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Life as a couple: A comprehensive system

A couple is not a static entity. Indeed, one need look no further than divorce rates to see that couples are made and broken, they are born and die. But even when they do stay the course, couples evolve and redefine themselves constantly. They form, grow and are remodelled in line with our changing morals and values, social upheavals and societal shifts, big and small. As a result, marriage and divorce, as expressed in rates and percentages, are no longer the only parameters, or even the best parameters, to gauge the evolution and functioning of couples.

This issue of *Integrating Science and Practice* is dedicated entirely to couples' research. As you read through it, you will see to what extent couple-based therapy is not just meeting with two individuals. It means coming face-to-face with a comprehensive system, where the fears and concerns of each partner may manifest themselves and become no longer personal problems experienced jointly, but systemic problems. In her article, Catherine Bégin discusses that reality when the concerns arise from physical appearance, and the resulting effects on the couple's functioning. For her part, Natacha Godbout shows to what extent each partner's history, imprinted at times with a variety of traumas, becomes a shared history, whether partners want it or not. To this is added other issues, such as conjugal violence, which Yvan Lussier points out is ever present today despite our societal advancements and values, widely discussed at present. As Anik Ferron asserts, infidelity has long rocked many couples, although it too has been transformed because of new technologies and all that is now possible with the Internet and other media such as texting. The result is that life as a couple is a different experience today, for heterosexual couples and same-sex couples alike, as discussed by Marie-France Lafontaine, and it is changing constantly and rapidly, creating a challenge for us all just to keep up.

With changes occurring as rapidly as they are, *Integrating Science and Practice* is all the more relevant. Long considered an intervention for people with only mild and fleeting concerns—the “worried well”—or an intervention of last resort (see, for example, Johnson and Lebow, 2000; Snyder, Castellani and Whisman, 2006), couple's therapy is now part of psychologists' therapeutic arsenal, so much so that is now recommended, as supported by conclusive evidence, for the treatment of major depression (NICE, 2009a), depression in adults with a chronic physical health problem (NICE, 2009b), substance abuse (NICE, 2007), and a host of other mental disorders (NICE, 2011). It is also recommended for guiding couples at odds with infertility problems (NICE, 2013), a topic discussed by Katherine Péloquin in this special issue. Couple therapy has thus been, for some time now, the subject of numerous scientific studies examining its efficacy and the processes that may explain its successes and its failures. Whereas a negligible number of articles is indexed by PsycINFO (with the key words “couple therapy”) for the 1960s and even the 1970s, there are nearly 2000 articles listed for the decade 2000-2010. With such an abundance of articles, it is difficult to keep abreast of scientific advancements without turning to knowledge syntheses, such as systematic reviews (Cochrane Library has half a dozen that refer to couple therapy), clinical guides such as those published by NICE and other independent organizations, or, of course... laying your hands on *Integrating Science and Practice*.

Long considered an intervention for people with only mild and fleeting concerns—the “worried well”—or an intervention of last resort, couple’s therapy is now part of psychologists’ therapeutic arsenal, so much so that is now recommended, as supported by conclusive evidence, for the treatment of numerous different conditions.

It is my hope that these few pages will enable the nearly 2000 psychologists who meet with couples in their practices to compare their clinical knowledge against the current state of research. As for other psychologists who do not offer couple-based services, myself included, I have no doubt that this special issue will help us see just how complex certain practices can be and, perhaps as well, just how much many of our colleagues deserve our admiration.




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Physical appearance and spousal relationships



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Research has shown that concerns over body image are associated with a variety of physical and psychological problems. In this paper, the authors examine the links that can exist between those concerns in men and women and the quality of conjugal life. Clinical recommendations for couple's therapy are also provided.

Keywords: physical appearance, couple, romantic relationship, spousal relationship, sexuality

Physical appearance is one of the most important attributes that a person has to charm a partner and start up a romantic relationship. It is even a significant criterion for evaluating a potential partner in both sexes, although more highly valued by men (Braun & Bryan, 2006; McNulty, Neff, & Karney, 2008; Shackelford, Schmitt, & Buss, 2005). In today's social context, weight concerns have become virtually the norm, with the promotion of health and thinness limiting the diversity of body shapes that are perceived as acceptable. Over the past 40 years, women have become increasingly dissatisfied with their physical appearance (Abell & Richards, 1996; Parks & Read, 1997; Swami et al., 2010), a phenomenon that is now observed in men as well (Hoyt & Kogan, 2001).

How widespread is body dissatisfaction?

62% of women in Quebec think they should be thinner or lose weight

34% of men in Quebec think they should be thinner or lose weight

50% of healthy-weight women and 22% of underweight women want to lose weight

20% of young men 15 to 24 years old want to gain weight (muscle mass)

(Ipsos Reid, 2008; Ledoux & Rivard, 2000)

In both men and women, concerns over body image are associated with physical and psychological problems such as less frequent healthy behaviours (e.g., less physical activity), low self-esteem, feelings of shame and guilt, greater risk of depression, and the adoption of dysfunctional eating behaviours (Grabe, Ward, & Hyde, 2008; Johnson & Wardle, 2005; Provencher et al. 2007). Thus, individuals who are dissatisfied with their bodies seem less inclined to act in positive ways generally and to take appropriate care of their bodies and health, which can also have significant consequences on their interpersonal relationships, particularly by interfering with their ability to develop satisfactory intimate relationships (Bohn et al., 2008; Tantleff-Dunn & Gokee, 2002).

Body dissatisfaction and conjugal life

As regards romantic relationships, empirical evidence shows that the more individuals are dissatisfied with their bodies, the more

they are at risk of being dissatisfied in their spousal relationship and vice versa (Friedman, Dixon, Brownell, Whisman, & Wilfley, 1999; Hoyt & Kogan, 2001; Weller & Dziegielewski, 2004). Body dissatisfaction is associated with greater relational anxiety, greater fear of intimacy in spousal relationships and a more preoccupied attachment style in both sexes (Cash, Thériault, & Annis, 2004). Women who are dissatisfied with their physical appearance, because they feel less attractive, would also seem to adopt fewer emotionally risky behaviours, such as self-disclosure, which may result in establishing less intimate and less satisfying relationships (Meltzer & McNulty, 2010; Murray, Holmes, & Collins, 2006). From that perspective, sexuality seems to be particularly impacted in persons who are dissatisfied with their bodies because it implies considerable self-disclosure both physically and emotionally (Cash, Maikkula, & Yamamiya, 2004; Meltzer & McNulty, 2010; Murray et al., 2006). For example, a study has shown that body dissatisfaction in women would account for 15% to 20% of sexual dissatisfaction (Pujols et al., 2010).

This study highlights the importance of two concrete mechanisms that link body dissatisfaction and spousal dynamics. First, in women, the more they are dissatisfied with their appearance, the more they report intrusive thoughts about

A study of intra- and inter-partner links between body dissatisfaction and spousal issues

Based on data from our study of 103 couples, body dissatisfaction would appear to lead to relationship dissatisfaction via the sexual sphere, particularly through problems of sexual assertiveness and the presence of cognitive distractions (Gagnon-Girouard, Turcotte, Paré-Cardinal, Lévesque, St-Pierre-Tanguay, & Bégin, 2012).

IN WOMEN

The link between body, sexual and relationship dissatisfaction in women is significant, regardless of the women's actual weight.

In women, what their spouses think of their appearance is not a significant determinant of their own sexual and relationship satisfaction.

IN MEN

The link between body dissatisfaction, sexuality and relationship satisfaction is associated with actual weight in men.

Men are more sensitive to their spouse's body dissatisfaction and what they believe she thinks of their bodies than to their own body image.

The spouses of women who are dissatisfied with their appearance report a less satisfying sex and conjugal life than other spouses.

their appearance and performance during sexual relations, which would result in them enjoying their sex life less fully and experiencing less satisfaction in their spousal relationship. In addition, the results highlight links between body dissatisfaction, sexual and conjugal assertiveness in women, and their partner's sexual and relationship satisfaction. Thus, women who are less assertive of their

sexual needs say they are less satisfied sexually and conjugally, just like their partners. Sexual assertiveness in women therefore seems to be a particularly important variable in the relationship dynamic, because it links body, sexual and relationship dissatisfaction in women, but also because it is directly linked to their partner's sexual and relationship satisfaction.

These results clearly show that how women perceive their bodies, regardless of their actual body weight, is closely connected to the relationship dynamic, particularly via its association with the spouse's level of relationship satisfaction. More specifically, sexual assertiveness and cognitive distractions may be concrete therapeutic targets that could be worked on to reverse the devastating effect of body dissatisfaction on the most intimate aspects of the spousal relationship.

Avenues for clinical intervention

Do not assume that a woman who is not overweight is not concerned by her appearance.

