems of communication with the partner are caused by inaccurate interpretations of the partner's behavior (most often related to his feelings of danger, non-acceptance, lack of appreciation, lack of adequacy or injustice of unfulfilled needs), and insufficiently developed communication skills (communication is either overly bizarre, from the fear of rejection there is lack of the expression of one's own needs or, on the contrary, it is offensive, censoring, forcing the other to provide basic needs for the person and by this reduce the anxiety or another discomfort of the individual) (Kreitman *et al.* 1970; Prasko 2005; Mitchell 2007).

In the problematic situations of the partners´ relationship of patients with anxiety disorders often occur the maladaptive stereotyped reactions – communication errors (Prasko 2005). They usually appear to be stereotyped by both partners, regardless of who suffers from an anxiety disorder. The problem situation can be repeated in slightly different variants over and over again. These errors can be a repetition of the parent's communication patterns, some of which have arisen in spouses with siblings, classmates, and friends in childhood, and some have been consolidated only in partnerships (Praško 2005). It is usually both distorted content of the message, and more often it is inappropriate form. There is a reciprocal degradation of the partners each other, and one is usually not aware of an own part in the maladaptive communication exchange. There are feelings of dissatisfaction and irritability developed, that may result in anxiety disorder or aggravation of its symptoms.

The most common communication errors include: thoughts reading, interrupting and jumping into speech, not responding to a message, non-verbal rejection, expressing feelings by a circle, dishonesty, ambiguity, and unclearness of communication, exaggeration, labelling, excessive generalization, attribution of intent, distortion of reality, incongruence, leakage from the subject and exaggerated emotional reactivity (Praško et al. 2007).

Stigma and self-stigma

The influence of relatives and another context, condemnation, humiliation, and victimization of the patient, personality of the partner, all this is reflected in the attitudes of the patient with anxiety disorder to himself. Although most patients with anxiety disorders develop only mild or moderate signs of anxiety disorder that can be adapted to life and work, it can have an adverse impact on relationships with a partner that understates the affected partner (Waring *et al.* 1986). The relation between the person and the environment is always multilayered, and this is even more complicated in people with anxiety disorder. Emotional vulnerability causes relationships to be both more limited and more labile. For example, panic attacks may change the relationship to a partner – the patient needs to be secured and protected by his partner, and so he is very much in favor of the partner. However, when such a person does not feel adequate protection, which happens easily because the partner does not realize what threatens the patient, the patient responds with reproaches or anger (Praško *et al.* 2011). Often a patient's partner gets into a more dominant role than formerly and it starts the sick. The partner who is dependent tend to be underestimated. Labels like "fool," "hysterics," "all over," "manipulator" etc. express some attitudes that point to the stigma of the sick partner. For some individuals, it is unacceptable that their partner has a psychiatric diagnosis because it "casts a shadow on them too." They often fight against it, discouraging the anxiety patient from visiting a psychiatrist, from medication and psychotherapy, urging him to". "This pressure is even stronger when encouraged by a partner's wider family. In such a case, there is a risk of

divorce or divorce that will interfere with the anxious patient. An inability to understand an anxiety disorder, marking it as madness or as an inability or weakness, sometimes leads to "exclusion" in the family, with an anxious person restraining communication, stopping to associate, partner devoting little time, staying longer at work, not communicate with his/her anxious partner. The situation is often exacerbated by the insufficient response to treatment or adverse drug reactions (particularly libido decline), as well as the development of associated disorders (depression).

Somatic symptomatology is better tolerated and increases sympathy "because it is necessary to protect," (Praško *et al.* 2011; Praško & Trojan 2001). The symptoms of anxiety in case of panic disorder are usually so dramatic that the partner simply believes that it is a serious physical illness. Both the patient and the partner are often disappointed by a psychiatric diagnosis at first. If a patient develops avoidance behavior, the partner is usually tolerant if it does not add much extra work. Avoidance is more often seen as "weakness," "lack of courage" and it is attributed to the personality of the affected individual. The patient then feels the same: "I am unable to fight" (Praško *et al.* 2011). Weakness, lack of courage and shyness are better tolerated in women than in men. Patients feel a problem similar to the others. Auto-stereotypes can hinder the treatment because these people believe, that it is their character and personality that they cannot change.

Frequently because the fear of stigma, a partner can discourage a patient from psychiatric treatment. He/she may be afraid that it will "be scandalous" for their family, and all will be stigmatized, including him/her and their children. Mothers in law can play a critical role here. "I have always told you, as you date with him/her, that it was abnormal." Partner tries to persuade the patient to "put together" or to "not show up to the family." Such behavior usually strengthens the symptoms of a disorder.

