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Andria Saptyasari

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Framing the Interpersonal Communication of Chronic Kidney Disease Patients Underwent Hemodialysis with Their Partners on Sexual Dysfunction

Andria Saptyasari

Abstrak/Abstract

This study elaborates on how patients with chronic kidney disease and their partners provide stimulation and response to sexual dysfunction problems using the relationship framing theory. Previous research has shown that 20-30% of patients with stage 3-5 chronic kidney disease undergoing hemodialysis experience sexual dysfunction. This study assumes that sexual dysfunction can lead to decreased sexual desire, commitment, and proximity between patients and their partners which impact their interpersonal communication. This study is interpretive qualitative research which applied an in-depth interview method. Relationship framing theory was used to explore the content dimensions related to the topics of passion, commitment, and proximity to describe the relationship dimensions, which are related to dominance-submissiveness and affiliation-disaffiliation of the participants’ utterances. The results show that the content dimensions consisting of passion, closeness, and commitment between chronic kidney disease patients and their partners could frame the relationship between them by looking at the stimulus and respective responses related to these three things. The stimuli and responses between these couples differ because there are four factors that influence it, namely (1) the context of the problem that is framed; (2) relational context; (3) sincerity of the participants in accepting the conditions; (4) partner’s sensitivity regarding empathy; and (5) values, religion and spiritual which both patients and their partners have.

Introduction

The kidneys are the organs in the body that are responsible for getting rid of extra fluid and impurities in the blood. When the kidneys lose the ability to filter and clean the blood, the fluids and waste in the body can poison the body. This is called as chronic kidney disease (Aisara et al., 2018). Patients with chronic kidney disease usually require hemodialysis. Hemodialysis comes from the words “hemo” which means blood and “dialysis” which means separation or filtering. Clinically, hemodialysis is defined as the washing or cleaning of material in the blood which is filtered through a semipermeable membrane.
(Gutch et al., 2005). Usually, the GFR (glomerular filtration rate) test is used to measure the filtering of waste in the blood by the kidneys based on creatinine levels in the blood, age, body size, and gender. Based on the GFR examination, stages of kidney failure can be divided into stage 1 (GFR value above 90); stage 2 (GFR value 60-89); stage 3 (GFR value 30-59); stage 4 (GFR value 15-29) and stage 5 (GFR value below 15). Stage 3-5 is called chronic kidney disease which usually requires hemodialysis (Sulistiowati, 2011). This study focused on pairs of participants; one of whom had stage 3-5 chronic kidney disease which required him/her to undergo hemodialysis.

In Indonesia, the number of chronic kidney disease patients continues to increase. In 2011, the number of chronic kidney disease patients was 15,353 and those undergoing hemodialysis were 6,951 people; while, in 2012 there were 19,621 people and 9,161 people who underwent hemodialysis (Tokala et al., 2015). In 2015, the number of chronic kidney disease patients reached 21,050 people, while in 2016, 2017, 2018 the numbers increased to 25,446, 52,000 and 77,000 people respectively (Tokala et al., 2015). Patients with stages 3-5 chronic kidney disease are required to undergo regular dialysis. Dialysis is usually performed 1-3 times a week depending on the severity of the patient’s illness. This dialysis results in substantial changes in the patient’s normal life, such as emotional changes (easily agitated and angry), changes in self-view (feeling helpless and hopeless), and changes in sexual dysfunction (decreased sexual desire) (Gerasimoula et al., 2015).

Decreased libido and sexual function due to diabetes and hypertension are felt by both male and female chronic kidney patients undergoing hemodialysis. The sexual dysfunction they feel sometimes causes them to be depressed. This statement is supported by previous studies which showed that 20-30% of patients with stage 3-5 renal failure who underwent hemodialysis felt depressed because of sexual dysfunction, a quarter of them suffered from major depression, and a fifth experienced minor depression (Edey, 2017).

Other studies showed that decreased sexual desire and sexual interest caused by health problems such as hysterectomy, menopause, andropause, hypertension, and chronic kidney failure caused depression in patients (Sawitri & Muhdi, 2019; Bachtiar & Hidayah, 2015). In patients with chronic kidney failure, both men and women, it was found that decreased libido was caused by feeling tired, weak, and less enthusiastic so that patients tended to avoid their partners (Haryani & Mismarti, 2016; Inayati, 2016). Decreased arousal and avoidance of patients from their partners have an impact on their interpersonal communication in terms of commitment and closeness as husband and wife.