Consider women's concerns about their appearance and the potential impact on intimacy and sexuality within the couple.

Investigate men's perception about what they believe their spouse thinks of their bodies.

Consider sexual assertiveness strategies and intrusive thoughts about appearance and performance as treatment targets in couples for whom these problems adversely affect the relationship dynamic.

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Spousal violence: Useful parameters for assessment and intervention



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This paper presents some concepts about spousal violence, in terms of prevalence, reciprocity and risk factors. Criteria are suggested to facilitate assessment of the intensity of violence within couples. Recommendations are proposed concerning the relevance of treating violent acts in couple's therapy.

Keywords: spousal violence, reciprocal violence, dangerousness, assessment, treatment

In clinical work with couples, spousal violence is a complex issue that is often underreported or concealed, as spouses consult more often for their problems with regard to managing conflict. However, escalating conflicts are an important precursor of violence within couples. Clinicians need to properly assess the presence, frequency and forms of violence (e.g., psychological, physical and sexual) and the severity of violent behaviours within couples before embarking on interventions with the spouses. This paper provides an overview of the scientific work on the prevalence, reciprocity and risk factors of spousal violence, in addition to providing avenues for assessment and directions for treatment in the context of violence.

Statistical portrait

Many epidemiological inquiries and studies have attempted to develop a statistical portrait of male and female psychological, physical and sexual spousal violence in the general population. Desmarais and her collaborators (2012a,b) examined studies on the prevalence of spousal violence published between 2000 and 2011 and observed that 22% of adults (female = 23%, male = 19%) reported having experienced physical violence in an intimate relationship, whereas 25% (female = 28%, male = 22%) reported having perpetrated physical violence against a romantic partner. Spousal violence is a complex and persistent phenomenon with high rates of recidivism (around 67%; Feld & Straus, 1990).

In the United States, nearly one in two Americans (male = 48.8%, female = 48.4%) say they have been victims of psychological violence during their lifetime, while one-third of women (35.6%) and one-quarter of men (28.5%) reported that they had experienced physical or sexual violence (Black et al., 2011). According to Statistics Canada (2013), violence between intimate partners accounts for 20% of violent crimes reported by the police; the vast majority of victims (80%) are women. The 2004 General Social Survey on victimization, which included 653,000 women and 546,000 men, revealed that approximately 7% of Canadian women and 6% of Canadian men living as a couple reported having been victims of some form of physical or sexual violence (from mere threats of hitting the partner to sexual abuse) by their spouse in the five years preceding the survey (Statistics Canada, 2005). Quebec ranked slightly below the Canadian average, with 5% of men and 6% of women saying that they had been victims of spousal violence. Rates of spousal violence in the general

population appear to be similar for men and women. It is important to point out, however, that women are victims of more severe and violent incidents and report more psychological consequences and injuries than men (Statistics Canada, 2005).

In studies among representative samples of couples in Quebec, Godbout and her collaborators (2009) evaluated different forms of violence and observed that 27% of couples (female = 31%, male = 23%) reported having exhibited at least one physically violent behaviour towards their partner in the past year. The rates rose to 83% for psychological violence, with a mere 17% of couples reporting the absence of violent behaviours in their relationship. In addition, 17% of men and 7% of women had been sexually violent towards their partner at least once during the same period (Lafontaine & Lussier, 2005). This form of violence is more widespread in young adults; 46% of women aged 18 to 25 said they had suffered sexual violence at least once in the past year (Lussier, Lemelin, & Lafontaine, 2002).

Clearly, there are marked disparities in the estimates of violence obtained in the different studies. The nature of the study (epidemiological, clinical, samples of cases going to court, samples of volunteers), the manner in which the study is presented to participants (study on conflicts or study on crime, crime victims, personal safety), the very definition of violence and its operationalization (type and number of questions), and the samples' characteristics (age, presence of children, etc.) are important factors that may contribute to such variations. For example, retrospective studies reveal that there is an increase in violence in terms of frequency, intensity and severity in many couples

over the years of living together (Holtzworth-Munroe, Beak Beaty, & Anglin, 1995). Despite the variations, the studies clearly demonstrate that violence is a real issue that undermines the quality of couple relationships and carries substantial social costs. Spousal violence, whether physical or psychological, is linked to many consequences. Some researchers highlight the particularly damaging effects of psychological violence, not only because it occurs more frequently (e.g., Marshall, 1992; Walker, 1984) but also because it often precedes physical violence (O'Leary et al., 2007) and is perpetrated by both men and women (Ehrensaft et al., 2009).

Reciprocal violence

Bidirectional spousal violence is considered the most frequent form of violence in intimate relationships, whether in the general population or in clinical populations (Langhinrichsen-Rohling et al., 2012). Because of this, it is important to consider the dyadic mechanisms that help foster or sustain spousal violence, owing particularly to their deleterious effects on spouses, on the relationship and on children who may be witnesses, and the risks of escalation associated with spousal violence.

Current data indicate that clinicians need to incorporate bidirectional violence assessment protocols and consider the relational dynamic, communication patterns, emotional regulation strategies, romantic partner selection processes, conflict management styles, and both partners' internal experiences in order to provide effective prevention and intervention services. Indeed, studies on the spousal interaction in violent couples indicate a "negative reciprocity" where each spouse tends to retaliate and

contributes to exacerbating the negative communication, leading to an escalation of the gravity of negative verbal exchanges that typically precede the perpetration of physical violence (e.g., Margolin & Gordis, 2003). Researchers also observe a pairing between partners who use violence (see Serbin et al., 2004), which results not only in reciprocal violence but is also associated with a risk of escalating violence leading to police intervention (Capaldi et al., 2007). In examining both members of the couple, studies thus highlight the dynamic influence of spouses.

The two-way nature of spousal violence does not necessarily imply a symmetry between the forms of violent acts that are committed, nor the resulting effects. Studies indicate that men tend to use more severe violence, are at less risk of injury, and experience less fear towards their spouse's violent behaviours (e.g., Langhinrichsen-Rohling et al., 1995). Likewise, according to a national survey, women are more likely to report being victims of "intimate terrorism," characterized by the use of severe violence and a control dynamic to subjugate the romantic partner (4% as compared to 2% of men; Laroche, 2005). Couples who perpetrate bidirectional violence should be referred quickly to assistance and protection services. According to the study by Gray and Foshee (1997), adolescent couples characterized by mutual violence sustain and perpetrate more spousal violence and their risk of injury is greater, as compared to couples characterized by unidirectional violence.

In short, current data indicate that clinicians need to pay special attention to the intra and interpersonal mechanisms underlying spousal violence, regardless of the type. Moreover, by

viewing the couple as an interdependent unit of intervention, whenever possible, the range of personal and relational dynamics underlying the violence and relationship dissatisfaction can be observed and targeted in order to offer adapted services.

Quebec and international work on predictors of spousal violence

Whether violence is unidirectional or bidirectional, Quebec and international researchers study the risk factors or predictors of spousal violence. Their work serves to identify the individuals most likely to resort to acts of violence, but also to target mechanisms leading to violence that can be the focus of therapeutic work. In that regard, Hamberger and Holtzworth-Munroe (2009) report that a diagnosis of mental disorder in one of the partners is a factor that increases the risk of perpetrating spousal violence. Reviews of the literature on the subject further reveal that certain sociodemographic factors are linked to a greater risk of violence (e.g., low income, young age, unemployment), but that violence can be found in all social classes (Holtzworth-Munroe, Smutzler, & Bates, 1997). Other works have pointed to the role of childhood exposure to violence (Godbout et al., 2009) and childhood sexual abuse (Brassard et al., 2013) as precursors to violent behaviours in adult romantic relationships. Attachment insecurity (Fournier, Brassard, & Shaver, 2011; Lafontaine & Lussier, 2005), low empathy (Péloquin, Lafontaine, & Brassard, 2011), jealousy (O'Leary et al., 2007), anger regulation difficulties (Brassard et al., 2013; Lafontaine & Lussier, 2005), dysfunctional communication patterns where one spouse makes demands while the other withdraws (Fournier, Brassard, & Shaver, 2011), and relationship dissatisfaction

(Lawrence & Bradbury, 2007) also appear to be factors that predict recourse to acts of violence against an intimate partner. More and more models are being proposed where multiple factors are included simultaneously. For example, Godbout and her collaborators (2009) have highlighted the link between childhood exposure to violence and the use of spousal violence, via the development of cognitive attachment patterns marked by discomfort with intimacy (violence used as an escape mechanism) and abandonment anxiety (violence used as a pursuit strategy). Brassard and her colleagues (2013) have tested a model where childhood sexual abuse is associated with the use of spousal violence in men via abandonment anxiety and difficulty regulating anger.

