Karen Skerrett · Karen Fergus *Editors*

Couple Resilience

Emerging Perspectives

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Editors

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To my family, for their love
and inspiration – KS

To Ken, for your love and support,
day in and day out – KF

And to the resilience of couples everywhere

Preface

The capacity to deal effectively, even creatively, with the challenges life brings our way is a topic of endless interest to scholars, clinicians, and researchers from a wide variety of disciplines. Over time, the focus has expanded from how one adapts in the face of adversity to how one might thrive. This book broadens the focus even further by applying the concept of resilience to relationship dyads and, specifically, to the ways in which resiliency expresses itself within an intimate relationship. Also of interest are the processes underlying this ability for relationships to endure adaptively and for partners to grow together in the face of life's ups and downs. A primary motivation for embarking on this project was a keen interest in the ways in which committed relationships impact coping and the ways in which coping efforts shape a relationship. It reflects the shared passion of two academics with originally independent interests in couple adaptation and the relational forces that promote coping. Over 10 years ago and in two different countries (USA and Canada) we had been individually studying couples who were coping with a breast cancer diagnosis. We discovered that we were both intrigued by a similar finding that couples with better outcomes on a variety of dimensions approached the cancer challenge from a unified, 'team' perspective. Our interests have since developed into an ongoing collaboration, one that is nourished by the desire to explore new ground in the couple relationship literature. The goal of this volume is two-fold: (1) to identify dynamics and properties unique to relational resilience and (2) to showcase the cutting edge thinking of scholars who are investigating these dynamics in various contexts. This book is intended for relationship scholars, those interested in deepening their understanding of resilience in intimate contexts and is suitable for courses in counseling, health, psychology, and social work.

Decades of work have examined resilience – the ability to transform challenge and adversity into adaptive outcomes – as an individual trait or characteristic. Despite the vast literature on individual resilient processes and outcomes, little has been done to examine qualities specifically involved in couple resilience. We have long known the profound impact close relationships have for the health and well-

being of partners in committed relationships. However, the couple literature, like psychology in general, has been skewed toward an emphasis on the more problematic, as opposed to life affirming, aspects of relational dynamics. This oversight has, in turn, contributed to a tendency to underestimate the human capacity to thrive and grow through challenge, as well as the capacity to grow as a relational entity in response to a shared challenge. This volume is our initial attempt to address such a gap by expanding current understanding of dynamic, growth promoting processes, as well as to identify resilient qualities that may be exclusive to the couple relationship. Ideally, this will lead to further investigations of the specific relational variables that can be identified and linked to resilient outcomes among couples.

Over the course of the past decade, one relationship process has emerged with greater frequency and clarity as critical to couple resilience. This process has to do with the couple's ability to approach life's challenges with a collective orientation that draws upon the couple's unique resources (both shared and individual). Variously referred to as 'communal,' 'dyadic' or 'collaborative' coping, and 'weness', this is the first volume to focus on this dynamic specifically, and to explore its promise and potential for relationship functioning. Accordingly, the construct of we-ness serves as an organizing principle for the volume with each contributor speaking either to an *integral facet* of the 'we' such as sexual intimacy, mutuality, shared memory, the capacity to forgive, or to the *holistic integrity* of the 'we' as in the 'essence' of a marriage, the intersubjective processes that bind partners together, or an examination of interpersonal coping within its broader sociocultural context.

It is important to situate the notion of committed partnerships within a broad historical, cultural and economic context. During the last half of the twentieth century, for the first time in human history, divorce replaced death as the most common endpoint of marriage. Since then, new options have evolved for the establishment of mutually exclusive and enduring dyadic relationships, or pair-bonding. These alternatives include but are not limited to cohabitation and non-married co-parenting. The factors behind the death-divorce shift are associated with and driven by three changes: the increased lifespan in western civilization, the shift in biopsychosocial roles of women, and legal and social value changes (Pinsoff, 2002). Because these shifts are likely to endure as long as the motivating conditions continue, Pinsoff (2002) calls for marital theory development to be replaced by the more inclusive notion of 'pair-bonding theory' as a way to acknowledge and address the viability of these multiple arrangements. In the spirit of such clarity, this volume locates marriage as a permanent pair bond and a relationship that is predicated on a love based, mutual value commitment to a lifelong often monogamous partnership. We acknowledge here that some long term, intimate partnerships also entail sexual agreements where it is normative and acceptable for partners to engage in sexual relations with others outside of the relationship. Such relationships would still fall within the scope of this work because there remains an intentional commitment to a particular other as the primary attachment and love figure. It reflects a Western civilization perspective, essentially North American and Euro-American and Euro-Canadian.

Specifically within the last 40 years, marriage and family life has been destabilized by two powerful forces: progress toward equality between men and women, and the growth of socioeconomic inequality and insecurity. These trends have changed the risks, rules and rewards of marriage (Coontz, 2014). The many alternatives to marriage referred to earlier, coupled with greater expectations for mutuality and equality, have resulted in the institution of marriage being more intimate, fairer and less violent but also have made it less likely that individuals will stay in unsatisfactory marriages (Coontz, 2006). In general, African Americans have experienced the same trends as White and Hispanic North Americans but only more so. Individuals are increasingly pairing off along class and education lines (Coontz, 2014). For example, the college educated are currently more likely to get married and stay married. Finkel (2014) argues that today's average marriage is weaker than the average marriage of yore in terms of satisfaction and divorce rates, but that the best marriages are much stronger. In describing the evolution from the companionate to the self-expressive marriage, he claims Americans have gradually elevated their expectations of marriage. The expectation that marriage will contribute to one's personal growth has resulted in unprecedented high levels of marital quality. The caveat is that such high quality is only possible for those able to invest a great deal of time and energy into the endeavor. Given that 'being married' is no longer sufficient motivation for staying married, and that there are socio-cultural and legal structures in place now that make it more acceptable and easier for partners to separate, efforts to unpack the components of the venerate 'optimal marriage' are needed. It is a good time to reexamine those components empirically and conceptually, something we have endeavored to do here under the umbrella of 'couple resilience.'

We have organized the volume in the following way. The initial chapters offer an overview of the domain of resilience in couples, defining the territory and summarizing significant literature. The topic is introduced from two sides of the coin: exploring the resilience afforded couples through this mutual self-sense or 'we-ness,' and then examining what it is about this 'we-ness' that promotes resilience. We then go on to elaborate on particular processes that contribute to, or underlie, couple resilience such as neurobiological and sexual processes, and how the concept of resilience applies to specific populations such as gay and lesbian couples, or couples where one partner is HIV positive or affected by cancer. The final section of the book focuses on empirical investigations or programs of research that examine resilience through a particular lens such as the importance of partner identification with the relationship, partners' mutual prioritization of the relationship, and the relevance of 'we-talk' in relationship-defining memories and its association with marital satisfaction. The final chapter in this section on the process of forgiveness was intentionally selected also to be the concluding chapter in the sequence of contributions – for where would 'we' be without the ability to forgive ourselves as well as our partners in our bumbling attempts to adapt to life and the unsavory array of challenges it throws our way, each time anew.

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Leslie S. Greenberg, Ph.D., is a distinguished research professor emeritus of psychology at York University in Toronto. He is the author of *Emotion-Focused Therapy: Theory and Practice* (2010) and has coauthored *Emotion in Psychotherapy* (1986), *Emotionally Focused Therapy for Couples* (1988), and more recently *Emotion-Focused Couples Therapy: The Dynamics of Emotion, Love, and Power* (2008) and *Working with Narrative in Emotion-Focused Therapy* (2011). He has received the Distinguished Research Career Award of the International Society for Psychotherapy Research and the Distinguished Professional Contribution to Applied Research Award of the American Psychological Association as well as the Canadian Psychological Association Professional Award for distinguished contributions to psychology as a profession. Dr. Greenberg is a past president of the Society for Psychotherapy Research (SPR) and an originating member of the Society of the Exploration of Psychotherapy Integration (SEPI). He conducts a private practice for individuals and couples and trains people in emotion-focused approaches.

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About the Editors

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Part I
Couple Resilience and We-ness

Chapter 1
Resilience in Couples: A View of the Landscape

Karen Skerrett

Resilience in Couples: A View of the Landscape

There continues to be considerable interest in the properties and processes that promote optimal functioning in the lives of individuals and committed partnerships (Fehr, Sprecher, & Underwood 2009; Maisel & Gable, 2009). Optimal functioning, including factors such as strengths, virtues, resilience, compassion and positive emotions, qualifies what makes life most worth living and is placed in complementary position to the traditional problem-focused or deficit-based paradigms.

If we attempt to identify exactly what optimal functioning looks like for individuals, let alone couples, it becomes obvious that this complex concept is both dynamic as well as responsive to the multiple challenges life presents across the span of togetherness. What may be optimal for a newly partnered pair is quite different than what will be optimal 5, 15 or 40 years forward. As individuals live longer, it is important to utilize concepts that are at once representative of particular relationship dynamics as well as flexible enough to accommodate change over time. The dynamics must incorporate those challenges that arise from the normative evolution of individual developmental change, "natural resilience" (Bonanno, 2005), as well as challenges of an unanticipated or traumatic nature. In this chapter, I propose an expanded view of resilience and explore it as a couple phenomenon as compared to individual resilience, with unique qualities and processes. I conclude by offering directions for future research and suggestions for therapeutic, educational and enrichment work with couples derived from the dynamics proposed.

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Coping, Resilience and Optimal Functioning

The related concepts of resilience and coping remain at the foreground of attempts to understand the qualities that assist couples to respond to challenges over time. While concepts of optimal functioning, flourishing, resilience and coping exemplify life enrichment models of behavior, it is important not to confound what might be subtle, yet important conceptual and practical differences between them. Flourishing is typically defined as a state of optimal mental health, one in which individuals not only feel good but do good (Catalino & Fredrickson, 2011). Flourishing may or may not involve the presence of adversity or stressors. At this level of functioning, one is said to be "thriving." Resilience, on the other hand, depends upon two conditions. There must be the presence of a significant threat or risk to one's wellbeing and second, there must be evidence of a positive adaptation despite the adversity encountered (Janssen, VanRegenmortel, & Abma, 2011). If a stressor is perceived as threatening, different types of coping processes are activated and the mobilization of strengths further influences the extent to which the threat unfavorably affects one's functioning and development. Ungar and Lerner (2008) state that the study of resilience and positive development across life are essentially the same enterprise. They make the important distinction that while the examination of positive development does not presuppose development under stress, the notion of resilience is usually reserved for those situations where successful growth is beyond that which is expected given the challenges of daily life. They also argue for an expanded focus that includes both the examination of coping with adversity and loss, as well as the examination of positive emotion, psychological strengths, and the regenerative capacity necessary to achieve growth and healthy longevity.