In terms of interpersonal communication between husband and wife, passion is one of the basic elements of libido in a husband-and-wife relationship. Wood (2016) stated that there are three basic elements in romantic relationships, namely passion, commitment, and proximity. This study assumed that sexual dysfunction could lead to decreased sexual desire, commitment, and proximity between patients and their partners. Relationship framing theory was used to explore the patients’ stimuli and their partners’ response related to the content dimensions in terms of three topics, namely passion, commitment, and proximity. Then, in order to describe the relationship dimensions related to dominance-submissiveness and affiliation-disaffiliation, the participants’ utterances were analysed.

**Literature Review**

Guerrero and Afifi (2018) and Edey (2017) stated that every husband-and-wife relationship has three basic elements, namely passion, commitment, and proximity where the three are interrelated. From the statement of Edey (2017), Guerrero and Afifi (2018), this study assumes that decreased passion has a domino effect on decreased commitment and closeness between the two. High commitment creates a high level of closeness as well, which is usually marked by a high sense of empathy, understanding, and affection for the partner. On the other hand, if passion decreases, what will happen is a feeling of inadequacy and indifference to their partner who has chronic kidney disease. Such conditions will create a gap and commitment loss between them. The ideal husband and wife relationship should have these three elements, namely passion, commitment, and balanced closeness, so the relationship and communication run harmoniously (Wood, 2016).

Romantic relationships such as husband and wife relationships are described as I-thou bonds in which the individuals involved know each other well as unique individuals (Wood, 2016). This romantic relationship must be supported by the three important elements aforementioned. First is passion, which is a positive emotional, spiritual, intellectual, sexual, or sensual power possessed by an individual in a romantic relationship. Second is commitment which is a decision to stay in a relationship. If the investment is positive, the commitment will continue. Conversely, if the investment is negative, the commitment ends. Third is closeness which is a feeling to voluntarily give affection, warmth, comfort, and togetherness (Wood, 2016). The decline of one of the elements including passion will cause the quality of their relationship and communication to decline. The above is consistent to DeVito’s statement that passion, closeness, and commitment can describe the quality of the relationship and communication between husband and wife (DeVito, 2016).

As explained above, this study framed the quality of husband-wife relationships based on the three elements namely passion, commitment, and closeness through the relationship framing theory. Hayes, Holmes, and Roche (2002) stated that this
theory is a post-Skinnerian development which observes one’s verbal operant as a stimulus to reinforce the responses of others. This statement implied that the relationship framing theory was applied to see a person’s response to other people’s stimuli (Hayes et al., 2002). Hayes, Blackledge, and Holmes (2002) asserted that the relationship framing theory seeks the cognitive relationship as a place for coding and decoding of messages and verbal language as a stimulus. In more detail, Holmes et al. (2002) explained that the relationship framing theory also considers contextual and historical relationships to explain the similarities, differences, and comparisons of responses between two individuals who engage in communication. The way they provide stimulation and respond to other people’s messages shows understanding, caring, and the depth of the relationship between them.

McLaren in developing the relationship framing theory stated that this theory was used to describe how a person provides a stimulus (meta-perspective) and responds (direct perspective) to messages conveyed by other parties (McLaren et al., 2014). A direct perspective occurs when someone interprets another’s behavior. A meta-perspective occurs when someone tries to infer another’s perceptions by using his experiences. Furthermore, McLaren said that an explicit message in the content dimension can show the relationship dimensions between two communicating people, whether it is dominant-submissive or affiliated-disaffiliated. The dominant-submissive relationship dimension refers to how one person controls or influences others. Meanwhile, the dimension of affiliation-disaffiliation refers to how a person accepts, respects, likes other people (Solomon & McLaren, 2008; McLaren et al., 2014; Hall, 2016).