Assessment of spousal violence

Before arranging an initial meeting with a couple, it is recommended to screen for the presence of violence in the couple over the phone. Most clinicians do not complete such screening. This preliminary screening does not replace direct inquiry with the victim, and a more thorough systematic assessment should follow during initial meetings (Lussier, Wright, Lafontaine, Brassard, & Epstein, 2008).

For safety's sake, it is preferable that a detailed investigation of severe current violence be performed in both spouses, during one-on-one meetings with each partner because (1) spouses may not admit to or may underplay the nature or intensity of the violent acts because of denial or fear of retaliation, and (2) the victim may have a false impression of safety during sessions and denouncing acts of violence may result in retaliation before a violence prevention program can get underway. It is further recommended that the word "violence" not be used

during the initial couple session, but rather that questions be asked regarding behaviours during conflicts (Epstein & Baucom, 2002). As Table 1 suggests, the procedure for investigating violence as advocated by Lussier and his collaborators (2008) implies a style of inquiry that is direct, yet respectful of each individual. Self-report questionnaires can also be used to validate the presence of violent behaviours, both perpetrated and sustained (e.g., conflict resolution strategies scale; Lussier, 1997) and motivations for the use of violence (e.g., Lafontaine, Péloquin, Brassard, & Gaudreau, 2013). They must be administered on an individual basis.

Decision-making model for choice of couple's therapy

The decision-making model proposed by Lussier et al. (2008) is based on clinical and empirical knowledge (e.g., Stith & McCollum, 2009) and seeks to help clinicians take the right clinical action during the assessment phase as regards the relevance of couple's therapy (CT) to treat violence in one or both partners, or individual therapy (IT) to treat the abuser's violent behaviours or the victim's behaviours. The model considers five forms of violence on a continuum of dangerousness (see Table 2). Psychological violence and physical violence are both taken into consideration, while sexual violence is included in one of those two forms of violence.

The process leading to the recommendation or not of CT (right column) is based on the clinician's strong familiarity with: (a) risk factors of dangerousness; (b) various clinical options available in cases of dangerous spousal violence; and (c) the pros and cons of couple's therapy in cases of dangerous spousal violence. Like Stith and McCollum (2009),

TABLE 1

Assessment of violence during initial contact with spouses.

1. What happens when you are angry?
2. Do you and your spouse raise your voices or shout?
3. Do you scream abuse or insults at each other?
4. Do you or your spouse do something at the height of the argument that you regret later?
5. When your arguments escalate, has either of you ever thrown objects or hit something?
6. When your conflicts escalate, has either of you ever pushed or shoved the other or done anything else of a physical nature?

who use a variety of criteria to determine the relevance of couple's therapy, the decision-making process considers 24 factors identified by Lussier and his collaborators (2008). The factors need to be assessed minutely (see Table 3). To assess the intensity of a factor, a four-point scale is proposed (0 = absence of behaviour, 1 = minor presence, 2 = moderate presence, 3 = strong presence). The first six factors directly concern the dangerous-

ness of the acts of physical violence. It is important to remember that the presence of just one of the first six factors is sufficient reason to contraindicate CT, as they are indicators of dangerous or potentially dangerous violence. In those cases, individual treatment of each spouse is recommended. Once that treatment is completed successfully by each partner (which corresponds to *type 4* violence in Table 2), couple's therapy can be recom-

mended on condition that there are few factors in Table 3 (*factors 7 to 24*) of moderate to strong intensity.

Throwing or breaking objects or hitting something (*factor 7*) is a strong indicator of potential physical violence. Violence is present, but it has not reached the victim physically yet. The acts are threatening and can be potentially dangerous. The abuser's ability for self-control needs to be assessed to determine whether CT is recommended: a score of 3 indicates a poor ability and is a contraindication to CT. If *factor 7* is of moderate intensity and is accompanied by severe psychological violence, CT is not recommended. In couples that exhibit minor and infrequent psychological violence or report one or a few sporadic episodes of physical violence in the past, CT would be appropriate (Cascardi & O'Leary, 1992). If *factors 8 to 24* are absent or obtain low scores (score = 1), spousal problems generally lie within the range of communication and problem-solving skills where intervention is possible so that the violence does not degenerate into more severe violence. Severe psychological violence can also be treated in CT. However, if a victim reports an intense fear with respect to his/her spouse (*factor 17*) or extreme psychological vulnerability (*factor 18*), it is preferable that IT be recommended before initiating CT. Likewise, if the scores are low (score = 1), but more than five risk factors are present, IT is recommended before CT. The presence of deficient relational skills, judgment or intelligence (*factor 23*) needs to be carefully assessed to determine the relevance of treatment. All in all, the intensity and the number of factors presented in Table 3 influence whether CT is appropriate for the treatment of spousal violence.

TABLE 2

Continuum of violence and recommendation for couple's therapy.

TYPE OF VIOLENCE	COUPLES THERAPY
1. Psychological violence, without physical violence <ul style="list-style-type: none"> • minor psychological violence • severe psychological violence 	Recommended Recommended on condition
2. Sporadic psychological violence and physical violence in the past	Recommended on condition
3. Current but minor physical violence	Recommended on condition
4. Severe physical violence in the past, but no longer active	Recommended on condition
5. Dangerous or potentially dangerous current physical violence	Not recommended

TABLE 3**Factors associated with dangerous spousal violence (Lussier et al., 2008).**

RISK FACTORS OF DANGEROUSNESS
1. Injury caused to spouse on more than two occasions in the past 12 months
2. Injury to children on more than two occasions in the past 12 months
3. Reprisals or threats of injury, suicide and/or homicide
4. Sadistic behaviours (e.g., torture, burns, deprivation of food or sleep)
5. Use of a weapon to threaten or injure, or use of martial arts to threaten or injure
6. Rape or forced sexual relations
7. Throwing or breaking objects or hitting something (e.g., wall or table)
8. Criticism, insults or bullying
9. Possessive behaviours, domination or control by coercion
10. Substance abuse (alcohol and/or drugs)
11. Interventions by persons from outside the couple during incidents of spousal violence
12. Police record or police intervention for violence inside or outside the home
13. Spousal dependence, jealousy or obsession
14. Borderline personality (inability to trust one's spouse because of paranoid thoughts or pathological jealousy)
15. Antisocial personality (impulsiveness, manipulation, crime, history of cruelty to animals)
16. Non-acceptance of responsibility for violent behaviours, lack of remorse for harm caused, or lack of motivation to change
17. Feelings of fear in victim with regard to abuser, fear of being killed, or personal blame for spouse's violence
18. Psychological vulnerability of victim (e.g., low self-esteem, lack of self-assertiveness, submission, acquired resignation, post-traumatic stress disorder)
19. Multiple family stressors (e.g., poverty, job loss, blended family, sick child)
20. Poor social support network
21. Social environment that encourages violence
22. Past history of childhood maltreatment
23. Deficient relational skills, judgment or intelligence
24. Clinician does not feel safe

Finally, *factor 24* was introduced because clinicians in contact with spousal violence can experience or feel concerns for their personal safety. Extremely little documentation exists on that subject. According to Lussier et al. (2008), violent men with an antisocial or borderline personality may use that type of threat, especially with female therapists (e.g., “when people push my buttons, they know I can get nasty”). Such threats must never be taken lightly. For that reason, familiarity with the various elements of the diagnostic protocol is important, not only for the well-being of the spouses, but for that of caseworkers as well. If clinicians are fearful for their safety, they best not pursue couple's therapy and should refer the violent spouse to a specialized treatment centre or work in co-therapy (mixed dyad; Lussier et al., 2008).

These few multi-dimensional avenues for the assessment of spousal violence can be used both by therapists working with couples as well as by clinicians who intervene with clients in individual therapy. When intervening in the area of spousal violence, we recommend that clinicians proceed with caution. Solid training is necessary. The intervention models need to consider the multiple developmental, personological, interactional and cultural factors that predispose, precipitate and maintain violence within couples.

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Childhood trauma and couple relationships



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Clinical knowledge and an emerging empirical literature are highlighting many long-lasting deleterious effects of childhood interpersonal trauma on couple functioning. Early experiences of violence and maltreatment seem particularly to affect the subsequent ability of survivors to establish lasting, satisfying intimate relationships. This paper presents an overview of the scientific work on the prevalence of interpersonal trauma and its effects on couple relationships, in addition to presenting conceptual models and offering avenues for assessment and directions for therapy.