Self-stigma, a process in which the patient uses a degrading sticker for himself/herself and identifies himself/herself with it, can be an even more severe problem, deeply interfering with a partnership relationship. The individual with the anxiety feels guilty about a partner, feels inferior, sometimes submissively grateful for staying a partner with him /her, may tend to serve him /her or, on the other hand, he /she begins to rebuke a partner stigma attitudes that he did not even say or even have. At other times, the patient may start to excuse himself for his psychological problems and seeks for help from others who, according to him, have to adapt. Consequently, he /she starts to check and criticize the partner.

Divorce rate

Some studies also claim that the presence of psychiatric problems correlates with the frequency of divorce (Frank & Gertler 1991; Rees & Fahn 2011). However, the conclusions of the studies do not explain whether the psychiatric problems are the cause of the divorce, or whether it is the result of a psychiatric problem. Kessler *et al.* (1998) have found that many psychiatric diagnoses, including GAD, lead to an increased likelihood of divorce. Divorce was tolerated by individuals with anxiety disorder mostly very heavily because it reinforced their feelings of danger, inability, abandonment or loneliness. The poor quality of marriages of anxious people can also stem from partner selection strategies where the anxiety individual often has insufficient social skills and chooses an inappropriate partner (McLeod 1994). We should realize in some cases that it is necessary to treat the couple as a whole in order to for the help of identified patient (Yoon & Zinbarg 2007).

THE MOST FREQUENT MARITAL PROBLEMS IN PARTICULAR ANXIETY DISORDERS

Panic disorder

People with panic disorder are often dependent on their loved ones who are clinging by the patient´s fear. In heavier cases, one of the close persons must constantly be present to help the affected person (Praško & Herman 2007). Whether the fear of abandonment is preceded by a panic disorder or its consequence 's hard to determine. In childhood, however, we often find premature separation from parents who have been treated with anxiety or resignation. Patient partners often feel confined. Sometimes, however, it can comply them because it gives them a sense of dominance. On the other hand, many partners feel significant constraint, and therefore the conflicts occur. The conflicts lead to increasing number of panic attacks or may result in the development of secondary depression in the identified patient.

Generalized anxiety disorder (GAD)

GAD, one of the most common anxiety disorders, is a common disorder with the problems in the field of work, relationship, and marriage. Numerous studies have shown that the issue of relationships is one of the major issues that people with GAD suffer from (Jackel *et al.* 1989; Roemer *et al.* 1997; Breitholtz *et al.* 1999). Patients with generalized anxiety disorder often have interpersonal problems that are related to symptomatology. The development of GAD is significantly more frequent as a reaction to life events that are related to interpersonal relationships (Brown *et al.* 1997). Sometimes, however, it is hard to distinguish whether interpersonal problems were preceded by the development of a disorder, or that it only arose. Similarly to depression, these include problems of changing the role of life (birth of a child, maternity leave, change of employment, family member illness, and family retirement), loss of partners, conflicts in roles (disputes in a partnership). The results of the studies describe increased

marital distress in people with GAD. The McLeod (1994) study found that women suffering from GAD described greater marital problems and increased stress in married life than women without GAD. Men, on the other hand, do not mention these problems even when their wives suffer from GAD. Even women who live in a marriage with a man with GAD do not have similar problems. In a study by Whisman *et al.* (2000) concluded that among the nine diagnoses (including MDD, mania, dysthymia, social phobia, agoraphobia, panic anxiety disorder, GAD, and alcohol dependence), GAD is the strongest predictor of marital dissatisfaction, both in men and women.

Zaider *et al.* (2010) examined the impact of anxiety on the relationship in 33 pairs, where the woman had a generalized anxiety disorder. They found that there is a connection between the occurrence of GAD in females and the perception of the quality of the relationship between the two partners. They described the relationship between woman anxiety and husband's distress. Consistency was stronger in men who adapted to the anxiety symptoms of their wives, which was their major coping strategy to cope with their partner's anxious manifestations (Zaider *et al.* 2010).

GAD women describe less developed satisfaction than women who do not suffer from GAD (McLeod 1994). The GAD process often complicates associated comorbidities, most commonly with alcohol abuse and other addictive crutches, which has proven to be the main reason for dissatisfaction and marriage problems. Poor quality of marriage may also trigger the onset of GAD during life (McLeod 1994).