Dominance is a condition for someone who has full power to decide something and others to accept what has been decided. Meanwhile, submissiveness is a condition of a person who leaves his position to obey all words of the dominant (Tiedens & Fra-gale, 2003; Jozifkova & Kolackova, 2017). Knight, Wilson and Nice’s explanation of disaffiliation is a behavior that is more in a negative direction, such as complaining, criticizing, and expressing their disagreement and dislike for others. Conversely, affiliation is a more positive behavior, such as giving support, praise, sympathy, and empathy to others (Knight, Wilson and Nice, 2018).

DeVito explained that interpersonal communication has two dimensions, namely content and relationships dimensions (DeVito, 2016). The content dimension in interpersonal interactions can describe the dimensions of the relationship that exists between them. In other words, the content dimensions in three topics in romantic relationships, namely passion, commitment, and closeness (Wood, 2016; DeVito, 2016) can show the relationships dimensions consisting of dominant-submissive and affiliation-disaffiliation (Rogers, 2006; Solomon & McLaren, 2008). This study wanted to combine the two dimensions (content dimension and relationship dimension) to describe the framing of the relationship between stage 3-5 chronic kidney disease patients undergoing hemodialysis and their partners. For this purpose, I formulated it into the matrix column of content dimensions vs relationship dimensions (see table 1 in the method section).

The exploration of content dimensions related to three topics in romantic relationships was expected to frame the way they communicated including how to provide stimuli (meta-perspective) and respond (direct perspective) to their partners regarding sexual dysfunction problems due to chronic kidney disease. The relationship framing theory was expected to describe the dimensions of their relationship; especially according to Wilson et al. (2002), this theory can also explain relationships between individuals in health contexts such as psychopathology and psychotherapy.

### Research Methodology

This research is an interpretive qualitative research. Participants in this study were drawn from the snowball technique and they have given written consent, as referred to in the agreement page, to be interviewed. The data collection tech-

<table>
<thead>
<tr>
<th>Participating Pairs</th>
<th>Patient with chronic kidney</th>
<th>Spouse</th>
<th>Duration of hemodialysis</th>
<th>Duration of marriage</th>
</tr>
</thead>
<tbody>
<tr>
<td>First (P1)</td>
<td>Mr. W (51 years old)</td>
<td>Mrs. W (46 years old)</td>
<td>2 years</td>
<td>25 years</td>
</tr>
<tr>
<td>Second (P2)</td>
<td>Mr. H (39 years old)</td>
<td>Mrs. H (36 years old)</td>
<td>1 year</td>
<td>15 years</td>
</tr>
<tr>
<td>Third (P3)</td>
<td>Mrs. E (45 years old)</td>
<td>Mr. E (48 years old)</td>
<td>2 years</td>
<td>22 years</td>
</tr>
<tr>
<td>Fourth (P4)</td>
<td>Mr. S (57 years old)</td>
<td>Mrs. S (51 years old)</td>
<td>3 years</td>
<td>30 years</td>
</tr>
<tr>
<td>Fifth (P5)</td>
<td>Mr. A (35 years old)</td>
<td>Mrs. A (33 years old)</td>
<td>1 year</td>
<td>12 years</td>
</tr>
<tr>
<td>Sixth (P6)</td>
<td>Mr. M (40 years old)</td>
<td>Mrs. M (39 years old)</td>
<td>2 years</td>
<td>17 years</td>
</tr>
<tr>
<td>Seventh (P7)</td>
<td>Mrs. P (42 years old)</td>
<td>Mr. P (45 years old)</td>
<td>1 year</td>
<td>20 years</td>
</tr>
<tr>
<td>Eighth (P8)</td>
<td>Mr. B (60 years old)</td>
<td>Mrs. B (58 years old)</td>
<td>2 years</td>
<td>35 years</td>
</tr>
<tr>
<td>Ninth (P9)</td>
<td>Mr. N (52 years old)</td>
<td>Mrs. N (49 years old)</td>
<td>1 year</td>
<td>29 years</td>
</tr>
<tr>
<td>Tenth (P10)</td>
<td>Mr. G (47 years old)</td>
<td>Mrs. G (42 years old)</td>
<td>1 year</td>
<td>21 years</td>
</tr>
</tbody>
</table>