Keywords: interpersonal trauma, childhood maltreatment, violence, couple, relationship, assessment, treatment

With alarming prevalence rates in the community (e.g., 35% of adults in Quebec report having experienced physical, sexual or psychological violence or neglect, or having witnessed domestic violence during childhood; Brassard et al., 2012) and clinical populations (e.g., 56% of women and 37% of men consulting for a sexual or conjugal problem report childhood sexual abuse; Berthelot, Godbout, Hébert, Goulet, & Bergeron, in press), a past history of childhood interpersonal violence is now viewed as an endemic public health problem that must be considered in our assessments and therapeutic interventions. The data indicate higher prevalence rates in lesbian, gay, bisexual, transgender and queer (LGBTQ) populations (e.g., 25 to 50% higher for childhood sexual abuse only), which may result in special clinical challenges (Walker, Hernandez, & Davey, 2012). Owing to the often intimate relational context in which they emerge, experiences of childhood abuse, violence or maltreatment can prove to be particularly deleterious for forming an intimate relationship and for spousal stability, sexual identity, and dyadic communication and satisfaction (Dillilo & Long, 1999; Godbout, Dutton, Lussier, & Sabourin, 2009; MacIntosh & Johnson, 2008; Whiffen & Oliver, 2004).

Whether it is due to a massive avoidance of intimate relationships, tension-reducing dysfunctional behaviours (e.g., self-mutilation), substance abuse, social isolation, problems of self-confidence and confidence in others, or severe psychological distress, some survivors have serious difficulties forging or maintaining a spousal relationship (Briere, Hodges, & Godbout, 2010; Godbout & Briere, 2011; Liang, Williams, & Siegel, 2006). Interpersonal trauma, especially sexual abuse, is also associated with the presence of sexual problems that impede or complicate intimate relationships (e.g., aversion, sexual ambivalence or concerns, sexuality as a bargaining chip; Meston, Rellini, & Heiman, 2006; Noll, Trickett, & Putnam, 2003; Stevens & Denis, 2009). In survivors who manage to establish a spousal union, relationship and sexual dissatisfaction is observed, along with high rates of separation or divorce, domestic violence and romantic attachment representations marked by abandonment anxiety (Godbout, Sabourin, & Lussier, 2007; 2009; Roche, Runtz, & Hunter, 1999; Watson & Halford, 2010). Indeed, many victims have never had the opportunity to develop the relational skills needed to forge and maintain a satisfying intimate relationship. Moreover, the control or violence dynamics that they have

experienced often guide their subsequent relationships, which are thus characterized by dysfunctional interaction patterns (Forouzan & Van Gijsegem, 2005; Godbout et al., 2009). Experiences of abuse or neglect can also elicit fears of intimacy which, when added to the coexisting need for connecting, lead to intimate relationships that are ambivalent, chaotic or short-lived.

Nonetheless, despite an imposing constellation of deleterious trauma-related symptoms, many individual variations are observed, from multiple severe symptoms to the absence of observable symptoms. Some effects emerge after a traumatic latency period that may range from several months to several years after the traumatic experience, or arise in conjunction with specific triggering events (e.g., first spousal or sexual relationship, marriage, conflict, separation, pregnancy or childbirth; Trickett, Noll, & Putnam, 2011). Finally, the effects are often complex, subtle or indirect. In short, current knowledge points to different patterns and trajectories of post-traumatic symptoms in childhood maltreatment survivors necessitating detailed and multi-dimensional assessments, not only of the past history of violence but also of the various associated factors. Indeed, direct inquiry is crucial since studies indicate that clients are not systematically forthcoming with their experiences and clinicians may pass by elements key to the course and efficacy of the treatments offered. Note, for example, the study by Lanktree, Briere and Zaidi (1991), which indicated a 300% higher prevalence (7 vs. 31%) when the presence of childhood sexual abuse was questioned directly in a medical/clinical context.

Owing to the complexity and variability of documented symptoms, integrative theoretical/clinical models have been developed and are advocated to understand the conjugal distress that can arise from childhood maltreatment. One theory suggests that the symptoms of post-traumatic stress are at play in impeding a victim's ability to engage in attachment behaviours specific to a couple relationship by reason of the distress generated by hypervigilance, lack of emotional regulation and self-deregulation (Whiffen & Oliver, 2004). Other authors suggest that childhood trauma is linked to vulnerabilities and complex symptoms that hinder development of the skills needed to engage in a spousal relationship, such as the ability to trust one's partner and deficient mentalization capacities, particularly in an intimate context (e.g., Brand & Alexander, 2003; MacIntosh, 2013; Risser, Hetzel-Riggin, Thomsen, & McCanne, 2006; Wolfe, Wekerle, Scott, Straatman, & Grasley, 2004). In that regard, a theoretical/clinical model proposed by Godbout, Sabourin and Lussier (2006) states that the childhood interpersonal trauma can possibly lead to the development of attachment representations marked by insecurities that, in return, are associated with greater psychological distress (i.e., anger, depression, anxiety) and diminished relationship satisfaction. This theoretical model has been the object of rigorous empirical testing using representative samples of Quebec adults in couple relationships (Godbout et al., 2006; 2007; 2009). The development of effective clinical interventions for victims and their partners requires a sound understanding of the complex linkages between

exposure to childhood trauma and conjugal distress, which includes, but is not limited to, basic symptoms of post-traumatic stress, and must be approached from a dyadic perspective.

An integrative model that considers the couple dynamic as a unit of analysis has provided rich and detailed information on how trauma and the spousal union are connected, highlighting the protective role of parental support upon disclosure of sexual abuse (Godbout, Briere, Lussier, & Sabourin, 2013). For example, in women, a lack of parental support is associated with their own attachment insecurities, but also with a tendency to forge a relationship with a spouse who experiences abandonment anxiety and psychological distress. These results suggest a possible partner selection effect in sexual abuse victims or a longitudinal influence of the past history of trauma on the partner (also called secondary trauma). Note that survivors who report parental support at the time of disclosure demonstrate a comfort with intimacy not only greater than other survivors of sexual abuse but also than persons who report no sexual trauma. This positive effect of parental support highlights the important role that an attachment figure can play following interpersonal trauma. Survivors can learn that their attachment figure is reliable in times of a critical situation when they were particularly vulnerable, which plants the idea that other significant persons might also be present and trustworthy in the future, even in difficult situations. Other factors help explain why some victims have fewer relationship problems than others, including: individual factors

In survivors who manage to establish a spousal union, relationship and sexual dissatisfaction is observed, along with high rates of separation or divorce, domestic violence and romantic attachment representations marked by abandonment anxiety.

(e.g., self-esteem, emotional regulation strategies), relational factors (e.g., couple and family dynamic), environmental factors (e.g., available resources), and trauma-specific factors (e.g., proximity to abuser, severity of abuse, complex trauma; e.g., Dufour, Nadeau, & Bertrand, 2000).

Couples can also promote adjustment of the survivor. Indeed, a quality relationship, characterized by emotional depth, can facilitate repair of the dysfunctional internal cognitive processes and patterns that were developed in connection with violence or abuse, provide a space to explore a new, healthy relational dynamic, and thus foster positive representations of self, others and the outside world, and promote better psychosocial adjustment (Trickett, Noll, & Putnam, 2011; Runtz & Schallow, 1997;

Whiffen, Judd, & Aube, 1999). Despite the specific effects of childhood trauma on intimate relationships and the possible moderating effect of a couple relationship on the impacts of childhood trauma, partners are often excluded from the therapy offered to victims. Partners report experiencing isolation, anger, frustration, a lack of spontaneity, communication problems within their union, feelings of shame or guilt in respect of their sexual desires or desires for intimacy, and a feeling that they are waiting for their spouse's therapy to end before they can move ahead in their relationship (Firth, 1997; Reid, Wampler, & Taylor, 1996). Thus, to potentiate the protective effect of the conjugal dyad on the impacts of trauma, some researchers and clinicians have attempted to develop couple's therapy that targets both the post-traumatic symptoms and the relational distress associated with the trauma (cf., Monson et al., 2012). These approaches, primarily developed within military populations, invite partners to take part in therapy so that they can help the survivor diminish his/her avoidance behaviours and manage his/her anxious hyperreactivity in both intimate and day-to-day situations.

These developments mark an important step for including partners in post-traumatic recovery, although the specific needs of childhood trauma survivors, particularly emotional deregulation, impaired representations of self and others, mentalization limitations and

relational problems, can also benefit from adapted couple's therapy. A process has been initiated via the validation of emotion-focused therapy in a couple's context, adapted for childhood trauma survivors (MacIntosh & Johnson, 2008). Further adaptations are underway and the data indicate that an effective couple's therapy for trauma survivors and their spouses should target not just symptoms of post-traumatic stress but also the developmental impacts of childhood trauma, including mindfulness and mentalization deficits, emotional deregulation problems, attachment insecurities, diffuse or other-focused identity, and dysfunctional relational dynamics (Briere et al., 2010; Cloitre, Miranda, Stovall-McClough, & Han, 2005; Cloitre et al., 2009; Hodges et al., 2013; MacIntosh, 2013).