Resilience, most often defined as the capacity to bounce back after challenges (McCubbin & McCubbin, 1988), developed from the domain of developmental psychology and the positive adaptation of children under adverse circumstances (Rutter, 1987). As a concept, resilience continues to hold wide appeal across a variety of disciplines and Richardson (2002) suggests that it is best seen as a metatheory, one that incorporates many areas of inquiry to explore individual strengths and developmental outcomes. Examinations of resilience have been extended to later periods of the lifespan including old age (Blieszner, 2007; Cheung, 2008; Janssen et al., 2011; Masten & Wright 2012; Yorgason, Piercy, & Piercy, 2007) as well as to the study of family systems (Black & Lobo, 2008; Walsh, 2011).

This chapter builds upon the work of Walsh (2011), Jordan & Carlson (2013), Surrey, Shem, and Bergman (1998) and others (Fergus, 2011; Kayser, Watson, & Andrade, 2007; Lepore & Revenson, 2006; Luthar 2006; Reid, Dalton, Laderoute, Doell, & Nguyen, 2006; Singer & Skerrett, 2014; Skerrett, 2010, 2013) by attempting to conceptualize a unique aspect of adult relational resilience, one reflected in a property called couple we-ness. Evidence is accruing that we-ness and the capacity to cope dyadically may have a protective influence on couple adjustment (Fergus, 2011; Singer & Skerrett, 2014). Despite the vast literature on individual adult resilient processes and outcomes, little has been done to highlight qualities specifically

involved in couple resilience. We are not claiming we-ness to be the only or preferred way that couples respond to the challenges of relational life but rather offer it as a phenomenon that may be particularly unique to couple coping processes. Clearly, just as there are multiple pathways to resilient outcomes for individuals, the same is true for couples. Key components of this dynamic emerged from ongoing, qualitative research in several groups of couples (Singer & Skerrett, 2014; Skerrett, 2013).

Resilience in Adulthood: The Big Picture

Students of adult development are increasingly being encouraged to pursue positive functioning, the rationale being that deficit-based approaches do not adequately address the full range of human potential. In fact, Kelley claims (2005) that psychologists have dramatically underestimated the human capacity to thrive after adversity and promotes the notion that all humans possess a natural capacity for resilience. Due to the recent advances in neuroscience, we now know that biochemical, genetic, and behavioral factors act together to restore our emotional equilibrium and that many individuals demonstrate astonishing natural resilience to the worst of life's experiences (Bonnanno, 2009). Bonanno has conducted numerous studies documenting the varieties of resilient experience, focusing particularly on individual reactions to the death of a loved one as well as responses to war, terror, and illness. The bulk of his work points to the fact that the majority of individuals, after an initial period of distress, return to functioning within a matter of months. Seligman and Fowler (2011) suggest that resilience is normally distributed- on one tail of the distribution are a minority who collapse in the face of adversity, in the middle are the great majority and on the other tail are those who achieve a higher level of functioning than they began with, so called post-traumatic growth. Lepore and Revenson (2006) proposed a tripartite process of responding to stressors: recovery, resistance and reconfiguration and Levine and colleagues (2009) examined comparisons between resilience and posttraumatic growth.

Major findings from over four decades of research in resilience are relatively consistent and are generally summarized in terms of protective and promotive factors associated with positive outcomes in diverse situations and populations. These factors, such as good parenting, self-regulation skills, or community resources, underscore that resilience arises from ordinary processes that serve to protect development under diverse conditions (Masten, Cutuli, Herbers, & Reed, 2009). Protective factors associated with coping from a couple perspective may include but not be limited to communication skills, beliefs regarding commitment, the relationship quality prior to the challenge and individual levels of mental health and religiosity/spirituality. Marriage itself, is widely thought to be a key protective factor for adult functioning (Kiecolt-Glaser & Newton, 2001). What exactly it is that is protective about marriage was part of the impetus for initiating our current research projects (Singer & Skerrett, 2014).

The two major approaches used to study resilience are described as variable-focused and person-focused (Masten & Wright, 2012). In variable focused, attempts are made to identify patterns among measures of characteristics of individuals, environments, and experiences in order to isolate what accounts for a good outcome when risk is high. Person-focused approaches typically look to case studies or the examination of a highly resilient sub-group of individuals in order to understand their assets and protective factors. However, developmental theories about resilience are considerably more dynamic than the research to date and assume that many levels across multiple systems are involved in the processes that lead to resilience (Cicchetti & Curtis, 2007; Curtis & Cicchetti, 2003; Masten & Obradovic, 2007). Pathways through life do not depend solely on individual or relationship strengths. Social location, gender, race and ethnicity, social class, and sexual orientation are all important determinants of life's opportunities and constraints.

Despite the fact that the resilience literature evolved through the study of children and adolescents recovering from traumatic conditions, results are often applied to adult functioning. Bonanno (2005) identifies two key differences between resilience in children and resilience among adults. First, he claims that resilience among adults represents a unique and empirically separate outcome trajectory than that associated with recovery from trauma in children and that there are multiple factors that inform adult resilience. Second, adults who experience potentially challenging experiences typically do so in the context of otherwise normal circumstances. The potentially traumatic event may be of brief duration and most adults have access to a greater array of resilience promoting factors. This highlights the particular relevance of behavioral flexibility, including emotional regulation, for adult resilience. Consider the couple encountering a partners' job loss. While often very disruptive and potentially traumatic, it is likely that partners bring a coping repertoire that includes previous experiences with job change or loss, financial resources in family and friends, the wage earning potential of the other partner and, critically, the support and understanding potentially available within the relationship itself.

For adults, resilience may be more of an inferential concept. It still involves some expectations for behavior and some exposure to challenge. Always implicit is the capacity for transformation and change—a property we now know extends well into old age. Bonanno (2005) summarizes adult resilience as characterized by a stable trajectory of healthy functioning across time, as well as this capacity for generative expression and positive emotion. Richardson (2002) suggests that what may be key to long term healthy functioning is the repeated reintegration of resilient outcomes that result from dealing with challenges. While resilience can be cultivated all along the family life cycle and learning positive coping strategies can enhance individual and family functioning during normative and unanticipated challenges (Patterson, 2002), less work has been done to examine these processes exclusively in committed relationships.

Neff and Brody (2011) agree that more needs to be known about the amount of stress marriages can withstand and the factors that aid in developing greater resilience. Seeking to address this gap, they examined resilience in two groups of couples-those in early marriage and those following the transition to parenthood.

They identified that one potential mechanism underlying the development of couple resilience was the experience of success in managing difficulties. If couples have adequate resources for addressing moderate stress in their lives, exposure may cultivate the belief of effectiveness. They concluded that spouses need both good initial resources plus the chance to practice in order to develop resilience.

Couple Resilience: From "I" to "We"

A pioneer in calling for systemic approaches to resilience, Walsh (2011) has long advocated nesting the concept into a multileveled, contextual perspective. Challenging the individualistic cultural bias, Walsh's definition of resilience is relationally based; one in which life crises are approached as shared challenges and a positive outlook is critical as is the ability to utilize spiritual, transcendent resources. While we know that every marriage brings not only promise but substantial risk, to date we know more about the harmful processes in relationships than we do about what makes them work (Maisel & Gable, 2009).

Walsh (2011) identifies empathic reciprocity as the key to relational resilience. Also described as relational empowerment (Fishbane, 2010, 2013) compassionate love (Neff & Karney, 2009) and relational competence (Hansson & Carpenter, 1994), relational resilience encompasses a collective emotional and social intelligence that includes awareness and factors such as generosity, curiosity, healthy boundary setting, and interpersonal sensitivity. These elements can be thought of as contributing to the "bounce back" quality of resilience and are essential to relational repair work during couple distress (Fishbane, 2010; Skerrett, 2004).

From a neuroscience perspective, we are talking about neuroplasticity. Resilience depends on the brain's capacity to change the patterns of energy and information or neural connectivity in response to new experiences (Siegel, 2006). Clinical scholarship has demonstrated that the reason it is so difficult for clients to modify self-defeating narratives is because these narratives are woven into the fabric of internal states which are hard-wired in the sense that they are neurologically based and automatically activated in daily living, often without conscious awareness (Atkinson et al., 2005). The foundation for change lies in the brain's ability to modify such wired-in painful experiences by activity both within an individual mind and between minds. When partners work through a stressful set of circumstances in their lives and arrive at a state of well-being, they have moved toward a condition of greater neural integration. Neuroscience literature clearly frames resilience for intimate partners within a system of mutual regulation (Atkinson, 2005; Cosolino, 2006; Fishbane, 2007, 2013). Many biological pathways contribute to this multifaceted process. Each partner in a relationship brings unique sets of responses that have been epigenetically translated into actual brain structures (Cosolino, 2006). These systems work alongside the attachment system, are embedded in procedural memory and prepare partners to move toward or away from each other, based on history and experience. Biologically, in a primary attached relationship, it is more efficient for

one partner to manage the other's arousal state than their own (Solomon & Tatkin, 2011). This reflects the reality of our wiring such that at close distance, one can see into the other's internal state before recognizing one's own. Such a regulatory system highlights the interactive, mutual nature of couple resilience (Solomon & Tatkin).

Another critic of the traditional separate self model of development, Jordan (1992) outlines five components of relational resilience. They are supported vulnerability, mutual empathic involvement, relational confidence and empowerment, and creating meaning in expansive relational awareness. Jordan posits disconnection as the primary source of stress in individual lives and sees change as resulting from awareness and the development of a more differentiated and flexible means for reconnection. This Relational-Cultural theory of the Stone Center (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991) has previously been applied to couples (Skerrett, 2004, 2013).

A recent term intended to capture relational dynamics is social resilience (Cacioppo, Reis, & Zautra, 2011). This notion emphasizes an individual's capacity to work with others, is intrinsically multileveled and can result in outcomes that transcend those that would be obtained from individual resilience alone. According to these authors, what is unique about social resilience is the potential for coordinated benefits, the sense of connection and 'we-ness'.

Building on the earlier work of Surrey, Shem, and Bergman (1998), 'we-ness' has been defined as the sense of mutual identification a couple describe as the lived experience of their relationship. Couples frequently and spontaneously use the words "we" and "us" in talking about this quality (Skerrett, 2010). It is a kind of thinking that reflects receptivity and the integration of the other's perspective in one's own and has been found to have defining as well as adaptive qualities throughout a couple's relationship (Skerrett, 2003, 2004, 2013). Reid (personal communication, 2010) in describing his development of a we-ness scale, stated that the measure incorporates a high level of self-other awareness and self-reflexivity and that partners can see how these two components interconnect. Just such a level of self/other and relationship awareness is what creates the "we." Reminiscent of Bowenian thinking (1978) and Bader and Pearson's (2000) model of couple differentiation, we-ness actually supports both the independence of partners and their capacity for intimacy.