Source: Analysis of the Study

24
nique used separate in-depth interviews between husband and wife for ten married couples, who consisted of eight male patients undergoing hemodialysis due to chronic kidney disease and their partners, and two female patients undergoing hemodialysis due to chronic kidney disease and their partners. The ten married couples are as follows:

The data obtained were processed and analyzed in several stages: (1) participants’ verbal data were transcribed; (2) the narrative transcript of the interview was coded in relation to meta-perspectives and direct perspectives of husband and wife related to three topics, namely passion, commitment, and closeness; (3) this coding would be reread to see if there were any elements of dominant-submissive and affiliation-disaffiliation in their relationship; (4) after the coding of the relationship dimension in stage 3 was complete, I would enter it into the content dimension vs. relationship dimension matrix as shown in table 2 by giving notes and comments on interesting things, such as similarities, differences, comparisons and contradictions on what the participants said related to the topic of arousal, commitment, and closeness when sexual dysfunction arose due to chronic kidney disease. (5) I did the same thing in stages 1-4 to the ten pairs of participants; (6) at this stage, I would look at the pattern of the findings in the ten pairs of participants and later analyzed the overall pattern theoretically based on the relationships framing theory.

Results

Proximity

The patient’s stimulus when he was first prescribed hemodialysis was rejecting reality, fear of death, and feeling helpless, to which his partner responded by providing warmth, comfort, and togetherness. This can be seen as follows.

1. Patients refused the hemodialysis therapy

Two out of ten participants (patients P6, P9) refused a doctor’s recommendation for hemodialysis as stated below.

“I reject this reality when the doctor said I had to undergo hemodialysis because my body was swollen and I couldn’t urinate [...] there was a feeling of fear” (patient P6/Mr. M)

“I looked for a second opinion from another doctor, maybe there was an alternative treatment aside from dialysis.” (patient P9/Mr. N)

The stimulus of the two participating patients which tended to be negative because they could not accept the doctor’s verdict for hemodialysis did not mean that their partner also responded negatively. Their partners actually tried to encourage themselves and the patients as spouses to accept reality and find solutions, as found below.

“Young condition is not as bad as what the doctor said, you must be optimistic that you can recover. Only God has power over our life and death.” (partner P6/Mrs. M)

“We are trying together to find other alternatives [...] before deciding to dialysis.” (partner P9/Mrs. N)

2. Patients were afraid to die

Three out of ten participating patients (patients P7, P4, P8) said the doctor’s decision for hemodialysis made them think that their disease was so
severe that there was fear of death as referred to in the statement below.

“Dialysis is a terrible word; I am afraid to die while having my hemodialysis. Many of my friends died during dialysis.” (patient P7/Mrs. P)

“I am very shocked by the verdict that I have to take dialysis. In my mind dialysis means I have no hope of life.” (patient P4/Mr. S)

“The doctor’s statement put me down, because I have a friend who also underwent one dialysis and he died.” (patient P8/Mr. B)

The stimulus of the three participating patients, in which they were afraid of the low life expectancy based on their friends’ experiences, was not responded negatively by their partners. Their partners were actually very supportive emotionally to patients, as the following statement shows.

“If Allah wants you to be healed, you will definitely be healed. Don’t look at your friend’s condition, because someone’s immune system is different.” (pair P8/Mrs. B). The same thing was also stated by pair P4/Mrs. S and partner P7/Mr. P to their partners, where they really hoped the patient had the motivation to live longer.

3. Patients felt no longer useful/helpless in life

Two of the participating patients felt that they were no longer useful for their spouses and children. This is reflected in their narrative below.

“I feel tired, I don’t want to do dialysis anymore, [...] it’s useless to live like this.” (patient P4/Mr. S)

“There is a feeling of being neglected at the office because I often ask for permission to go home early due to fatigue, weakness. But I have to work to pay for my children’s school fees.” (patient P5/Mr. A)

The stimulus of these two participating patients which tended to be negative is more because they were the backbone of the family, and their wives were housewives who did not work. However, their partners’ response was caring for the patients’ recovery. It can be seen as following.

“The most important thing is my husband’s health, and I will save for my children’s tuition and our daily needs.” (partner P5/Mrs. A)

Description for the data about proximity between patients and their partners above may be found in table 3.