Agoraphobia

Patients who have agoraphobia have a fear of abandoning and at the same time fear of being attached to a second person (Nemiah1988; Manassis *et al.* 1994). Therefore they have an excessive need to control relationships. Because a high level of interpersonal control is unattainable, most of them developed the feeling of tension. Also, the disordered have difficulty with the identification and processing of the negative emotions (Guidano *et al.* 1987; Zeitlin & McNally 1993). The state of increased stress is attributed to external conditions and not treated as an internal conflict (Pollock & Andrews 1989). Typical defense mechanisms are suppression, transmission, avoidance, and symbolism. Agoraphobia may also help to keep people who are in close relation with patients – if the close persons assume certain responsibilities and assist patients not to face the dreaded situations – they strengthen the self-image of "incompetence" and allow patients to gain "secondary profits." Eg. the husband dares his wife to work because she cannot travel, instead of her, etc. On the one hand, this behavior is charming and human; it is obvious the effort to help a partner who is troubled. On the contrary, these benefits contribute to maintain anxiety disorder. Also, any such protectorate gesture reduces the self-confidence of the individual and strengthens his/her tendency to disaster: "I cannot handle it anymore ..." or "Neither husband does not believe I can do it."

A patient with agoraphobia may feel over-committed to his or her partner who "secures" him /her. This can lead to the fact that he/she cannot express his / her other needs openly, he /she must subdue and retreat even in situations where he is not nice (e.g., always responding positively to partner's sexual needs), which leads to deep dissatisfaction with the relationship. Very often a strong ambivalence occurs in the relationship (Pollock & Andrews 1989). The patient is dependent, therefore in a very subordinate, he also perceives a partner with considerable aversion. The situation is blind alley because of the need not to be alone. Agoraphobia can also lead to open partnership conflicts. Demanding a partner to accompany the patient, restricting the whole family in traveling (e.g. on vacation), avoiding cinemas, theaters, concerts or shopping, and demanding that someone else go shopping – all these facts can limit the whole family.

Social phobia

Most studies show that people with social phobia are less successful in interpersonal relationships than in partnerships (Beidel *et al.* 1985). About 25% of them have never experienced partnership (Rapee 2012). These people are limited by the level of their interpersonal anxiety and also have weak social skills. Less often they start talking, less talk and reveal less than others, other interactions perceive them as less satisfactory, unpleasant, and have little incentive to become partners (Spence & Donovan 1999). The social phobia partner notices most of the time, at the date of becoming acquainted, and classifies it as "shyness," sometimes in persistent avoidance behavior like "stubbornness" or "coldness." This "absurdity" or "stubbornness" is often the target of a variety of "cheering" or mocking or scolding, which further affirms that in the social situations "everyone sees it" fails. A partner often starts to "save" a social phobia by allowing him to avoid dreaded situations. The consequence is underestimation and sometimes disdain. He/she calls for him/her, goes after him/her to do business with the authorities, etc. However, that also greatly enhances his/her movement in the vicious circle of social anxiety.

People with social phobia have limited sources of social support in their neighborhood just because of their closeness and fewer relationships they can establish and sustain. This increases their vulnerability to additional stress and leads to deepening of psychopathology. Their ability to experience proximity in relationships is low, they less often open to others, they do not appear and are not assertive enough. At the same time, it seems corresponding to the people with social phobia describe less satisfaction about their partner and experience less intimacy (Wenzel 2002). Building

a relationship is very important to be able to experience intimacy and self-esteem. It is these two factors that people with social phobias cannot bring into the relationship. This results in their dissatisfaction with the relationship. They cannot experience such intimacy as other people. This causes limited access to support resources, leads to feelings of loneliness, destitution, and depression.

Specific phobia

A lot of people in the nonclinical population have some specific phobia. In some cases, a specific phobia can significantly affect life with a partner and a family, especially when phobia restricts leisure time, or a partner has to accompany the affected person, disrupts certain activities, or when phobia restricts the children care (Praško *et al.* 2007). Healthy partners can respond to the disability of the patient with overprotection and profit from the phobia themselves (the partner's dependence, less fear of infidelity), or on the opposite they can be very critical and offensive because they do not want to do activities they do not like.

It seems, however, that the phobia itself, when a woman suffers, it usually does not affect the quality of the marriage (McLeod 1994, Arrindel & Emmelkam 1986). However, that does not apply if a man has a phobia. In this case, it has an adverse impact on marriage from both partners (Arrindel & Emmelkam 1986). There must also be taken into account the gender stereotypes, to which not only the partner but also the wider family and society respond. Socially, fear is more acceptable to women than to men where gender requires courage. In families where a husband has a phobia, they perceive him as a more distressing factor in marital coexistence than when a woman has a phobia. At the same time, the phobia seems to be „better tolerated" if any of its forms suffer both in a couple. In particular, wives are more supportive and understand the expression of husband's phobia if they have such experience. They are therefore more empathetic (McLeod 1994).

CONCLUSION

The link between anxiety disorders and family relationships is bi-directional: psychological problems adversely affect patient relationships and attitudes of the partner towards the patient significantly affect his anxiety. It is often difficult to determine what the cause and what the consequence is, and how much anxiety symptoms overlap with partner problems.

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