Differentiation, the dynamic process of self-expression, also means being able to tolerate, support, and enhance one's partner in doing the same. This lays the framework for connection and individual as well as relational growth. In fact, Reid et al. (2006) reports that changes in partners sense of self in relation led to robust improvement in marital satisfaction in two studies and a follow-up.

Thus, a growing body of scholarship is accruing that points to the profound impact close relationships have on health and well-being. Specifically, marriage appears to be related to positive health and positive psychological outcomes when the marriage is happy and non-distressed (Hawkins, 2005; Kiecolt-Glaser & Newton, 2001). Yet, given the reality that life presents many challenges that impact the emotional tenor of a relationship, how is it possible to deal with the stressor *and*

think and act with the best interests of the relationship in mind? How might the individual stories of wants and needs translate into a joint story that might enhance coping efforts? With these questions in mind, a series of studies was designed to explore ways that couples describe coping with various challenges in their relational lives and highlighted the critical importance of qualitative aspects of the relationship (Singer & Skerrett, 2014; Skerrett, 2010, 2013).

Story Projects

Story-telling in nonclinical (Skerrett, 2010) and clinical (Skerrett, 2013; Singer & Skerrett, 2014) couples was examined and has been reported elsewhere. The protocol for the nonclinical sample can be summarized briefly. Thirty couples were identified through convenience sampling and paid a nominal fee for their time. Twenty one were Euro-American, seven were African American and two were Asian. All were in first marriages from 30 to 43 years in length. By virtue of their marital longevity, they offered more experience with meaning making and relational wisdom. These were couples who had time to develop their shared stories and as volunteers, self-identified as being willing to talk about their relationship. Couples were interviewed at length using the Life Story Protocol of McAdams (2001). Interviews were tape-recorded and lasted from 1 to 2 h. Partners were then asked to write a two page summary based on the interview questions, calling it their ‘Life Story.’ Qualities of ‘good enough’ stories were identified and couples were then coached by the investigator to blend their individual life stories into a ‘Couple Story’. Interview transcriptions were read by the investigator and three outside raters familiar with the Life Story Protocal and theme identification (see McAdams, Diamond, & de St. Aubin, 1997). The verbatim transcriptions were read multiple times, coded and the coded interviews became the data source for evaluation. Reliability across all raters on all transcriptions achieved 91 %. The theoretical framework followed the phenomenological tradition, particularly Giorgi’s method of data analysis and coding (1985). Each partner’s narratives were organized into the broad categories addressed by the interviews.

The majority of our couples (22) were able to develop ‘couple-stories’ and even name their stories, such as “Caring and Sharing”, “The Dream Team”, “The Resilient Duo,” and “Everyday a Little Better”. The nine couples who had difficulty creating a joint story from the directions given told stories with considerably less evidence of reflection. They gave a more superficial reporting of life events, with less complexity, coherence or thoughtful interpretation of their experiences. For example, one husband commented, “I gotta tell you, I really tried to think about these questions but I can’t come up with much. I’m a guy that just tries to do what needs doing-I guess I’m not a thinker about these kinds of things”.

The couple stories, those shared by both partners about their relationship appeared to lend a sense of meaningful coherence and guide for engagement. The stories reflected a mutual identity that couples spontaneously described as the experience of ‘we-ness’.

Couples who were successful in creating a couple story commented that the task assisted them to expand their awareness of the relationship- their 'we' consciousness.' The process of co-creating their stories appeared to enhance relational processing or the ability to think about self in relation to other, take perspective or empathize and apply that knowledge to relate to one another (Reid et al., 2006). These partners also remarked that the mutual vision (the 'we-ness' of their partnership) was the quality that helped them not only adjust to life's challenges, but also helped them develop as individuals.

Since the initial project, we have continued to collect couple stories in couples presenting for treatment (Singer & Skerrett, 2014; Skerrett, 2013) as well as non clinical couples to a current n of 46, expanding the number of years married from 15 to 55 years. They now include African American, Indian, Asian and partnered but unmarried LGBTQ pairs.

Our data analysis increasingly supports that the notion of relational resilience can be exemplified in 'we-ness.' Stories show evidence of partner willingness to work together, interpersonal sensitivity, generosity and the ability to set boundaries with a confidence that both separate and coordinated action would lead to mutual benefit. In addition, stories qualifying as 'we-stories' showed evidence of security, empathy, respect, acceptance, pleasure, humor, and shared meaning and vision (SERAPHS) (Singer & Skerrett, 2014). The following story dimensions emerged as key: self/other and relationship awareness; empathy and respect; mutual vulnerability; the joint creation of meaning; skill sets to support relational positivity, and the reintegration of relational wisdom. We will look at each proposed component in turn. As with any systemic model, components do not operate linearly but in an integrated, dynamic fashion where each component builds off and enhances others.

Self/Other and Relationship Awareness: Empathy and Respect

Essential to relational resilience is the ability to notice what it is we are picking up in the internal state of the other, then to internally self-reflect and identify one's own thoughts, feelings, wants, and desires. Once known, individuals can develop the ability to congruently express and expose more of who they are to one another. Partners can learn how to notice the relationship and understand how each person contributes to relationship functioning. To put in other terms, it is the capacity to shift from the individual brain to the couple brain in a back and forth manner (Badenoch, 2008). Through the process, couples can distinguish self from other, take ownership of the personal and appreciate how an individual response has consequences for a partner and how the partner's response reciprocally impacts their response. In this way, they identify with the relationship and understand that it is an entity incorporating but separate from either of them as individuals. They are also learning to develop a coherent individual and couple narrative, which becomes grounded in a securely functioning relationship. Consciousness of the relationship is clearly the most challenging aspect of this dimension because it involves a radical

shift in awareness. Partners from western cultures raised within a separate self perspective, often view relationships from an egoic attitude, the familiar 'what's in it for me' and are unaccustomed to reflecting on the implications of their actions for the relationship. Yet it is precisely the ongoing cultivation of the relational dimension that can move partners out of a focus on their individual agendas and into an investment in a mission larger than themselves. This is captured in the comments of the following couples:

Bill: She's not like me. I like to have everything figured out ahead of time…my ducks in a row. When I know what I'm up against then I can plan.

Janet: And I'm more likely to go with the flow. I hardly ever read directions…I like to make it up as I go along. We never realized that it was those differences that kept us bickering so much of the time. My way used to make him nuts but when our daughter got sick, we found out that it's better to work together than against each other. If we talk about ways to plan and let me not plan, we like each other better and even get more accomplished. We have to get away from our own agendas and try to get the other's point of view.

Bill: Yeah, things definitely go smoother in our relationship when we can do that.

Another couple, married 44 years, put it this way:

Sally: It really took me awhile to realize I could be myself and still be part of this marriage. In the early years, we never went anywhere alone-we were like joined at the hip. After awhile I realized I couldn't figure out whether something was his thought or what I thought.

John: That's for sure. I think I got to resenting her cause I thought she just always went along with me and after awhile I think I started losing respect.

Sally: Yeah, that's probably when we started talking about how that habit wasn't helping our relationship very much.

Sally and John highlight the way in which empathy and respect are connected to self/other and relationship awareness. The ability to be aware, to notice the thoughts, feelings and actions of self and others, are foundational to the capacity to empathize with and ultimately respect those responses. The following dialogue, from a couple married 35 years, reflects that capacity as well as how it was nurtured over the years:

Mary-Lou: Stan was probably like most men…..unconscious! I spent a lot of time repeating myself and feeling so angry that I wasn't being listened to.

Stan: I have to admit I was pretty out of it but in my defense, I was trying to get a business started, we had young kids and I was totally focused on making it all work. I know I was just into myself.

Mary-Lou: Then we went through a spell where I had strange medical problems that were pretty scary for awhile. I felt so terrified and vulnerable and kept telling him I didn't know how I could take care of the kids.

Stan: That must have woken me up cause finally I really got how my focus on me all the time didn't let me appreciate what she was going through. She'd have to feel alone!

Mary-Lou: The medical problems cleared up-thank god- but we made a big decision during that time and that was to make time every week to talk together about what bothers us, what scares us, what we're facing that week. I cannot tell you what a difference that has made. I know it is not always easy for Stan to figure out what he feels but I have so much respect for the fact that at least he tries. I always feel closer to him cause I get what he is going through more.

Stan: Yeah, I actually look forward to our times. We have talked through some tough stuff.

Mutual Engagement in Supported Vulnerability

As Mary-Lou and Stan describe, one of the most difficult tasks individuals face is to recognize their fears, anxieties, and vulnerabilities and then expose them to their partner. Socialized in a culture that promotes independence, men and women alike see it as a sign of strength to operate like the Energizer Bunny—deny the impact and keep forging ahead. Empathy and compassion for a partner may come easier than self-compassion but it is a fragile gift. Without a capacity for self-compassion, it is common to revert to shame, blame, or avoidance, particularly under stress. There is considerable evidence for the value of mutual and active engagement in the relationship (Johnson, 2008) and for relying on the other which recursively strengthens couple bonds (Beitin & Allen, 2005; Ben-David & Lavee, 1996). Yorgason et al. (2007) clearly identified resilient outcomes when couples discussed their weakness and vulnerabilities over time. Here is where the idea of shared vulnerability becomes so important. When partners know that their real strength resides in the shock-absorbing capacity of the "we," it may encourage them to embrace, rather than avoid challenges.

The debilitating effects of isolation and disconnection are reflected by the comments of a couple, married 27 years:

Becky: We had a series of things happen in our family…my sister had a Down's child, our daughter was diagnosed with ADHD, Sam's job got shaky and I felt so alone with all of it. Like I was the weak one, the crabby one, the one who should have but couldn't take it.

Sam: Yeah, I actually felt the same but even worse 'cause it was my fault my job might put our family at risk. But when she started to talk about how she felt, I felt more OK to talk about me. I had no idea what all was going on in her head and it was a relief to know how she felt. I could reassure her or do something instead of feeling helpless, responsible and scared, alone.