Passion

The patient’s stimulation related to his inability to fulfill sexual desire for his partner was divided into three, namely feeling sad because he cannot have his sexual activity like before, accepting his condition, and fulfilling his sexual desire because of nature. The response to this stimulus varies depending on the sex of the partners as found below.

1. Patients felt sad/sorry for his/her partner because their situation was not what it used to be

Four of ten participating patients (P1, P10, P6, P7) felt sad and sorry for their partners because they could not have sexual intercourse as before, which can be observed from their narrative as follows.

“I feel it is useless, it is of no use, both in matters of relations with my wife and in my life as a man.” (patient P1/Mr. W)

“I am sad because I cannot provide physical and mental support to my wife.” (patient P10/Mr. G)

“Sometimes I feel sorry for my wife, I try to do it but I can’t get an erection.” (patient P6/Mr. M)

“I often apologize to my husband because I can’t be like before [...] can no longer satisfy my husband’s desire.” (patient P7/Mrs. P)

The stimuli of patients P1, P10, and P6 were utter dismay because they could not get an erection. Thus, as men they were unable to fulfill their wives’ sexual need. In contrast to patients P1, P10, and P6, their partners (wives) emphasized that the most important thing was not the sexual need fulfillment but the health of patients P1, P10, and P6. This can be seen from the P6’s partner who said, “I am already extremely grateful to see my husband healthy, although I don’t get a sexual need fulfillment, it doesn’t matter.” The partner of P1 (Mrs. W) also stated, “For women, it does not matter not getting the sexual need fulfillment, because women are more capable to hold back this desire than men.” Meanwhile, patient P7/Mrs. P felt guilty because she could no longer satisfy her husband’s desires. P7’s partner/Mr. P responded by not asking her to serve too often. He only occasionally asked his wife considering her condition. The partners’ response was different based on the partners’ sex. Female partners did not make the fulfillment of sexual needs as the main focus. For them the patient’s health was much more important. Meanwhile, for the male partner, he still considered the fulfillment of sexual needs as something which needed to be fulfilled. However, he still considered the patient’s health.

2. Patient could accept his sexual condition

The stimulus of patient P2/Mr. H and his partner’s response was the same, i.e. they accepted the P2/Mr. H’s condition. This can be seen from their statement below.

“When my health condition is good, I still often do it like a normal person. For me this is a necessity, so I still do it, even many times. But, I still look at my health condition first.” (patient P2/Mr. H)
“Still having sexual intercourse but look at his health condition. I can accept this situation.” (partner P2/Mrs. H)

“Sometimes I motivate him by telling the experience of a friend who has had hemodialysis for three years but was still able to impregnate his wife. Now his child is 1 year old […] Yes, this is only for motivating my husband.” (Partner P2/Mrs. H).

Their utterances showed that the patient and his partner accepted the patient's condition, where the patient was no longer able to fulfill sexual needs as before. However, the patient was still trying to fulfill this sexual need both for himself and his partner, especially the partner also gave motivation by saying that people who underwent dialysis could still impregnate their partner.

3. Patient fulfilled sexual desire as a nature

The stimulus of patient (P3/Mrs. E) is a feeling of responsibility for her husband’s sexual fulfillment and the partner’s response (P3/ Mr. E) was consistent to the patient’s stimuli that the husband’s sexual needs had to be fulfilled. However, the patient’s condition shall be considered. It can be seen below.

“Yes […] I still fulfill my obligations towards my husband by serving my husband’s sexual desires because this is my duty as a wife. But it depends on my condition too.” (patient P3/ Mrs. E)

Statement of patient P3/Mrs. E above shows that she still adhered to the concept of a traditional wife who still serves the husband’s biological needs, even though it depended on her health condition. This emphasizes that patient P3/Mrs. E fully respected her husband. This is also supported by her partner’s (P3/ Mr. E) response as follows.

“Alhamdulillah, we can still have sexual intercourse but the intensity is much less. We reduce the frequency […] of course this can’t be like before. We will consider the patient’s condition first before doing it […] I also understand it […] We limit the frequency. It can’t be if there is no at all. But Alhamdulillah we can still do it. The key is to accept this condition sincerely.” (partner P3/ Mr. E)

Description of data about passion between patients and their partners above can be found in table 3.