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An overview of same-sex couples' love lives



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Attitudes in regard to homosexuality and gay and lesbian couples have certainly changed over time, as reflected in the recent legalization of marriage for same sex partners in various countries and the recognition of the right to adopt a child. In this article, the authors review the research on commitment and marital satisfaction, divorce and separation, sexuality, attachment, parenting, domestic violence, and communication within same sex couples.

Keywords: homosexuality, same sex couples, couples, couple satisfaction, conflict resolution, parenting, violence, attachment, communication

Social attitudes towards homosexuality and homosexual dyads have been shifting significantly for some time in a more liberal direction (MacIntosh, Reissing, & Andruff, 2010). The obvious manifestations of that shift have been the recent legalization of gay marriage in various countries, including Canada in 2005 (Parliament of Canada, 2005), the right to adopt, and the removal of homosexuality in the revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). It is highly possible that these social changes have had an impact on the functioning of homosexual couples (Gotta, Green, Rothblum, Solomon, Balsam, & Schwatz, 2011).

Homosexuality, as the term is used here, refers to a “sexual orientation characterized by fantasies, desires and sexual conducts directed mostly towards persons of the same sex as oneself” (Crooks & Baur, 2003, p. 134). As for homosexual dyads, they are viewed in this paper as being comprised of two persons of the same sex— independently of their sexual orientation (e.g., bisexual)— in a romantic relationship. The 2011 Canadian census counted 42,035 married same-sex couples and 8,120 couples living together (Statistics Canada, 2011).

Like heterosexual couples, homosexual couples aspire for love, recognition, support and sexual intimacy. They face common challenges, such as negotiating day-to-day conflicts, violence between partners and the desire to start a family. That said, persons in same-sex partnerships have relationship trajectories that can be tainted by discrimination, victimization, stigmas, intolerance, isolation and rejection (Kaiser Foundation, 2001; Williams, Connolly, Pepler, & Craig, 2005). Thus, our understanding of same-sex conjugal life must consider the realities specific to that minority population. The concept whereby heterosexuality is the norm against which same-sex couples must be compared is problematic and criticized (e.g., Stacy & Biblartz, 2001), since it implies that heterosexual relationships are inherently healthy and a standard for all other forms of spousal relationships. Bear in mind, however, that the literature includes comparative studies on the functioning of same-sex and heterosexual couples. We invite readers to review the 21 recommendations for psychological practice with lesbian, gay, and bisexual clients, adopted by the American Psychological Association in 2011 (<http://www.apa.org/pi/lgbt/resources/guidelines.aspx>). The last recommendation concerns research and encourages psychologists to represent research results on

sexual orientation fully and accurately and to be mindful of the potential misuse or misrepresentation of research findings. It is from that perspective that the findings below are represented.

Commitment and Relationship Satisfaction

Generally speaking, very few differences are seen in relationship satisfaction among individuals in same-sex relationships as compared to heterosexual partners (Duffy & Rusbult, 1985; Kurdek, 1998; Kurdek, 2001; Mackey, Diemer, & O'Brien, 2004; Peplau & Fingerhut, 2007). The majority of individuals in long-standing same-sex relationships generally report high rates of relationship satisfaction (MacIntosh et al., 2010; Mackey et al., 2004; Quam, Whitford, Dziengel, & Knochel, 2010). In addition, lesbian women and gay men differ little in terms of their relationship satisfaction (Kurdek, 1991). Variables of general couple functioning, such as communication, intimacy, trust, and conflict resolution strategies, and variables specific to the social reality of same-sex couples, such as sexual identity and stigma perception (e.g., Kurdek, 1998; Kurdek, 1994; Mohr & Fassinger, 2006; Peplau & Fingerhut, 2007), contribute to relationship satisfaction in those individuals.

Dissolution of Partnerships

Partnerships may break down more frequently in same-sex couples (Kurdek, 1998). Separation rates would seem to be similar, however, among gay men and lesbian women (Kurdek, 1998; Kurdek, 2003). To explain the higher frequency of relationship breakdowns, Kurdek (1998) points to the lack of formal social and cultural support towards same-sex couples. In comparison to heterosexual couples, same-sex couples have fewer institutional barriers (e.g., divorce, children, financial dependence) that may prevent or delay the dissolution of unhappy relationships.

Romantic Attachment

Secure attachment is linked to greater relationship satisfaction (Elizur & Mintzer, 2003; Kurdek, 2002; Horne & Biss, 2009; Ridge & Feeney, 1998) and stronger commitment towards one's partner (Kurdek, 1997; 2002), in both gay men and lesbian women.

Sexuality

Holmberg and Blair (2009) found that same-sex dyads reported higher levels of sexual desire than their heterosexual counterparts. Research by sociologists Blumstein and Schwartz (1983) suggests that the frequency of sexual activity in gay couples is higher than in heterosexual couples, which in turn is higher than in lesbian couples. This reflects social stereotypes with regard to the homosexual population. However, Izena (2002) noted that sexual contact between lesbian women lasts longer than for heterosexual women, suggesting that the sex life in lesbian dyads is defined more by quality than by quantity. Other studies illustrate an outright absence of differences between lesbian and heterosexual women in terms of sexual frequency (e.g., Matthews, Tartaro, & Hughes, 2003). Furthermore, many studies support the fact that sexual frequency in gay dyads also diminishes over time, as it does in heterosexual unions (Bryant & Demian, 1994; Deenen, Gijis, & van Naerssen, 1994; McWhirter & Mattison, 1984). A study that compared the data for lesbian, gay and heterosexual couples compiled in 1975 and 2000 pointed to greater monogamy for all these types of couples (Gotta et al., 2011).

Communication and Problem Resolution

Problem resolution is associated with greater relationship satisfaction, while conflict and withdrawal are associated with diminished satisfaction in gay and lesbian couples (Kurdek, 1994; Metz, Rosser, & Strapko, 1994). Similarly, demand-withdraw behaviour, which occurs when one partner demands change, complains or criticizes and the other partner avoids, ends or withdraws from the discussion (Christensen, 1988), is associated with conjugal distress in couples in same-sex relationships (Baucom, McFarland, & Christensen, 2010).

Spousal Violence

Spousal violence is a reality that can occur in any couple relationship, independently of whether it is heterosexual or homosexual (O'Leary & Woodin, 2009). The rates of spousal, physical, psychological and sexual violence are equivalent between homosexual and heterosexual dyads (Jose & O'Leary, 2009), and the violence is typically mutual between partners (see Murray & Mobley, 2009).

Same-sex Parenting

A broad range of studies now exists to show that a parent's sexual orientation has no significant impact on a child's psychosocial development (e.g., Patterson, 2006). Nonetheless, homosexual parents need to cope with significant challenges, such as discrimination in the adoption process, the lack of protection of their parental rights in the legal system, stigmatization stemming from various institutions, and the lack of social support (Bos & van Ballen, 2008; Brown, Smalling, Groza, & Ryan, 2009; Julien, Jouvin, Jodoin, l'Archevêque, & Chartrand, 2008; Puckett, Horne, Levitt, & Reeves, 2011). Other studies have looked at the unique challenge faced by lesbian women in the decision-making process about who will be the birth mother (Leblond de Brumath & Julien, 2007) and identity changes linked to parenthood in gay men who have opted to adopt (Armesto & Shapiro, 2011).

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Infertility: A social and spousal reality that needs to be studied



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Nearly 15% of couples are affected by infertility (Bushnik et al., 2012). In Quebec, Bill 26 recently came into effect and provides free access to assisted procreation. This has resulted in more and more couples seeking fertility treatments. Current research shows that considerable stress is associated with a diagnosis of infertility and its treatments. For mental health workers, a proper understanding is needed of these clients' particular characteristics and psychological health needs. This paper discusses the issues encountered by couples coping with infertility and examines the psychological, spousal and sexual impacts of that reality. Avenues for assessment and intervention with these couples are then proposed.

Keywords: Infertility, emotional reactions, couple and sexual functioning, psychological interventions

Infertility is defined as a failure to conceive a child after 12 months of attempted conception with regular sexual relations (World Health Organization, 2002). In Canada, 11 to 15% of the adult population, or approximately one in six couples, is affected by infertility (Bushnik et al., 2012). In Quebec, infertility is in the spotlight, not only because of its high prevalence but owing to the response to Bill 26, which came into effect in August 2010 and provides free access to assisted procreation. Moreover, the current social context favours a tendency to postpone decisions to start a family. This situation inevitably results in a larger number of couples experiencing conception difficulties because of their more advanced age (Collins, 2004; Ford et al., 2000) and consequently the need to resort to assisted medical procreation. It must be remembered that at age 35, approximately 30% of women will experience problems conceiving and that this number rises to more than 50% in women 40 years of age and older. Finally, the grieving that occurs following a diagnosis of infertility and the innumerable challenges and constraints associated with fertility treatments add considerable stress for many, and that stress can have psychological, spousal or sexual consequences. Thus, for all the above reasons, there is a need, for mental health workers, to properly understand these clients' particular characteristics and psychological health needs.