Creating Meaning for the Relationship

The scientific study of meaning has repeatedly demonstrated that people who believe their lives have meaning or purpose appear better off (King, Hicks, Krull, & Del Gaiso, 2006; Lyubomirsky, 2007). The creation of "meaning" (understanding

where we've been, where we are, and where we're going) is one of the most human and critical tasks we face and a vital part of resilience (Walsh, 2011). Furthermore, those who find meaning following adversity or traumatic life events report better outcomes than those who do not (Janoff-Bulman & Yopyk, 2004).

While these represent studies of individuals, a growing scholarship suggests that the co-creation of meaning, a unified framework for understanding an experience, can be important for couples. Couples who constructed a unified meaning for a cancer diagnosis (specifically defining it as "our problem") found that it lent coherence, provided direction, and helped them manage the accumulation of stressors and illness demands (Skerrett, 1998). Indeed, in sharing their couple story, Mark and Justine described the effect of an ovarian cancer diagnosis on their relationship. They described not only the salience of mutual meaning but the fluidity with which it changed and evolved over time:

Justine: I struggled for a long time with the 'why me?' issue; I just couldn't make sense of it and I desperately wanted to make some sense of the whole thing.

Mark: She was really hard to live with for awhile…nothing I said seemed to make a difference and we were going in different directions.

Justine: When I had a recurrence and he came to chemo treatments with me, we had long times to talk and eventually we realized the way to make sense of what was happening was to pull together. There was no magical reason I got cancer…it just happened and if we did not work together, I would go under. WE would go under.

Mark: After that, we really started to get some traction. The ugly 'why me' question comes up from time to time, but we ask it together and try to figure stuff out together and it really helps. It helps me anyway.

The Construction and Maintenance of Relational Positivity

Our couple stories were filled with vignettes of the central role that positivity played in relationship quality, particularly among the longer married. Most often, it was a combination of spontaneous gestures that arose from mutual caring and affection and the use of humor and light-hearted good fun. Less often, the positivity was a conscious effort to inject good will or appreciation or desire to 'lighten up.' Lois and Bill, married 24 years, comment:

Lois: I came from such a grim, negative family. No one ever said a kind word, or at least that is how it felt. Of course, you heard about it if you did something wrong! One of the things I love about Bill is that he can defuse even the most challenging conversations. He can find something funny or offbeat or just lighten the mood and it makes such a difference to our life together.

Bill: I have learned how being positive, gets you more positive and that is really cool! Over the years, she has gotten more positive herself and I sure get the feeling she appreciates me! That, all by itself, makes me feel better.

Their brief interchange also exemplifies the recent finding that expressions of positivity, especially gratitude, promote relationship maintenance in intimate bonds (Gordon, Impett, Kogan, Oneis, & Kelter, 2012).

Now at the forefront of the work of leading neuroscientists, positive emotion is being given a central role in the body's ability to galvanize change and guide healing (Fosha, Siegel, & Solomon, 2009). From the neuroanatomic to interpersonal levels, relationships form and nurture the self-regulatory circuits that enable emotions to enrich, rather than enslave, our lives. The influential broaden-and-build theory of Frederickson and her colleagues suggests that positive emotions: (1) broaden people's attention and thinking, (2) undo lingering negative emotional arousal, (3) fuel psychological resilience, (4) build consequential personal resources, and (5) trigger upward spirals toward greater well-being in the future (Fredrickson & Branigan, 2005; Fredrickson & Joiner, 2002). Fredrickson (2006, 2013) found that individuals who experienced more positive emotions were more likely to find positive meaning in stressful situations. She writes that as these effects of positive emotion accumulate and compound over time, they carry the capacity to transform individuals for the better, making them healthier and more socially integrated, knowledgeable, and effective.

This literature as applied to couples points to the importance of creating, a "culture of positivity" (Gottman & Gottman, 2005). If the relationship itself can be seen as a source of positive emotion, couples are more likely to view the relationship as an entity that nourishes, sustains, and is worthy of time and attention. Such a belief set and related expectations promote relational empowerment and confidence, qualities that exert a synergistic effect on marital interactions.

Reintegrations of Relational Wisdom

Neff and Brody's (2011) work suggests that skills- relational or otherwise, must be given the chance to become habit and stress inoculations early in married life can have a positive effect on coping over time. Our couple stories suggest that the habit of we-consciousness promoted such relational wisdom. Each time partners struggled with a challenge and experienced a positive outcome, it became a part of the relational arsenal – a talent that could be returned to and honed again and again.

Resilient reintegration means to experience some insight or wisdom through these accumulated disruptions (Richardson, 2002). It requires the ability to identify, access and then reinforce adaptive responses-all of which rely on reflective capacities. Recycling through such a process results in reinforcement and strengthening of individual and relational resilience and confers potential protection. The growth and development of a relationship depends on such repeated resilient reintegrations that arise from both planned and unplanned challenges.

The following conversation between a couple married 40 years, is exemplary:

Joann: Somehow, we learned early on that you have to keep talking to each other or it will not work. It is not like either one of us had particularly great role models

for parents….maybe we saw what we did not like and decided to do it different but we made this agreement with each other to keep talking and it has not failed us.

Eric: Yeah, you can bet that was not always easy for me. Lots of times, I preferred to keep my pissy mood to myself but the more I (usually Joann) pushed me, the easier it got and I realized that staying on top of stuff really made a difference between us. It gives me a sense that we are a team and that she cares about me, no matter what.

Joanne: It really paid off when our son was sick, when Eric had a scare with his heart, when my brother died suddenly….by then, we had this habit of talking things out and it really kept us sane.

Eric: and together!

It is the narrative movement from emotional conflict to an end point of caring that elevates their particular story from simply a couple story to a we-story. Becoming aware of the various ways in which that happened became their relational wisdom. This is reminiscent of the work that identifies that the lessons narrators draw in telling a story (life lessons) are particularly associated with better adaptation and greater emotional maturity (Blagov & Singer, 2004). More vivid, positive and well-rehearsed favored stories are linked to greater levels of marital satisfaction (Alea & Vick, 2010). In addition, the sharing of more personally significant relationship memories (especially for women) produced greater intimacy among couples (Alea & Bluck, 2007).

Our stories suggest that the development of a we perspective is the epitome of relational wisdom. The capacity to craft and maintain a mindset of mutuality involves capacities for self reflection, attunement to self and other, the interpretation of rules and principles in light of the uniqueness of each situation, and the ability to balance conflicting aims. We suggest it to be the master virtue of relationship development, related to virtues of knowledge, curiosity, generosity, gratitude, compassion, built through mastering adversity, and cultivated across the lifespan of the partnership. These capacities are developed through dialogue such that the resulting story of an us or ‘we-story’ becomes a touchstone to what is most vital and precious in the relationship. It is this wisdom that can be passed forward to the generations that follow (Singer & Skerrett, 2014).

We propose that it is the synergistic dynamic of all the components of relational resilience that gives couples the distance and objectivity necessary to cope with ongoing challenges. The stressor, whatever it is, becomes disembodied from either partner and their we-ness becomes the source of relational resilience. It is not just about me or what is happening to me, but rather to “us” and the relational coping responses have different potential than either individual’s alone. Particularly because our relational schemas are prone to disruption under stress, having a clear and operational awareness of the “we,” equates with the resilience potential available to partners. The “we” functions as an umbrella both sheltering and all encompassing, with regular input from each partner to recursively inform and shape the “we.”

Suggestions for Future Research

A key limitation to the Couple Story Project research cited here is the relatively homogenous nature of couples examined. While we have and continue to expand story collection to a more diverse population, couples primarily represent white, educated, well-functioning partnerships. Plans are underway to continue to expand to a broader range of socioeconomic, ethnic and gender diversity.

Proposed next steps would include an examination of the various pathways to we-ness as well as the identification of other relationship attributes associated with strong states of "we." Might this vary by gender and does we-ness confer particular protective advantages for women or men?

We-ness should also be examined within various complex contexts involving multiple stressors. How might the mutuality of we-ness impact couples struggling with both chronic health conditions and multiple situational challenges? It would also be important to look at partner ability to cultivate and sustain we-ness under a variety of circumstances, for example the sudden vs. gradual onset of challenges or challenges that were solicited vs. those that were uninvited.

Research studies that are longitudinal and multi-method in design and follow couple resilience patterns across the life cycle would be ideal. Such designs would allow us to map out the specifics of what constitutes resilient outcomes for particular kinds of couples at particular points in time. Couples could be recruited who identified themselves as "strong" or well-functioning and could be our co-theoreticians in these foundational stages.

Implications for Relationship Enhancement and Therapy

These ideas represent a framework of positive, optimal couple functioning that attempts to locate the components of relational resilience within the relationship itself. Couple resilience is proposed to have a major role in relationship enhancement, assessment, and may suggest guidelines for couples in distress. Assessment of couple functioning is crucial, both to identify where in the resilience distribution a couple falls as well as to develop data sets of couple profiles.

Clinical work with couples reinforces the essential nature of self, other, and relationship awareness for change. ATUNE interventions (awareness, tolerance, understanding, non-defensive listening, and empathy) utilize comparable building blocks and propose similar elements as necessary to cultivate couple intimacy, friendship, positive affect, and shared meaning (Gottman & Gottman, 2005). Similarly, moving couples toward a COAL state (curious, open, accepting, and loving), promotes movement into a visceral, mutual state of regulation and that sweet spot of optimal brain plasticity (Siegel, 2006).

Since couples present for therapy in distress, it is unlikely that they are focused on the resilient qualities of their relationship. Some couples may never have considered

the idea. Paramount is the ongoing education of couples regarding the primacy of their relationship – that it is the cultivation of "we-ness" that operates as the safety and security system for both. They are in the care of one another. Without that understanding, neither can thrive. Helping couples to jointly focus on that third entity, their relationship, builds secure functioning and promotes the capacity to mutually amplify positive moments between one another. Gradually beginning to shift couple sights to their assets and strengths infuses the climate of the therapy with positivity, hope, and potential. For example, Sheila and Jim were a couple in their late thirties who were seeking therapy to help them co-parent their young children with less conflict. The individual online evaluations they completed (www.authentichappiness.org) indicated Sheila's lead strengths as curiosity, persistence, and kindness and Jim's as love of learning, creativity, and persistence. They were able to see how they could mobilize all of those assets, particularly love of learning, curiosity, and persistence to join together in building a joint platform that would provide options when they became polarized or deadlocked around a parenting issue.