Commitment

Two of ten patients wanted to break their relationship with their partners because of their pain and guilt of not being able to provide sexual satisfaction for their partners. Meanwhile, the other eight patients never said they wanted to separate from their partners. There is even one partner who actually said that she was very afraid of losing her spouse (the patient). This can be found below.

Patients wanted to break their relationships with their partners

The stimulus of two of ten patients who wanted to break their relationship with their partners can be seen as follow.

“I always apologize to my wife because I can’t provide financial and emotional support nor fulfill my wife’s sexual needs […] I implore and allow my wife to divorce me […] I feel like a useless man […] I am sincere if my wife will marry someone else.” (patient P6/Mr. M)

“I said to my husband that sorry, I can’t serve you; I am in so much pain. If you wish, I allow you to marry a woman who can satisfy your sexual desire because I am no longer able to satisfy you.” (patient P7/Mrs. P)

Those stimuli were responded by their partners by ignoring the patients’ words. Their partners still continued and maintained their relationship. This is reflected below.

“I ignore my wife’s request to find another woman who can satisfy me. Because I still love my wife […] but I sometimes get annoyed with my wife’s strange requests.” (partner, P7/Mr. P)

“I do not take importance to my biological needs, so why should I look for other men […] I am more focused on healing my husband rather than busy looking for other men.” (partner, P6/Mrs. M)

Patients wanted to continue the relationship with their partners

Eight out of ten patients still wanted to continue their relationship with their partner. Here, both patients and their partners tried to maintain their feelings for each other. They knew each other well. Patients did not demand to fulfill their biological desires if their partners were tired and their partners also did not demand fulfillment of their sexual needs if the patient’s condition was not possible. It can be seen from their narrative as follows.

“Nothing is different from our relationship […] only when I start thinking about having sex with my wife while I know I can’t do it well, I tend to turn my attention to other things like feeding my cattle.” (Patient P9/Mr. N)

“We behave as usual […] still pay attention to each other even though there is a sexual decline problem in one of us.” (Partner P9/Mrs. N)

“My wife and I maintain our marriage life as usual. It’s just that now we understand more about the partner’s condition. If I see my wife is tired from taking care of me, I will not show my anxiety from the problem of my decreased sex desire.” (Patient P10/Mr. G)
“I emphasized to my husband that whether we are happy or unhappy, we live together. Don’t you have the feeling our relationship will end just because of sexual problems.” (Partner P10/Mrs. G)

Their utterances show that the stimulus of patients and their partners’ response reflect the same feeling about their relationships, even though there is a sexual problem in the patients. Description of data about commitment between patients and their partners above can be seen in table 3.

Discussion
The results show that the stimulus of patients tends to be negative. Haryani, Misnarti (2016), and Inayati (2016) explained that chronic kidney disease patients suffer from depression and stress when facing a decrease in libido due to hemodialysis therapy. Depression and stress cause the patients to have a negative stimulus to their personal life and relationships with their partners.

However, from the description of the pairs of participants’ utterances regarding their stimuli and responses to the three topics of content dimensions namely passion, proximity, and commitment, it shows that their interpersonal relationship dimension is classified as affiliation (see table 3).

This affiliation can be seen even though the patients provide a negative stimulus such as fear, weak, hopeless, and asking for divorce, the partners always provide a supportive and motivating response. However, the affiliation given by the partners can take different forms based on the following.

First is the context of the problem being framed. When the context of the problem framed is about the patient’s health problem, it will create the partner’s sympathy and empathy towards the patient’s condition. This partner’s intense sympathy and empathy for the patient will propel the situation into affiliation. This will be different if what is framed is a negative problem such as the context of an affair or polygamy. Of course, the stimulus and response will also be different.

Second is relational context. When the relational context discussed is marital relations, the relationship tends to be more affiliated than friendship. This is more because the marital relationship has a high commitment and is especially built in a long process than friendship.

Third is the participants’ sincerity in accepting the conditions. The patient’s stimulus in which s/he sincerely accepts her/his condition will be responded positively by her/his partner by providing support and understanding for the patient. Therefore, there are positive stimuli and responses between the two. This really supports the healing process for the patient, as observed from the pair of participant 2 who is more likely to be affiliated. This finding confirms the statement of Wilson et al., (2002) that by looking at the dimensions of the relationship under the relationship framing theory, it is possible to describe psychotherapy in the family which can encourage the patient’s enthusiasm for life.