There are many possible causes of infertility; approximately 30% of cases can be attributed to male factors (e.g., low sperm count or reduced mobility of sperm), 30% to female factors (e.g., absence of ovulation, tubal blockage or early menopause) and 30% to a combination of the two. However, a certain proportion of cases, or approximately 8%, remains unexplained (Practice Committee of the American Society of Reproductive Medicine, 2006). And yet, independently of which person receives the diagnosis, infertility is a reality for the couple. Partners need to join together to face the countless upsets and challenges raised by the difficulty to conceive a child and by the fertility treatments—no less complex—that ensue. Indeed, the fertility treatment process (e.g., numerous medical appointments, tests, medication) can become overwhelming, to the point of interfering with professional obligations. Often, spouses turn to psychologists for support and guidance throughout the process.

Common and normal reactions to infertility

Many scientific studies have documented the elevated stress associated with a diagnosis of infertility and the corresponding treatments (Benyamini, Gozlan, & Kokia, 2005; Paul et al., 2010). Research on stress has demonstrated that stressful events have four common features, namely, lack of control, unpredictability, novelty and threat to ego (Lupien, 2010). Experiencing infertility and its treatments meet all those conditions. Indeed, awaiting diagnosis, having to submit to multiple treatments, all with different constraints and at times painful, and repeated attempts to conceive followed by multiple failures generating major cycles of hope and disappointment are just a few examples illustrating the conditions with which couples must cope. Moreover, during treatments, couples often learn at the last minute that they need to take a test, go to the hospital or take medication with no knowledge of the side effects. Consequently, they frequently report feeling bounced around and ill informed, further upsetting their already fragile emotional state. In that context, common individual reactions include, for example, anger, sadness, incomprehension, a feeling of loss of control, stress, anxiety, depression, changes in body image and self-esteem, guilt, blame and shame (e.g., Bermingham, 2011).

Research points to a number of differences in the way men and women react to infertility. They would seem to be explained, in part, by the different significance given to motherhood and fatherhood, as the female identity often cannot be dissociated from motherhood and a mothering role. Reviews of the literature constantly show

that women generally experience greater distress than men over the inability to conceive a child (Huppelschoten et al., 2013; Wichman et al., 2011). Nonetheless, it must be kept in mind that most studies have been conducted in primarily female samples and relatively few studies have looked specifically at the male experience. In addition, the invasive character of fertility treatments most often borne by women, and the side effects from the hormone medication that is prescribed, contribute to accentuating the intensity of psychological reactions in women. Overall, studies show that, in women, infertility is perceived as an injury to their self-esteem (e.g., loss of identity as a mother and a feeling of being less feminine and “empty”), and women are more likely to experience shock, denial and grief reactions upon learning the diagnosis. Women also exhibit more symptoms of depression and anxiety than men. For their part, men are more affected by male infertility, which is perceived as an injury to their manhood. They are more likely to report anger, isolation, and a feeling of personal failure (see Petok, 2006, for a review). It should further be noted that reactions to infertility

are embedded in social reality, dictated by the couple’s cultural and religious beliefs, in addition to being influenced by the reactions of family and friends and stigmatization from not having children (Hynie & Hammer Burns, 2006).

Despite the countless upsets inflicted by infertility and its treatments, the members of infertile couples generally differ little from general population norms in terms of their level of psychological distress (e.g., Péloquin & Lafontaine, 2010; Verhaak et al., 2007), although they exhibit more psychological symptoms as compared to control groups made up of individuals presumed to be fertile (Fassino et al., 2002; Wang et al., 2007). Nonetheless, close to one-quarter of them report clinically significant distress (Verhaak et al., 2010; Volgsten et al., 2008), hence the importance of properly understanding the reality specific to couples in the context of infertility and of identifying the clinical presentations that merit more serious attention. Tables 1 and 2 provide a few pointers for assessing and targeting psychological symptoms that go beyond the expected reactions in this context.

TABLE 1
Detecting symptoms of depression

EXPECTED REACTION...	MORE SERIOUS DISTRESS...
✓ Discouragement	✓ Despair and bleak thoughts
✓ Situational sadness	✓ General sad mood
✓ Alternating low and high interest levels	✓ More generalized loss of interest
✓ Presence of guilt feelings	✓ Excessive guilt feelings
✓ Sleep disturbances	✓ Chronic insomnia
✓ Periods of fatigue alternating with periods of energy	✓ Loss of energy and chronic fatigue

TABLE 2
Detecting symptoms of anxiety

EXPECTED REACTION...	MORE SERIOUS DISTRESS...
✓ Worries, fears and doubts	✓ Anxiety/anguish, excessive and invasive worries
✓ Periods of acute stress and return to calm	✓ Uncontrollable stress, panic attacks
✓ Moments of forgetfulness during periods of extreme stress	✓ Memory loss, impaired concentration, professional disturbances
✓ Sleep disturbances	✓ Perturbed sleep, chronic insomnia

Decision-making model for couple’s therapy

Partners’ individual reactions cannot be overlooked in the context of couple relationships and each spouse must deal with their own as well as the partner’s reactions. Indeed, infertility can cause individuals to question their relationship or experience relationship dissatisfaction. A review of the literature by Coëffin-Driol and Giami (2004) revealed that infertile couples generally differ little from fertile couples in terms of conjugal well-being. Some more recent studies, however, show greater relationship dissatisfaction in infertile couples as compared to fertile couples (Wang et al., 2007) or infertile couples who adopted a child (Daniluk & Tench, 2007). Finally, studies find that deleterious effects can coexist alongside beneficial effects of infertility on couple functioning (Onat & Beji, 2012; Schmidt et al., 2005). It is possible that infertility exerts a strong pressure on couple functioning, which translates into relationship problems in some couples, particularly those already in a shaky relationship. In others, however, the stress associated with infertility provides conditions favourable to spousal commitment and reinforcement of the relationship. Few studies, however, have examined the

factors that could distinguish these two relational trajectories.

Studies show that blaming oneself for the fertility problem or placing responsibility on the partner is associated with lower relationship satisfaction in both partners (Péloquin, Brassard, Purcell-Lévesque et al., 2013; Peterson et al., 2006). Other studies reveal that the stress management strategies employed by each are related to the relationship adjustment of each partner. For example, when both partners use task-oriented coping strategies (e.g., planning, seeking information and support), women report greater relationship satisfaction. Conversely, women’s relationship satisfaction is lower when they use task-oriented strategies and their spouse instead favours emotion-oriented strategies (e.g., rumination; Levin, Goldman Sher, & Theodos, 1997). Relationship satisfaction is also lower in couples where the man uses many, and the woman uses few, distancing and avoidance strategies, and in couples where the woman favours self-control strategies and the man uses few (Peterson et al., 2006; Peterson et al., 2009). Finally, when both spouses exhibit a high level of psychological distress and the woman favours emotion-oriented coping strategies in particular,

both spouses’ relationship satisfaction is lower and both report greater deterioration in the functioning of their couple because of the fertility problem (Péloquin, Brassard, Sabourin et al., 2013). These findings underscore that, beyond the contextual aspects of the fertility problem and spouses’ individual reactions, the partner’s reactions and his/her way of addressing the situation can influence each partner’s individual adjustment.

As regards sexuality, qualitative studies show that “sex on demand,” a rigid/routine approach to sex and sex for the sole purpose of procreation are associated with difficulties in terms of functioning and sexual satisfaction (Onat et al., 2012; Wirtberg et al., 2007). In addition, quantitative studies reveal that approximately one-quarter of women and men reports symptoms suggesting the presence of a sexual dysfunction (Nelson et al., 2008; Schindel et al., 2008). On the other hand, being satisfied with a partner’s support is associated with greater sexual desire, less sexual anxiety and greater sexual satisfaction in both genders (Purcell-Lévesque et al., 2013), underscoring once again the role that spousal interactions play in coping with infertility.

Helping infertile couples

Boivin (2003) documented 25 studies that examined the efficacy of psychosocial interventions in the context of infertility. Based on her review, she concluded that the more successful interventions: (1) lasted between 6 and 12 weeks; (2) had a strong educational component that emphasized medical knowledge; (3) emphasized the acquisition of specific skills (e.g., stress management skills); and (4) used a group format (which reduces isolation and validates the spouses’

reactions). In addition, a meta-analysis conducted by Liz and Strauss (2005) documented 22 studies that assessed the efficacy of various forms of psychological interventions (group/individual/couple) in an infertility context. That study concluded that psychotherapy, whether delivered in an individual, couple or group format, produces positive effects (moderate effect size) by diminishing distress among infertile individuals.