The reflexivity component-building couple consciousness of the "we" is both challenging and essential. Since earlier research identified that optimal couple functioning depended on the ability of both members of the couple to define a challenging experience as "our problem" (Skerrett, 1998, 2003, 2010, 2013), several therapeutic techniques have shown promise in helping couples develop a "we" awareness. Teaching couples about the differences in self, other awareness, and their relationship not only from the earliest encounters but throughout therapy is vital. Pointing out the stories they have constructed around the challenge they face is a first step toward helping them re-craft more positive outcomes and expand their coping repertoire. Sheila and Jim had developed a story that they were "ineffective, stupid parents" who could never agree on what was best for their children and bound to conflict. A contributing storyline was that Sheila, as the fulltime parent, knew best how to discipline and relate to the children and that Jim should agree with and always support her decisions. They each had a tendency to stockpile resentments until one or the other "blew" which only further supported their mutual belief that they were "bad communicators." They could easily see that such meaning-making left little room for mutual empathy, understanding, compromise, or a successful outcome.

In contrast, the story of Susan and Brad offers a very brief illustration of the ways in which the elements of relational resilience can be worked with in therapy. Susan was a 59-year-old accountant who came to therapy for help with increasing feelings of sadness, despair about her 30-year marriage, and a sense of being imprisoned by the demands of work, family, and life in general. A diabetic previously struggling with numerous complications, she had been successfully stabilized and pronounced healthy by her doctor. She described feeling mystified as to why, in the face of such good news, she was so miserable. A driven perfectionist all her life, she knew she needed to modify her over functioning but could not seem to interrupt old habits. The self, other, and relationship awareness teaching began immediately with coaching on a strategy to invite her husband to join us. Brad told a story of similar levels of frustration, feeling "cut off" by Susan and not loved in the old ways even

after he had been supportive and attentive during her chronic and difficult health crises. He no longer felt needed by her and had "no clue" how to get her attention anymore. A successful accountant himself, he believed himself to be slipping into depression, gaining none of the usual pleasure he obtained from work, sports, or contact with their three adult children. They both agreed that if they did not redefine and revitalize their relationship, they doubted they would continue together.

They learned that in order to begin the challenging work of revitalizing their relationship, both would need to feel that they had a voice and that both would need to risk becoming reinvested in the relationship. Teaching essential brain basics oriented them away from blame and shame and toward their shared human biological nature. Our work revolved around building awareness of and compassion for the acute vulnerabilities expressed in one another's innate wiring and expressed in story form. As they shared the story of their meeting and early years together, we identified qualities of the relationship (we-awareness) they had developed that they summarized as "hard working teammates." They were coached to regularly notice the relationship outside of sessions and ask the questions: "Is it working right now? What am I doing that is contributing to where we are at?" They were reminded that they were responsible to bring only their self-awareness to the other and were not responsible for the thoughts, feelings, or behavior of their partner. This promoted the mutual ability to approach challenges from the question of "what do I need to learn to help us better function as a team"? Sessions were infused with techniques and homework to increase positivity such as individual and couple journaling (Niederhoffer & Pennebaker, 2009), everyday acts of caring (Lyubomirsky, 2007), gifts of gratitude (Emmons & McCullough, 2003), and positive re-storying (Singer & Skerrett, 2014; Skerrett, 2010).

Building from an earlier foundation of empathic knowing and the capacity for mutuality, we were able to identify together the ways in which they had gotten off track with one another and how they had begun to view the relationship as a problem rather than a resource for change. Gradually, as they came to understand the necessity for mutual compassion, responsibility, and re-engagement in the relationship, they began to report renewed energy and interest in one another. They worked together to craft a current vision for the relationship that they titled "caretaking teammates."

Conclusions

It is recommended that resilience be examined and explained as a couple phenomenon and a dynamic process qualitatively different than the combination of individual partner resilience. Drawing from Walsh (2011) and Jordan's (1992) identification of empathic reciprocity as the key to relational resilience, we have offered the concept of we-ness as the unique dynamic that characterizes couple resilience. Such a perspective may help to explain why, under the same conditions, some couples are resilient and others are not. It also allows us to examine whether the capacity for we-ness contributes to individual partner and couple stability and growth.

What remains is the complex work of systematically investigating each of the processes; identifying how they interrelate and which, if any, most contribute to optimal individual and couple resilience. For example, is the capacity for mutual empathy or the ability to activate positive skill sets more critical for we-ness and relational resilience? What kind and how much practice in the teamwork of we-ness is necessary? Can this best be taught through relationship education or through the long term 'school of hard-knocks'?

It is also crucial to identify the various indicators for treatment and intervention, as opposed to resilience promotion. If certain kinds of adversities in the lives of couples result in a natural return to pre-challenge states, intervention may prove to be contra-indicated. Likewise, relationship enhancement programs would be directed toward those circumstances that prove most amenable to change and growth.

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Chapter 2
Theoretical and Methodological Underpinnings of Resilience in Couples: Locating the 'We'

Karen Fergus

In the previous chapter, Skerrett demonstrates how relationship resilience is founded upon the couple's mutual self-sense or 'we-ness.' In this chapter, I examine this phenomenon from the opposite end – that is, what is it about we-ness that promotes resilient adaptation by couples? I propose that the 'we' may even in itself be considered an expression of resilience in the way that it maintains, expands and differentiates across time and experience. The *we* would not *be* if not for the capacity to weather the storms of loss, crisis, chronic stress, and major life transition. Such challenges in turn, when dealt with successfully, endow the relationship with a tensile strength or hardiness – even vigor – further preparing it for stressful yet unknown times to come. Resilience in this sense is the result of a spiraling interplay between adversity and relational resources with the couple's we-ness figuring as 'resilience in the raw' if you will, or as the relational essence (Reid & Ahmad, 2015) that precedes, and is brought to bear upon, the particulars of any given hardship.

As integral as we-ness is to couple adaptation, it is also highly elusive. Josselson (1994) indicates that of all the dimensions comprising relatedness "this sense of 'us'… is the hardest to talk about, partly because it exists so completely between selves" (p. 97). Finding ways to tap this interstitial third entity then becomes the challenge for academics and clinicians alike. Although post-modern perspectives on the nature of the self have successfully challenged the assumption of a monadic 'I' that is bounded and contained, the study of the individual nonetheless continues to profit from the clarity and relative simplicity afforded by persons being skin-bound. The study of couples in contrast, and specifically partners' unified self-sense and their corresponding collective identity, does not have as concrete or defined a place upon which to stand and launch itself. My intention here is to present two promising platforms for the examination of 'we-ness' corresponding broadly with the style and

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content of couple communication – one linguistic, emphasizing language and pronoun usage, and the other storied, emphasizing partners' co-construction of shared meaning and the narratives they live and often tell. Whereas the former 'points at' the partners' shared affiliation, the latter is a substantive expression of the unique life-world that partners co-create and inhabit. As much of my work as a clinician and researcher centers on the impact of cancer on intimate relationships, I draw heavily on this background when offering examples intended to concretize abstract concepts.

Intersubectivity theory (Crossley, 1996) and dialogic dialectics (Baxter & Montgomery, 2000; Montgomery & Baxter, 1998) form the basis for this discussion. Both frameworks assert that communication between individuals (intimates in this case) functions as the substrate for the 'we.' We-ness is evident in 'our' talk and the couple's idiomatic vocabulary including the subliminal linguistic choices partners make; it is lived through and captured by story and the memories partners share; it anchors partners' experience of personal identity affording a sense of assurance about oneself and the world; and it is infused with intricate, highly idiosyncratic self-other knowledge and mutual attunement. All aspects are expressions of partner intersubjectivity and, as I hope to demonstrate, foundational if not fundamental to couple resilience.

We-ness as the Interstitial 'Third'

A long-term intimate relationship entails a dynamic interweaving of selves in which the individual experience of self is altered, enhanced, constrained, and buttressed by virtue of partners' continuous mutual engagement with one another (Berger & Kellner, 1964). Baxter and Montgomery (1996) maintain that the closeness of a relationship may be determined by the extent to which the 'self becomes' or changes through participation in that relationship, suggesting that boundaries between 'self' and 'other' are more permeable and fluid in a close, intimate relationship. To the extent that personal identity is fundamentally social (Gergen, 1987; Mead, 1934), perhaps nowhere is identity formation so pronounced as within the crucible of a longstanding intimate relationship. By the same token, intimate partners are continuously shaping the relationship they reside within thus defining, while being defined by, their unique "micro-culture" (Baxter, 1987a). 'We-ness' may therefore be understood as "relationship partners' often non-conscious participation in a highly implicit collective reality that is both shaped by, and integral to, the personal identity of each member of the couple" (Fergus & Reid, 2001, p. 387). Not surprisingly, this collective sense of an 'us' appears to grow stronger with time and age with older couples demonstrating greater levels of we-ness than couples at middle-age (Seider, Hirschberger, Nelson, & Levenson, 2009).

This blending of relationship partner identity has been construed as a type of cognitive closeness in the social psychology and relationship science literatures. The theory of cognitive interdependence proposes that a person's self-representation

becomes pluralistic and collective in direct correspondence with a deepening of commitment to the other and the relationship, to the point that one's sense of self is rendered inextricable from "self-in-relationship" (Agnew, Van Lange, Rusbult, & Langston, 1998). Similarly, Aron and Aron (1986) maintain that love entails an "expansion of self" whereby individuals are rewarded through their participation in relationships because of the perceived ability to expand the bounds of oneself through another's resources, perspectives, and characteristics. This supposition has been supported by a series of experiments demonstrating how "cognition about the other in a close relationship is cognition in which the other is treated as self" to a greater degree than cognitions concerning people of lesser personal significance (Aron, Aron, Tudor, & Nelson, 1991, p. 242). The 'we' is therefore apparent in how spouses conceive of themselves, one another, and the relationship. To experience a sense of pride in a spouse's accomplishment, for example, in which one feels almost as uplifted as the spouse him or herself does over having achieved a long-term goal, is a reflection of such cognitive closeness. In a different vein, to feel the pain of a spouse's loss as though it were one's own, as in losing a breast to breast cancer, or losing one's libido as a result of hormonal treatment for prostate cancer, is similarly indicative of the extent to which the self has expanded to include the other.

A common assumption underlying discussions of the I-we interface is that the more individuated or differentiated the 'I' is, the more flexible and adaptive the 'we' will be (Bowen, 1978; Karpel, 1976). In other words, the well-being of the relationship rests on respective partners' capacity for both intimacy and autonomy and the ability to strike an integrated balance between the two. To do so results in a we that is 'differentiated' rather than 'fused' (Karpel, 1976). A couple's experience of mutuality, for instance, depends on partners' negotiating their individual needs in ways that acknowledge and prioritize the needs of the other and the relationship (Singer, Alea, Labunko Messier, & Baddeley, 2015). It has been suggested that a differentiated we, while secure and predictable in one sense, will also exhibit greater responsiveness and flexibility in relation to change (Karpel, 1976; Minuchin, 1974), an assumption with clear implications for couple resilience.