Fourth is the sensitivity of the response which is related to the empathy that the partner has. It was found that the partner gave high empathy when the patient was afraid of death, felt useless and imperfect because he could not meet the sexual needs of his partner. Negative stimulus when it is responded positively by a partner with high empathy will lead to affiliation. This is contrary to the statement of Hayes et al., (2002) that positive stimuli will be responded to positively by the recipient and confirm the relationship between them in a better and positive direction as well.

Table 3 Stimulus response related to proximity, passion and commitment between patients and their partners

<table>
<thead>
<tr>
<th>Content Dimension:</th>
<th>Stimulus/meta-perspective (patient)</th>
<th>Response/direct perspective (partner)</th>
<th>Relationship Dimension</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Proximity:</strong></td>
<td>Unwilling and rejection</td>
<td>Encourage to remain optimistic in life</td>
<td>Affiliate:</td>
</tr>
<tr>
<td>Expressing feelings about the severity of the disease</td>
<td>Feel hopeless in life</td>
<td></td>
<td>Provide encouragement and support</td>
</tr>
<tr>
<td></td>
<td>Fear of death</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Passion:</strong></td>
<td>Feel useless</td>
<td>Accept reality and remain optimistic</td>
<td>Affiliate:</td>
</tr>
<tr>
<td>Expressing fulfillment of sexual needs</td>
<td>Accept the decrease of sexual desire</td>
<td></td>
<td>Provide empathy, motivation and support</td>
</tr>
<tr>
<td></td>
<td>Accept it as nature and an obligation</td>
<td>Pay attention to the patient’s health</td>
<td>Reduce the frequency of sexual needs fulfill-ment</td>
</tr>
<tr>
<td><strong>Commitment:</strong></td>
<td>Ask for divorce</td>
<td>Ignore patients’ request for divorce</td>
<td>Affiliate:</td>
</tr>
<tr>
<td>Prefer to break or maintain the relationship</td>
<td>Pay attention to each other</td>
<td>Pay attention to each other</td>
<td>Provide love support</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Provide understanding feeling</td>
</tr>
</tbody>
</table>

Source: Analysis of the study
Fifth is values, religion, and spirituality. Values, religion, and spirituality that a person has will influence the stimulus and the response of others which leads to affiliation. It was observed that the patient had strong religious and spiritual values to respect her husband while still serving her husband’s biological needs as her nature. Her husband also responded to this by asking her to make sure that his biological needs were fulfilled, even though he still considered the patient’s condition at that time. There are other patients and their partners who are grateful for their condition and make their relationship led to an affiliation.

Sixth, Wood (2016) stated that there are three basic elements in the interpersonal romantic relationship namely passion, commitment, and proximity, but the results show that the decrease of passion or libido does not mean the commitment and proximity also decrease. It depends on their values, religion, spirituality and the context of the problem being framed.

Seventh, dominance is a condition for someone who has full power to decide something and others to accept what has been decided. Meanwhile, submissiveness is the condition of a person who leaves his position on the side that obeys all words of the dominant (Tiedens & Fragale, 2003; Jozifkova & Kocolakkova, 2017). Dominant and submissive do not exist in this study, because all participants have 12-30 years of mature marriage that means they know each other very well. Thus, in terms of the patients’ health problems, the partners will give attention, caring, empathy, and other positive support to encourage the healing process of the patients by using symmetrical and complementary relationships.

Conclusion
From the description above, it can be concluded that in the context of health problems in a marital relationship, the three topics of content dimension namely passion, proximity, and commitment between chronic kidney disease patients and their partners can frame the dimensions of the relationship between them by looking at the stimuli and responses respectively related to those three topics. The results show that the stimuli and responses between these partners in the context of health problems in a marital relationship are different because there are four factors which influence it, namely (1) the context of the problem which is framed; (2) relational context; (3) sincerity of the participants in accepting the conditions; (4) partner’s sensitivity regarding empathy; and (5) values, religion and spiritual which both patients and their partners have framed.

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