Authors' Response

New Ways to Explore the Relationship-Emotion-Health Connection

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The commentaries by Rimé (this issue) and Scherer (this issue) underscore and extend many of the central themes discussed in our target article (Sbarra & Coan, this issue). Briefly, our paper reviewed nine prominent theories about why and how social relationships (and social resources) are connected to physical health. From this review, we extracted four broad *mechanistic processes*—embodied information processing, appraisal processes, contingent interaction, and transactional perspectives—that likely give rise to the ways in which affective experiences can drive health-relevant physiological responses (cf. DeSteno, Gross, & Kubzansky, 2013). Rimé's (this issue) commentary focuses on the social sharing of subjective emotional states as a mechanism of how transactional (interpersonal *and* cultural) affective processes might be connected to health. Scherer's (this issue) commentary focuses the comorbidity between mental disorder and somatic illnesses, and the ways in which impaired emotional competence may be a key process underlying this comorbidity.

Rimé (this issue) takes a decidedly transactional view of how emotions implicated in modulating health and well-being are regulated through the social sharing of internal emotional states. In his view, the necessarily subjective and private nature of our emotional states is stressful, and relief from that stress comes in part from making our internal states known to our social community through sharing. Sharing, in short, contributes to feelings of being known, which reduces stress and, therefore, promotes health.

In our paper, we describe the transactional perspective as one in which the individuality of social interactions gives way to the emergent properties of the relationship (see Ruiz, Hamann, Coyne & Compare, 2006). Similarly, Rimé (this issue) cites research demonstrating that when people share internal emotional experiences, the stress relief

they experience occurs in tandem with an increase in social cohesion—the degree to which the individuals in a dyad or group begin to bond and coordinate (cf. Parkinson, Fischer, & Manstead, 2005, Paez, Rimé, Basabe, Wlodarczyk, & Zumeta (2015)). This is an excellent example of a transactive process in which the whole can be greater than, or at least separate from, the simple sum of its parts. We note, however, that Rimé's (this issue) ideas about social sharing are not limited to the transactive domain; indeed, the social sharing of emotion pertains to many other parts of our model. We can easily envision how the social sharing of emotion can play a key role in basic appraisal processes, can change the way we perceive environmental demands, and of course can alter basic patterns of contingent interpersonal interactions. The observation comes with the additional benefit of highlighting how our four mechanisms can themselves be viewed as dynamic and interacting. On these fronts, we have much to learn, but the Rime (this issue) commentary provides an excellent example worthy of much more empirical exploration.

Scherer's (this issue) commentary, with its focus on emotional competence and the link between emotional competence and somatic illness, provides a second set of excellent ideas for exploring the themes outlined in our paper. Although it is clear that emotional disorders and emotion dysfunction must be understood in their own right, problems in generating and regulating emotions, as well as in using emotional information, create informative "knock out" paradigms for understanding the ways in which relationships shape, organize, and ultimately rely on healthy emotional responding to function well. To begin with a simple example, consider emotional competence within the dyadic framework of an actor-partner independence model (see Kenny, Kashy, & Cook, 2006). In this framework, each person's emotional competence may be associated with their own

physical health, and this is typically referred to as an actor effect. We can also examine *partner effects* in which one person's emotional competence is associated with their partner's physical health, independent of the partner's own emotional competence. How might this process operate? That is, what are the mechanisms linking one person's emotional competence to his or her partner's physical health?

The model outlined in our paper provides a reasonable approach for beginning to unravel the answers to these questions. First, we might look to the contingent interpersonal exchanges in these dyads. Is there more cumulative conflict when one person suffers from chronic emotional dysfunction or dysregulation? And might this conflict alter what we described in our target article as embodied information processing? When you live with and interact with someone with relatively low emotional competence, how does this change the extent to which environments (the home, the world) are perceived as stressful, threatening, or negative and, accordingly, whether and how you should deploy physiological resources to respond to these potential demands? To borrow an analogy from our paper, can a partners' emotional competence become part of the "ruler" people use to scale "units" for perceptional action (cf. Proffitt and Linkenauger, 2013)? We can envision even basic perceptual affordances being partly shaped by a relational partner's emotional competence.

Undoubtedly, there many ways to analyze the primary themes raised by Rimé (this issue) and Scherer (this issue) in their stimulating commentaries. We thank both authors for the thoughtful consideration of our paper. As a set, the commentaries raise new questions about how emotions and health operate together. Central to our response—and, for that matter, to our target article as a whole—is that relationships provide a vital context

for the types of emotional responding outlined in the commentaries, whether it is the social sharing of emotion (an inherently interpersonal process) or the link between emotional competence and physical health (which can unfold both within and between people).

The utility of the ideas outlined in our target article rests not how we viewed the prior literature, but the extent to which our conceptual organization of this prior work can help frame new research. Both Rimé (this issue) and Scherer (this issue) raised two topics we did not consider with any detail in our paper, and we appreciate the opportunities to view these problems through the lens of our paper. Ultimately, only time will tell if this model has broad implications, but we remain hopeful that many different ideas about relationships, affect, and health can be informed by the framework outlined in our paper.

References

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