In one study, differentiation of self (i.e., the ability to maintain a sense of self and self-regulate within a close, interpersonal relationship) was positively associated with marital adjustment for both male and female partners (Skowron, 2000). Self-differentiation has been further related on a conceptual level to "Power To" which includes the ability to self-soothe or self-regulate strong emotions particularly in times of conflict or tension, and as such, is considered essential to the experience of "relational empowerment" along with the capacity to experience "Power With" in the form of mutual respect and empathy (Fishbane, 2011). Interestingly, self-differentiation and the corresponding recognition of the other's *otherness*, has also been linked to the experience of lasting sexual satisfaction and eroticism in couples (Perel, 2006). What's crucial however, especially from a Western individualistic standpoint, is to resist granting primacy to differentiation over fusion; rather, from a dialogical perspective, relationship vitality depends on the ongoing dialectical dance between the 'we' and the 'me' (Baxter, 1990, 1993), between unity and difference (Baxter & Montgomery, 2000).

Yet for as strong and capable as a differentiated we is, it nonetheless remains elusive and mercurial. In reference to Buber's (1958) concept of the I-Thou relationship, Crossley (1996) speaks to the "irreducibility" of mutual engagement and, in so doing, helps to clarify why we-ness is so difficult to locate:

> Such a situation is meaningful and thoughtful but the meanings and thoughts that it entails are strictly irreducible to either participant. They are formed in and belong to the interworld which forms between them. Moreover, each participant is decentred in relation to the joint situation. Their thoughts and experiences are dialogically interwoven with those of their other. (p. 12)

Couples themselves are often rendered momentarily speechless when asked directly what they mean by 'we' or 'us.' As one spouse expressed, "It's very hard to put into words. I guess after 34 years of marriage, you are a very close entity. It's a unit, not an individual type thing." Another responded by describing herself and her husband as "…a pair, a couple, intertwined together. That's the we" (Fergus, 2011, p. 104). Indeed the metaphor of interlacing strands forming a durable fabric or intricate tapestry is offered time and again in couples' descriptions of their unity. This braiding of selves results in a relationship that is both greater than, and inextricable from, the two individuals comprising it. It is in reference to the complexity and embeddedness of relationships that Josselson (1994) claims so rightly, we are "doomed to imprecision when we stray into the realm of communion" (p. 83). Furthermore, the automaticity and lack of reflective consciousness with which this intermingling occurs cannot be sufficiently emphasized (Berger & Kellner, 1964). Relational schema, interpersonal scripts, emotional signaling and the like provide quick routes to interaction enabling relationships to unfold and maintain without much awareness or forethought (Baxter, 1987b; Burnett, 1987). It is conceivable, then, that in order for relationships to grow and improve, or adapt to changing circumstances, individual partners must enlist their reflexive faculties – that is, to step back and reflect upon self, other, and 'us' in relation to each challenge as it unfolds within, or before, the couple (Fergus & Reid, 2001; Reid & Ahmad, 2015; Reid, Dalton, Laderoute, Doell, & Nguyen, 2006).

We-ness and Resilience

There is a growing consensus among relationship researchers and clinicians that relationships may be improved by enlisting the couple equivalent to the 'observing ego' (Glickhauf-Hughes, Wells, & Chance, 1996; Reid & Ahmad, 2015; Reid et al., 2006; Wile, 2002). Drawing on William James's (1890/1950) famous distinction between the subjective, experiencing 'I' and the objectified 'me,' intimate partners have the capacity to engage in a similar form of reflexivity whereby the conjoined 'we' steps back and gives thought to the unified 'us.' Such relationship awareness as defined by Acitelli (1993) entails an individual's thinking about the patterns and interactions in the relationship as well as partners' respective thoughts and feelings, and includes consideration of the relationship as a whole (p. 151). This process

occurs most readily in contexts where partners' respective 'I's feel safe and secure (Fishbane, 2011). However, it has also been suggested that the very process of reflecting upon the relationship in this way, is in itself a means by which relationship schisms may be bridged (Fergus & Reid, 2001; Reid et al., 2006). The couple's ability to reflect and conjointly objectify when applied to external stressors is also instrumental to couple resilience – a point I will return to later. Moreover, there is emerging evidence that one's tendency to be mindful in the moment is associated with general relationship satisfaction as well as the capacity for partner empathy and perspective taking (Barnes, Brown, Krusemark, Campbell, & Rogge, 2007; Burpee & Langer, 2005; Kozlowski, 2012; Wachs & Cordova, 2007) bearing clinical implications for enhancing relationship interactions (and the corresponding neurocircuitry) through mindfulness training (Atkinson, 2013, 2015).

Giving the relationship thought and attention, that is "minding the relationship," has been associated with enhanced closeness and marital stability in daily life (Harvey, Pauwels, & Zickmund, 2005), but what accounts for the common observation that relationships are often, like people, strengthened in the wake of more extreme, troubling conditions? As Walsh (1996) contends, "resilience is forged through adversity, not despite it" (p. 7). According to Richardson (2002), such strengthening is the result of a succession of lifelong "resilient re-integrations" whereby the individual accumulates more knowledge and know how with every situation that challenges normative functioning. Such disruptions, both "planned and reactive," (Richardson, 2002, p. 313) spur resilient reintegrations that, in turn, lead to growth and adaptation rather than simply recovery and re-equilibration. This point echoes Walsh's (2003) framing of resilience as "bouncing forward" rather than the more common metaphor of bouncing *back*, as well as Lepore and Revenson's (2006) concept of "reconfiguration" as one type of resilience along with "resistance" and "recovery" – with reconfiguration referencing the capacity to emerge from difficult circumstances more strong and resourceful than before. In other words, resilient adaptation leaves a constructive imprint and that imprint is carried forward.

The process of resilient reintegration at the level of the couple underlies the development of "relational wisdom" (Skerrett, 2015). Resilience in couples has been attributed to a type of practice effect in which experience with past adversities prepares partners for future ones (Neff & Broady, 2011). In one study of couples' transition to parenthood, it was found that experience with *moderately* stressful life events, combined with observed support-seeking behavior on the part of both spouses earlier in the marriage, predicted greater self-reported relationship adjustment shortly after the birth of a first child (Neff & Broady). Too much stress, however, may have the opposite outcome creating a "spillover" effect that is detrimental for couples (Neff & Karney, 2009). The latter finding speaks to the importance of having time and opportunity for *integration* or assimilation as a necessarily prelude to resilient *re*integration. Too much stress or change and not enough stability may be a risk factor for couples. An accumulation of stressors such as one partner's threatened job security or eventual job loss, combined with the other partner's chronic autoimmune disease and/or pain, as well as increasingly dependent aging

parents, and one teenager's withdrawal or hostility within the family system – could be one such constellation of factors that tip the scales from resilient reintegration to disintegration and possible dissolution, even in the strongest of marriages.

I-We Identity Processes and Resilient Adaptation

There are a number of processes specifically related to we-ness that are instrumental to couple resilience. While those more overt expressions of couple intersubjectivity are examined in greater detail below, there are a few processes related to identity formation – both shared and reciprocal – that bear mentioning at this juncture. This discussion is particularly relevant to stressors that affect relationship partners unevenly. That is, where one member of the pair is directly impacted by the stressful occurrence or circumstance, and the other is, by default, cast in a supporting role such as in the case of illness or injury. This discussion is based on the premise that when individuals feel strong in their relationships, they feel strong in themselves and thus more equipped to withstand challenging situations.

Owing to the "communal" character of close relationships in which partner give-and-take is determined on the basis of need, not exchange (Clark & Mills, 1979, 2012), partners will tend not to feel under-benefited in the relationship despite apparent inequities in the exchange of support when, for example, one partner is physically impaired (Kuijer, Buunk, & Ybema, 2001). The resulting transformation of motivation from one of self-interest to one which favors the other's interests and/or those of the relationship (Agnew et al., 1998; Rusbult, Wieselquist, Foster, & Witcher, 1999) in part accounts for how the needs of the more vulnerable spouse tend to become naturally centralized in resilient couples during times of acute stress or crisis. Of course less tangible yet universal experiences such as love and compassion also need to be recognized in discussions of pro-social behavior between partners.

From the standpoint of the self-expansion model of love (Aron & Aron, 1986), allocation of personal resources becomes communal in close relationships because "benefitting other is benefitting self" (Aron et al., 1991, p. 242). In other words, owing to the myriad of ways in which self and other merge in communal relationships, a well-spouse's helping behaviors toward an ill or impaired partner effectively function to support the spouse as well. In this sense, caring for an intimate other is unlike caregiving for any other individual because not only has the self in relationship expanded by including the intimate other, but the other has become included in oneself. Therefore, caring for the other and ensuring the other's well being is, to some degree, *caring for self*. From a cognitive closeness perspective, there is an element of self-care built into caring for one's partner, and this blending of personal and communal motivation contributes to the resilient adaptation of the collective.

Another identity-related source of strength in couples has to do with the ways in which intimate partners assume a vital role in validating one another's sense of self

(Berger & Kellner, 1964). It is through "eye to eye validation" that we become real to ourselves and we feel most secure in ourselves when we are able to ascertain "what we mean, and that we mean for others" (Josselson, 1994, p. 94). It has been demonstrated, for example, that affirmation by one's partner that is in keeping with one's own self-ideal, is associated with better relationship adjustment and stability (Drigotas, Rusbult, Wieselquist, & Whitton, 1999). Moreover, if a spouse's positive view of his or her mate is more favorable than the mate's own view, and if the spouse tries to stabilize such positive impressions then, over time, the person's negative self-view could begin to change for the better (De La Ronde & Swann, 1998). Thus to the extent that traumatic life events or major life transitions such as retirement significantly challenge or disrupt one's personhood, spouses have a crucial role to play, by virtue of their identity supporting function, in facilitating the affected partner's process of constructive self-redefinition.