Owing to the multitude of issues that couples encounter when faced with infertility, clinicians working with infertile clients must first conduct a thorough assessment of the areas affected by the problem in order to develop a treatment plan tailored to the couple's specific needs. FertiQoL is the recommended tool to measure quality of life in couples experiencing fertility problems; the questionnaire, validated in more than 15 countries and translated into 26 languages, measures problems in the emotional, social and

relational domains, in addition to assessing the impact of treatments on individuals' physical and psychological functioning. The tool can be downloaded free of charge at www.fertiqol.org.

In regard to intervention, clinical work consists, first, in normalizing and validating the multitude of emotions felt by each partner. Stress management is then core to the therapeutic work, particularly the teaching of constructive stress management strategies and work to promote the spouses' ability to understand and mutually support each other throughout the fertility process. The linkage between stress and fertility is complex and findings in that regard are mixed. A meta-analysis revealed no relationship between pre-treatment psychological symptoms and post-treatment pregnancy rates (Boivin et al., 2011). Current research suggests, however, that stress may reduce in vitro fertilization success rates via certain behavioural and biological mechanisms. For example, adjunctive intervention programs to reduce stress by means of yoga and mindfulness techniques seem to be linked to higher treatment success rates (e.g., Domar et al., 2011). Stress and psychological distress are associated with the abandonment of treatments, which in turn reduces their chances of success (e.g., Boivin et al., 2012). Thus, effective stress management is crucial for the primary purpose of maintaining the patients' quality of life and of fostering a more positive treatment experience. That

is what must be communicated to clients. If the chances of pregnancy are greater for that reason alone, then it represents an added benefit.

Second, interventions targeting the countless challenges that couples come up against during treatments are often necessary as well. This may include, for example: work on assertiveness with the medical team and one's employer, negotiating relations with family and friends, seeking reliable and valid information, and problem-solving in respect of scheduling constraints, appointments, medication, etc. These interventions have the benefit of augmenting a feeling of control among couples and diminishing their distress in the face of the unknown and of the unpredictability of fertility treatments. Finally, work on possible grieving and consideration of alternative options to start a family often becomes increasingly important on the heels of repeated treatment failures and as couples move forward in their own infertility experience. The clinician's role is to guide the couple, in active listening and compassion, and in personal reflection on future life choices and objectives. For more information, readers are encouraged to consult the Assisted Human Reproduction Counseling Practice Guidelines, developed by Canadian psychologists and adopted by Health Canada and the Canadian Fertility and Andrology Society (www.cfas.ca).

Qualitative studies show that "sex on demand," a rigid/routine approach to sex and sex for the sole purpose of procreation are associated with difficulties in terms of functioning and sexual satisfaction.

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Spousal problems arising from Internet usage

Cyber infidelity and Sexting



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Infidelity is a serious spousal issue with numerous psychological, family, social and economic consequences. It is one of the reasons for consultation reported most frequently in psychotherapy. Easy access to the Internet has created new opportunities for extra-conjugal relationships. This paper examines the issue of cyber infidelity and provides clinicians with directions for evaluation and treatment. The second part of this paper deals with sexting, a new phenomenon which involves sending and receiving sexually explicit pictures.

Keywords: infidelity, Internet, couple, extra-conjugal relationship, sexting, explicit photos

Now part of everyone's daily life, the Internet makes it easy to join social networks, chat, and meet new friends and romantic partners but, conversely, it can also create tensions within couples (Cooper, McLoughlin, & Campbell, 2000; Hertlein & Piercy, 2006).

Cyberinfidelity

Cyber infidelity is a new reality that is on the rise and may be a factor in conjugal breakdown (Whitty, 2008). It is defined as the use of the Internet to create emotional or sexual interaction when a person is already involved in a spousal relationship. It therefore violates emotional or sexual exclusivity (Schnarch & Morehouse, 2002). Secrecy is an integral part of infidelity and many strategies are used to keep discussions over the Internet secret, for example, by deleting chat and search histories (Schneider, 2000). However, Internet infidelity is often discovered by a partner when checking the spouse's emails either by chance or because of suspicions about the other's conduct (Glass, 2003). Such surveillance behaviours occur in one of three couples (Whitty, 2003). In addition, Internet infidelity is often emotional in nature (Underwood & Findlay, 2004), as it helps fill a void felt in the existing relationship. Being able to create a virtual identity without being recognized also opens the door to a variety of forms of online sexual behaviours (Cooper, 2002), making online infidelity anonymous, affordable and accessible. For example, numerous dating sites make it easy for people to connect at a low cost, outside the watchful eye of family and friends. Added to that are countless sites offering pornography (there are more than 4.2 million pornographic websites; Ropelato, 2013), adult entertainment and erotic material online. The multiplicity of ways to access sexuality can create a dependence on cyber sexuality in persons (Jones & Hertlein, 2012). It can also trigger exceptionally strong feelings of betrayal in a spouse upon learning that his or her partner is satisfying sexual needs and fantasies in other contexts and behind his or her back. Schneider, Weiss and Samenow (2012) report that those who discover that their partner is sexually active on the Internet, 71% lose trust in their partner. Many specialists therefore conclude that the Internet facilitates the adoption of infidelity behaviours (Wysocki & Childers, 2011).

Recent results on cyber infidelity in Quebec

In a study of 907 adults conducted online in 2012, Ferron and Lussier (2012) asked participants the following question: *Have you ever been emotionally involved with a partner other than*

your own on the Internet (for example, used seductive behaviours, expressed love, paid compliments or felt love) while you were in a spousal relationship? In total, 33.4% of participants reported having had emotional infidelity behaviours on the Internet. No difference was observed between men and women as regards this type of infidelity.

Participants were also asked the following: *Have you ever had sexual exchanges on the Internet with a partner other than your own (for example, watched the other person fondle and stimulate themselves sexually) while you were in a stable spousal relationship?* In all, 17.3% of participants answered “yes,” with a more significant number of men (25%) than women (13.5%) reporting this type of infidelity.

The above percentages are nonetheless low (see Table 1) when compared to those reported by Wysocki and Childers (2011) who, in a sample of 5,187 participants, found that 63.6% of people admitted that they had cheated on their partner online (that percentage rose to 73.7 for infidelity behaviours in real life). In the latter study, cyber infidelity behaviours did not differ between the two sexes. The data further revealed that, in individuals who engage in cyber infidelity, the risks of infidelity in real life are multiplied by two. These high rates of infidelity online or in real life are substantially higher than those reported in past studies and can be explained, no doubt, by the nature of the website used to recruit the participants (AshleyMadison.com), created specifically for married adults in search of an adventure.

TABLE 1

Frequency of extra-conjugal intimacy behaviours in a Quebec study conducted among 907 participants (Ferron & Lussier, 2012).

	VIA THE INTERNET	FACE-TO-FACE
Emotional exchanges	33.4%	55.3%
Sexual exchanges (excluding full sexual relations)	17.3%	34.3%

Recommendations

Although emotional and sexual infidelity behaviours face-to-face are still generally higher, the increase in cyber infidelity leads us to recommend that clinicians working with couples question, during the assessment phase, not only “traditional”

extra-conjugal behaviours but those occurring on the Internet as well. The text box contains sample questions that can be asked during a one-on-one interview or by means of a questionnaire, for each partner in the couple.

Questionnaire

Some individuals forge relationships with a person other than their romantic partner that go beyond a mere friendship, where an emotional attraction and interest develop, regardless of whether or not there is intimate physical contact with that person.

1. Have you ever used seductive behaviours on the Internet (paid compliments, expressed tender words, etc.) towards another person and/or been charmed by another person on the Internet when you were already in a relationship?
2. Have you ever used one of these physically intimate behaviours on the Internet when you were already in a relationship?
3. Have you ever sent photos of yourself of a sexual nature to another person or received photos or a video of a sexual nature from another person when you were already in a relationship?
4. Have you ever engaged in cybersex or “Internet sex” (for example, fondled yourself or masturbated) during an exchange on the Internet with another person (ask whether a Web camera or no camera was used)?

Because the Internet is still a recent phenomenon, the rules defining what is acceptable and what is not in virtual encounters or when engaging in sexual activities online are not clearly defined in couples (Whitty & Quigley, 2008). Spouses need to be made aware of these phenomena, and discuss and establish clear rules on their virtual sexual activities. Even when sexual behaviours are online only, partners can lose trust in their spouse's romantic feelings, identify themselves as victims of a traumatic event and

need to seek professional assistance (Schneider et al., 2012). In the view of Barak and Fisher (2002), cybersex will become a major factor in the deterioration of spousal relationships and thus one of the multiple causes of conjugal distress and breakdown. Clearly, the Internet now modulates the development and organization of sexuality within couples and families. Widespread use of this medium creates new challenges for identifying and classifying the resulting problematic cyber behaviours (e.g., computer, Internet and

cybersex addiction, cyber compulsion; Jones & Hertlein, 2012). The development of a nomenclature may facilitate the diagnosis and treatment of such behaviours. Indeed, Hertlein and Piercy (2012) clearly show that the majority of psychologists have not been properly trained to assess these situations even though they often have an impact on the course of treatment. As regards therapeutic targets, Hertlein and Piercy (2012) recommend a few, as outlined in text box below. Although there exist treatment models for cyber infidelity and some indication as to their efficacy, they still need to be validated more rigorously by science (Hertlein & Piercy, 2006).