Related to the bolstering of the more vulnerable partner's identity is the intricate self-other knowledge intimate partners possess of one another. That is, the capacity to respond to one's partner in an appropriately supportive manner is predicated on this implicit relationship knowledge (Gottman, 1999) as well as on accurate empathy for the other (Ickes & Simpson, 1997). Perceiving one's partner as responsive to one's needs, goals, values and so forth has generally been associated with greater relationship satisfaction and personal well-being (Reis, 2013). The concomitant experience of feeling validated, understood and cared for (Reis & Shaver, 1988) would arguably be that much more imperative when one partner is in distress. Such responsiveness entails the ability "to discern non-verbal cues, and to 'read between the lines' about motivations, emotions, and experiences," (Harvey et al., 2005, p. 424) what Harvey and colleagues term, "knowing and being known." Being attuned and responsive to non-verbal and para-verbal cues, in turn, is conducive to couple coping because it enables well spouses to be appropriately supportive *without having to be explicitly directed or asked*. The intersubjective dance of signaling and responding in this manner has implications for identity maintenance. A man recovering from prostate surgery and struggling with the prospect of incontinence, for example, may find it difficult to ask directly for help with cleaning his catheter. However, his partner's attuned responsiveness to his unexpressed practical need helps to preserve what little sense of self-sufficiency he might be experiencing in that moment (Fergus, 2011). An intimate partner therefore provides a highly customized form of support, one that is deeply rooted in the pair's intersubjectivity and has a critical role to play in couple resilience by virtue of the identity maintenance function he or she enacts.

We-ness as an Intersubjective Process

The main premise of intersubjectivity theory is that relationships entail "interacting subjectivities" comprised of "reciprocally interacting worlds of experience" (Stolorow, Atwood & Brandshaft, 1994, p. x). Within an intersubjective framework,

there is a movement away from intrapsychic formulations of self and mind, to one that is interpersonal and contextual (Stolorow, 1994). Drawing on the theories of (Buber, 1958; Husserl, 1960; Crossley, 1996) proposes two types of intersubjectivity respectively: *Radical* intersubjectivity based on Buber's notion of the I-Thou relationship, and *Egological* intersubjectivity based on Husserl's phenomenology. Radical intersubjectivity entails a type of "communicative openness" (p. 23) and non-reflexive merger with the other whereby 'self' and 'other' essentially dissolve in that moment. Egological intersubjectivity, on the other hand, entails the experience of separate I subjects who are able to bridge their divide through empathic relating, which is in turn, dependent on the imagination. The other is experienced via an "…imaginative transposition of self into the position of the other" (p. 23). For Crossley, intersubjectivity enlists both forms of engagement loosely corresponding with non self-conscious immersion (in the radical sense) and reflective awareness of the other and the interaction (in the egological sense). To dialogue with another involves continually shifting in and out of, and in between, the two modes. The resulting "interworld" that unfolds through dialogue is therefore irreducible to any individual; that is, the shared situation transcends its respective participants while remaining inclusive of them.

Below are some examples offered in an attempt to clarify further the difference between the two modalities – the first being a scene depicting egological engagement:

When two acquaintances meet by chance, there is a question of whether the conversation will continue beyond the initial greeting. The two participants may at first find themselves standing 'outside' of the conversation, perhaps thinking of the last time they spoke, or remembering that something significant has occurred for the other since their last encounter, such as the birth of a grandchild. They may also be wondering whether the conversation will continue for much longer beyond the exchange of pleasantries. Within this mode, the individual is, in a sense, entering into the world of the other through a process of remembering and imaginative inference. He or she is also reflecting on the life of the conversation itself – or on the other, and/or, on oneself. Whether reflecting, remembering, or empathically imagining, there is an implicit sense of a separation between the two parties (not withstanding the attendant willingness to close this gap in the discursive moment). Such is egological intersubjectivity where the 'I' and 'you' remain distinct and intact despite the bridging of two people through the dialogical interchange.

Contrast the previous scenario with that of two intimate partners' greeting each other at home at the end of a workday. They might discuss some highlights of the day – an interaction with a boss or co-worker, what they did over lunch, a report they submitted for review etcetera. Each might imagine the other earlier in the day, and possibly attempt to grasp empathically what the other might have been experiencing in a given moment or context. Very quickly however, they slip into a more radical form of intersubjectivity – where they start to communicate in shorthand about a shared frustration with one of their children, or about a television show they are both excited to watch after dinner referencing their favorite line from the last episode. Or perhaps this conversation never had a chance to get off the ground

because one partner, Sarah, is feeling agitated and preoccupied and thus unopen to the conversation. Robert, in turn, quietly yet non-defensively disengages from the conversation and leaves the room – picking up perhaps unconsciously on Sarah's closed state. Sometime later, Sarah, having recognized that she shut Robert out by failing to respond in kind to his attempt to connect, attempts to mend the small tear between them – through an affectionate touch, or perhaps an apology and accompanying overt recognition of the earlier displaced emotion and the impact it might have had on him. Some of the nuance and subtlety of these forms of communication would be lost to an 'outsider' witnessing the scene because that person would be more restricted in his or her ability to "enter into" this interaction having mainly at his or her disposal, a more egological mode of relating to it. Moreover, that shared 'headspace' (or better, mind-body-feeling space) is one where the alterity of the other, if apprehended at all, is barely visible. The partners are immersed and embedded, one within the other; their respective experiences are intertwined and overlapping and as such cannot be teased apart (Crossley, 1996). The meta-awareness of being 'in conversation' is also backgrounded to the point of being scarcely perceptible. Such is intersubjectivity in the radical sense.

These examples are not intended to imply that egological and radical intersubjective states are the exclusive domain of acquaintances and intimates respectively. On the contrary, according to Crossley, there is often a shifting between modes occurring in all forms of discourse regardless of degree of closeness between participants. I would maintain, however, that the intersubjective interworld Crossley references is exceedingly more textured and layered in the context of an intimate relationship owing to the pair's shared history, interdependency, and overlapping identity. Nevertheless, Crossley's description helps to elucidate the radical-egological back-and-forth common to conversational interaction:

> Sometimes we are deeply engrossed in others, too engaged to be aware of either ourselves or of them. At other times, and rapidly, we become sharply aware of both, constituting them as reflective and reflexive aspects of experience. All spontaneous interactions can be stultified by a reflective block, only to be undermined later by a genuine and spontaneous communication which collapses the reflective barriers of self and other. I's push their me's to the side and become joined. (p. 71)

Both forms of intersubjectivity have a role to play in couple resilience, and in my view, distinct ones at that. On the one hand, that capacity to know deeply the other and to be aware of and attuned to the needs and vulnerabilities of the other, and the capacity to 'be with' in a way that is open, validating, and loving *is* a radical form of engagement. Such I-thou relating – when achieved – might be considered the bedrock of the couple's mutual support structure. On the other hand, for partners to step outside of that communal form of engagement and, in an egological sense, enlist their reflexive faculties enables them to individually or conjointly consider one another and the stressor being faced. This capacity is necessary in order to discern how best to help the other in the moment, or cooperatively problem solve. The ability to reflect together is a double-barreled strength in that not only might it lead to salubrious outcomes, but it is indirectly reinforcing of the 'we' – a point that I will return to shortly.

According to Crossley (1996) dialogue is the means by which individuals transcend their separateness. In keeping with this notion, intimate relationships are forged through an ongoing dialogical interchange or "marital conversation" (Berger & Kellner, 1964). And like the relationship itself, the communication it is founded upon continuously evolves at the edge of competing dialectical forces (Montgomery & Baxter, 1998). For one, both fusion *and* separation are necessary in order for this conversation to occur (Baxter & Montgomery, 2000; Hermans, Kempen, & Van Loon, 1992) because two respective subjects (and corresponding subjectivities) are the pillars propping up a shared understanding. In reference to the following quote by Voloshinov (1973), Baxter and Montgomery (2000) outline three additional contradictions specific to relational dialogues: "Each and every word expresses the 'one' in relation to the 'other'… A word is a bridge thrown between myself and another" (p. 86 as cited in Baxter & Montgomery, 2000). These discursive tensions include: (1) that which is 'said' in and through language, versus the 'unsaid' which is implied based on context; (2) the constraint imposed by existing or inherited meaning, versus the freedom associated with new meanings that arise through the interaction; and (3) 'inner' versus 'outer' speech distinguished on the basis of personal as compared to explicitly social meaning.

Not only does this ongoing dialogue serve a crucial function in terms of the identity-formation and identity-preservation of each partner, but it also affirms and reifies the couple's subjective experience of the world between and around them. In other words, it is by means of this unending string of conversation between intimates, that a sense of stability and coherence are knit. According to Berger and Kellner (1964), partners' continuous intersubjective engagement and the dominance of the conjugal conversation, eventuates in the creation of a shared construction of one another and the world, one which, over time, becomes "objectivated" and solidified (p. 170). They go on to stress that, "The process (is)… one in which reality is crystalized, narrowed and stabilized. Ambivalences are converted into certainties. Typifications of self and others become settled…" (p.175). And as partners' feet touch solid ground each step of the way, they derive a sense of security in themselves and the world about them. A long-term relationship therefore functions as a vehicle for satisfying the basic human need for stability and coherence (Epstein, 1990). Spouses possessing a stronger sense of coherence (i.e., who experience of the world as comprehensible, manageable and meaningful) are expected to reorganize more adaptively following a crisis in the family (Antonovsky and Sourani 1988).

Both the content and structure of couple discourse are revealing of partners' intersubjective processes and as such, have received increasing attention in the study of relationships. This growing body of work spans research into marital satisfaction and therapy outcome, as well as couple adjustment to challenging life events such as a health crisis in one partner. Before turning to the content dimension of couple communication and specifically the shared narrativization process underlying mutual identity construction, I discuss the structural linguistic analysis of couple discourse in general, and later, its relevance to couple adaptation.

We-Talk and Couple Resilience

In terms of the structural aspects of conjoint communication, much of this research has focused on linguistic indicators and specifically, first person plural pronoun usage – that is, ‘we’ talk between intimates, as well as we-talk relative to ‘I’ and ‘you’ talk. Such surface features of language are considered significant in the way they reference or ‘point to’ each partner’s identification with the other and the relationship they share (Pennebaker, Mehl, & Niederhoffer, 2003, p. 567). An assumption here is that the interaction between degree of pronoun inclusiveness, and the type of personal pronoun used (first or second person), carries meaningful information about the relationship. In fact, because pronoun usage generally occurs spontaneously and outside of the speaker’s conscious awareness or volition, it is potentially even *more* revealing of the state of the couple’s union than the content words such particles link together.