TABLE 2

Therapeutic Tasks	Specific Strategies
Develop physical boundaries	Limit or cease access to the Internet. Presence of partner while using the Internet
Develop psychological boundaries	Review relationship contract, review definition of infidelity
Manage accountability, trust, and feelings	Validate and normalize, hearing the betrayed partner, acknowledge the sexual and/or emotional nature of the cyber relationship, discuss the actual events and their impact on each person
Increase "at-fault" partner's awareness around etiology of the cyber relationship	Explore motivations, explore potential relationship needs, work on boundaries, insight-oriented questioning
Assess the couple's context and readiness for change	Ask about negotiation skills, previous positive relational experiences, previous history of infidelity throughout the generations; evaluate relationship expectations; identify goals for both individuals and the couple; assess commitment
Assess the frequency of cyber infidelity	Determine whether it is an addiction; evaluate whether there are physical issues contributing to the problem; evaluate expectations of gender and if or how they play into the relationship; clarify presence of third person
Work toward forgiveness	Assess willingness to move toward forgiveness; psychoeducation around forgiveness as a decision

Sexting

"Sexting" is a relatively new phenomenon that has come out of the use of new electronic media and refers to the sending and receiving of sexually explicit photos and/or text messages of a sexual nature by means of a portable telephone with a built-in digital camera. Short videos can also be sent. In a study conducted among 5,187 adults aged 40 or so, Wysocki and Childers (2011) reported that 29% of them, specifically 35% of women and 25% of men, admitted having sent and received text messages of a sexual nature. Moreover, the proportion of individuals who had sent nude or nearly nude photos of themselves via email or from their cell phone was 51%. The actual percentage was 60% for women and 45% for men. These results highlight a marked prevalence of the phenomenon, extending well beyond adolescence and the stratum of young adults. In addition, they reveal that women are significantly more active than men when it comes to sexting. Additional studies conducted among large samples of teenagers

(National Campaign, 2008) and mostly young adults (Benotsch, Snipesa, Martin, & Bul, 2012; Gordon-Messer, Bauermeister, Grondzinski, & Zimmerman, 2013; Lenhart, Ling, & Campbell, 2010; Nagel, Cummings, Hansen, & Ott, 2013) confirm that this type of sexual activity occurs with remarkable frequency (i.e., 20% to 85%). The large size of the samples (ranging from 763 to 3,447 participants) allows us to identify a variety of the sometimes deleterious consequences that can ensue as a result of these virtual sexual behaviours. For example, the study by Nagel et al. (2013) indicates that 76% of 1,064 participants had sent a sexually suggestive text message and 34% had sent a text containing a nude photo. Needless to say, these sex text messages can be found on the Web and forwarded quickly to social networks.

Because research on sexting is recent, analysis of the phenomenon's causes is preliminary and the explanatory assumptions, heterogeneous. From a social perspective, sexting is, for some authors, a manifestation of hypersexualization and objectification of the human body in general, and the female body in particular (Dake, Price, Maziarz, & Ward, 2012). By extension, sexting has also been depicted as a dangerous avenue, often leading to harassment, bullying and sexual coercion (Farber, Shafron, Hamadani, Wald, & Nitzburg, 2012). Other specialists maintain that these new forms of communication are mostly the sign of a liberalization of sexual mores and an original strategy for

intensification of the seduction process in dating or established couples (Parker, Blackburn, Perry, & Hawks, 2013). Finally, from a clinical standpoint, it would be important to be able to validate whether these sexual behaviours can be interpreted as symptoms of dysfunctional interaction patterns marked by exhibitionism and voyeurism. However, empirical evidence exists to show that these behaviours can signal the presence of an attachment style characterized by abandonment anxiety (Weisskirch & Delevi, 2011). In those cases, individuals who believe themselves unworthy of love and need constant reassurance seek to mitigate their feelings of insecurity by adopting a variety of sexual initiatives and behaviours, such as sexting, to establish their worth and retain the attention of their spouses or potential romantic partners. Finally, some claim that sexting represents a new opportunity accentuating the risks of cyber infidelity (Wysocki & Childers, 2011). As yet, none of these assumptions is backed by a body of evidence. It will therefore be necessary to evaluate their accuracy in the context of new research. In the meantime, prudence is necessary. Sexting is a complex behaviour that is evolving and adopted by different individuals in a variety of circumstances. Consequently, the determinants and adaptive value of these new sexual activities undoubtedly vary on the basis of those characteristics.

New clinical challenges

Many clinical issues are raised in light of the new phenomenon that is sexting and will face clinicians in the future (see text box).

- Is sexting associated with sexual precocity, hypersexualization and the number of sex partners?
- What place will cyber sexuality occupy in the lives of emerging adults?
- What effects can sexting have on committed relationships?
- Will sexting contribute to an increase in cyber infidelity?
- What are the legal and psychological consequences of sexting?

Clinical recommendations

Owing to the prevalence of sexting, we recommend that clinicians, and more specifically those working with adolescents and emerging young adults, raise their awareness of this phenomenon and include, in their assessment protocol, screening questions to properly circumscribe the characteristics, causes (e.g., peer pressure, attracting attention, having fun, joking, feeling sexy, sending a sexy "gift", flirting) and consequences (embarrassment and bad reputation for oneself and one's family; disappointing family, friends or someone else; regrets; problems at school; negative image in the eyes of a future employer) (National Campaign, 2008).

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COUPLES

AN AREA OF FOCUS FOR PSYCHOLOGISTS AND RESEARCHERS IN QUEBEC

Prof. **Catherine Bégin**, of the Université Laval, is interested particularly in eating disorders and obesity. More recently, she has contributed to research initiatives on couple relationships in persons with a weight problem.

Dr. **Claude Bélanger** is a full professor with the Department of Psychology at the Université du Québec à Montréal and an adjunct professor with the Department of Psychiatry at McGill University. He is interested in the cognitive and behavioural determinants of conjugal adjustment, and the impact of anxiety disorders and physical and mental health problems in conjugal partners.

Dr. **Sophie Bergeron** is a psychology professor at the Université de Montréal, where she carries out work on assessing the efficacy of psychological and medical interventions in the treatment of dyspareunia, and on the role of various affective, cognitive and conjugal variables that impact the non-resolution of that problem.

Prof. **Sophie Boucher** is a psychologist and professor with the Department of Sexology at the Université du Québec à Montréal. The focus of her work includes conjugal violence and personality factors that may contribute to establishing or maintaining different types of violent dynamics within couples.

Prof. **Audrey Brassard**, of the Université de Sherbrooke, carries out work, in particular, in the area of conjugal and sexual functioning in adults, romantic attachment, and predictive factors of distress and conjugal violence.

Dr. **Natacha Godbout**, a psychology professor at the Université du Québec à Montréal, is interested in the long-term effects of childhood traumas, particularly on couple relationships.

Prof. **Francine Lavoie**, of the School of Psychology at the Université Laval, carries out work on couple relationships in young people, particularly violence in romantic and non-romantic relationships during adolescence and sexual abuse. She is also interested in young people's opinions with regard to sexualized social activities and sexting.

Prof. **Yvan Lussier** leads the Couple Psychology Laboratory at the Université du Québec à Trois-Rivières. His interests include the development of intimate relationships, provisional models of dyadic adjustment and conjugal violence.

Dr. **Heather MacIntosh** is a psychologist and professor in the School of Social Work at McGill University. Her work is on the long-term effects of childhood traumas on intimate relationships, as well as on same-sex couples.

Dr. **Katherine Péloquin** is a psychology professor at the Université de Montréal, where she carries out work in areas such as assessing the impacts of infertility on couples, assessing the specific needs of couples being followed for fertility treatments, and developing interventions to build well-being in those couples.

Prof. **Stéphane Sabourin**, of the Psychology Department at Université Laval is interested in the functioning of couples, particularly the functioning of couples where one partner has a personality or other mental disorder.

Prof. **Gilles Trudel**, of the Psychology Department at Université du Québec à Montréal is interested in the relationship between the conjugal functioning of retirees/the elderly and moderate or severe psychological distress. He is also interested in sexual dysfunctions and sexual functioning in retired and elderly couples.

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