The evidence supporting the correlation between communally oriented language (or lack of) and relationship satisfaction has been steadily accumulating. In one textual analysis of couple conversations where cardiovascular arousal was measured during the interaction, we-words were related to lower autonomic arousal and more positive emotional behavior, whereas I-talk was associated with reduced relationship satisfaction and negative interpersonal behavior (Seider et al., 2009). These findings are consistent with another investigation in which we pronouns were correlated with greater observed positivity and lower observed negativity in problem focused discussions (Williams-Baucom, Atkins, Sevier, Eldridge, & Christensen, 2010). We language has also been positively associated with greater commitment (Agnew et al., 1998), and to marital satisfaction in older couples suggesting that interdependence of identity becomes stronger with age (Seider et al.; Sillars, Shellen, McIntosh, & Pomegranate, 1997). It should be noted, however, that *asymmetric* use of we-talk on the part of well-partners relative to patients while discussing health-related areas of disagreement, was associated with greater demand-withdraw conflictual communication (Rentscher et al., 2013). Findings pertaining to the use of second-person pronouns have been particularly robust in that ‘you’ talk is consistently associated with lower relationship satisfaction (e.g., Robbins, Mehl, Smith, & Weihs, 2013; Sillars et al., 1997; Slatcher, Vazire & Pennebaker, 2008) and negative martial interaction (e.g., Rentscher et al., 2013; Simmons, Gordon & Chambless, 2005; Williams-Baucom et al., 2010).

In the literature on couple coping and adjustment, we-talk is viewed as possessing “adaptive significance” beyond the more general finding that we-talk relative to I- or you-talk is related to marital satisfaction (Rohrbaugh, Shoham, Skoyen, Jensen, & Mehl, 2012, p. 116). This shift from being devastated and alone, to feeling fortified by the support of the spouse and the ‘we’ of the couple, is revealed in one man’s movement from singular to plural pronoun use while recounting his early reaction to his cancer diagnosis:

> I just couldn’t adjust to it. I couldn’t handle it. I went outside and broke down and cried. But after I think about three, four, five days, logic began to kick in, and we said, ‘Well, let’s find out what the hell we got here.’ We were hooked up to the Net, and within two weeks, [partner name] and I knew more about prostate cancer than the average physician. (Fergus, 2011, p. 102)

In their review of the psychological implications of we-talk in natural language, Pennebaker and colleagues (2003) report on how collective pronoun use often increases following a shared crisis and then returns to normal levels proportionate to the passage of time from the crisis. Indeed partner use of we-talk was related to better couple adjustment and reduced patient depression in a recent study of familial coping with breast cancer (Robbins et al., 2013), as well as greater adherence to a smoking cessation program for patients with smoking related health concerns (Rohrbaugh et al., 2012).

For as promising a direction as pronoun analysis is, it is important not to lose sight of the fact that we-talk is not so meaningful in and of itself; rather, it is the collective identity that it is referencing that makes the study of pronoun use valuable. More specifically, in studies of couple coping and adjustment, we-talk is assumed to signify a communal coping orientation (Rohrbaugh, Mehl, Shoham, Reilly, & Ewy, 2008; Rohrbaugh et al., 2012). Communal coping is broadly defined as adopting a team approach to addressing any stressful occurrence that is impacting upon the group – irrespective of whether one of its members is more directly affected by the stressor (Lyons, Mickelson, Sullivan, & Coyne, 1998). The responsibility for coping with the adversity is therefore not ascribed to one individual but rests with the collective. In couples, the sharing of collective resources and exchange of mutual support in this manner has been termed "dyadic coping" (Bodenmann, 2005) or "collaborative coping" (Berg et al., 2008). Embodying a we orientation in couples coping with cancer of various types and stages has consistently been associated with better adaptation in both quantitative (e.g., Badr, Carmack, Kashy, Cristofanilli, & Revenson, 2010; Berg et al.) and qualitative (e.g., Fergus, 2011; Kayser, Watson & Andrade, 2007; Skerrett, 1998) investigations. In speaking about his wife's surgical treatment for breast cancer, one man's striking use of we language offers a glimpse into his communal orientation to her disease. He remarked that, "…after the surgery, it was discovered that it was the right decision, because at the time we were thinking, well, should we have a lumpectomy or a mastectomy, and … you know … the first surgeon, like we had gone in with our list of twenty questions…"

Alongside the concrete-instrumental and emotional-affectional processes underlying conjoined coping, the development of a shared outlook vis-à-vis the problem is also instrumental to couple resilience. Open communication related to the stressful situation not only fosters transparency and trust within the relationship system (Walsh, 2003), it also tacitly objectifies the problem. This objectifying function is crucial to tapping the couple's collective resources because it presumes a shared consciousness that is enacting this objectification (Fergus & Reid, 2001). The we is therefore *indirectly* reinforced by making the problem external (White & Epston 1990), and this externalization occurs through the couple's ongoing dialogue in relation to the stressor, as well as through the coordination of their coping efforts. Like mint that is planted in a clay pot rather than the garden, when the problem is situated 'outside' of the couple, it is less likely to infiltrate and overtake them; as a result, the relationship remains defined by the greater 'us' rather than the adversarial

'it' or stressor. I suggest that this objectification process is one mechanism by which resilient reintegration occurs in couples, and specifically accounts for the fortification of the couple's experience of we-ness reflected in the common declaration by partners that, in meeting adversity, "It made us stronger."

Despite its promise, linguistic analysis is inherently limited by its reductionistic exclusion of the contextual, non-verbal, and paralinguistic features of couple communication. In other words, the study of pronoun usage fails to account for the fundamental discursive dialectic between the 'said' and the 'unsaid' (Baxter & Montgomery, 2000). This shortcoming is particularly problematic in the study of intimate partners where their communication and intersubjective meaning are based so heavily on para-verbal and non-verbal cues (Hollingshead, 1998). It is with this recognition in mind that Reid and colleagues stress that we-oriented pronouns are an epiphenomenon within the couple's ever-emergent system *secondary* to partners' *primary* experience of a mutual identification with one another and the relationship (Reid et al., 2006). Accordingly, they developed a more contextually inclusive approach to measuring we-ness that entails coding audio-recordings of couple interactions according to six "macrolevels" of we-ness. This dimensional coding scheme ranges from Level 1 in which there is a domination of "I versus you" in recounted relationship episodes, to Level 6 in which there is a mutual reflexive awareness of the relationship and an appreciation for the other's views, feelings etc. Although it includes consideration of pronouns, the coding system also accounts for intersubjective meanings and paralinguistic features of couple communication. Using this instrument, they were able to demonstrate reliably how marital satisfaction increases along with increases in relationship identity brought about through clinical intervention (Reid et al., 2006).

Co-constructed Narrative and the Reestablishment of Coherence

Couples' day-to-day conversations, and the experiences they reference, provide the material for relationship narratives. Just as personal narratives are integral to one's experience of selfhood chronicling one's values, beliefs, habits and the like (Singer & Salovey, 1993), the overlapping story of the couple is essential to the identity of the relationship and the 'we.' These are held within the relationship collective at micro and macro levels, as small story 'parts' of the larger we-story 'whole.' Regardless of whether such stories ever reach the light of day, they reside deep within the subjective world of each partner at an implicit level. Such storying and stories integrate past, present and an anticipated future into a unified whole (McAdams, 1985). In this way, shared narratives contribute to the organization and unification of the couple's intersubjective world, in a manner similar to how personal narratives serve the individual (Widdershoven, 1994). Moreover, because

shared narratives are temporally arranged, they provide a sense of continuity for those who carry them (Maines & Bridger, 1992), as well as a sense of enjoyment, and even celebration, in their telling and retelling. The mutual savoring of such 'our' stories is deftly captured in Carol Shield's (1993) novel, *Happenstance*:

> When they tell these stories to friends (as they sometimes do) Brenda never says to Jack, 'Please don't tell that old story again,' and he never says to her, 'We've all heard that one.' They love their stories and tacitly think of them as their private hoard, their private stock, exquisitely flavored by the retelling. The timing and phrasing have reached a state of near perfection; it's taken them years to get them right. It seems to Brenda that all couples of longstanding must have such a stock of stories to draw upon. (p. 142)

Shared stories are not only a testament to the life of the couple; they also define the couple and the relationship they share. As social acts, relationships are shaped through couples' stories just as societies are established and maintained through collective narratives (Maines & Bridger, 1992). This emphasis on storying as a creative, relationship building and defining process offers insight into Reik's (1944) provocative assertion that, "There is no such thing as a love story. Love is a story within a story" (p. 40). Love is not a romanticized ideal. First and foremost, love transpires through a narrativizing process that may then be fashioned into a story – or not. Perhaps, just as important as what couples *include* in their narratives is that which they choose to exclude, as Sarbin (1986) points out, "Not to spell out one's engagements means the studied avoidance of those contextual features that would render the story inconsistent, unconvincing, or absurd" (p. 16). Such "narrative smoothing" (Spence, 1986) and the related perceptual biases and selective attention processes underlie the "Glorifying the Struggle" narrative tone of satisfied couples (Carrere, Buehlman, Gottman, Coan, & Ruckstuhl, 2000). Likewise, such processes are likely enlisted in the re-establishment of continuity and coherence following biographically disruptive (Bury, 1982) life events that invariably come the couple's way.

Hermans and colleagues (1992) argue that the creation of a story necessitates interconnecting often-disparate events in meaningful ways. Thus to story is, by definition, to build coherence. If life in general is messy and fragmented, life crises are that much more so, making the need for coherence that much more pressing. A key process for fostering relational resilience is the creation of a system of belief about the adversity that is both meaningful and positive (Walsh, 2003). As Walsh states, "Although past events can't be changed, they can be recast in a new light that fosters greater comprehension and healing" (p. 409). In contrast, couples who repeatedly fail at this task, *lack* coherence. These couples – rated highly on the Chaos narrative dimension – feel distinctively out of control and unable to problem-solve around disruptive events within and impacting upon the relationship (Buehlman, Gottman, & Katz, 1992). Chaotic marriages, as compared to the "Glorifying our Struggle" marriages, are more likely to dissolve (Buehlman et al., 1992). Findings such as these support the notion that the we is contingent on successful re-integrations of past adversities, and that such re-integrations depend on an intersubjective process of co-constructed meaning-making and narrativization.

Stories about the couple's past that are vivid and emotionally charged have been construed as "relationship defining memories" (Alea, Singer, & Labunko-Messier, 2015). Such memories, when positive and well rehearsed have been associated with greater marital satisfaction (Alea & Vick, 2010). The intriguing concept of a "transactive memory" (Wegner, Erber, & Raymond, 1991) highlights another aspect of intersubjective remembering, one which functions most directly as a shared memory *system* for the encoding, storage and retrieval of relationship relevant information (Wegner, 1986) rather than as a means of establishing shared identity. Nevertheless, the transactive memory whereby each partner naturally, often unconsciously becomes the storehouse for semantic and procedural information corresponding with their respective relationship roles and "expertise," aids in the management and coordination of the couple's daily life. Moreover, the fact that partners know who-knows-what-best is a subtle expression of their intersubjectivity and a reflection of the couple's "emergent group mind" (Wegner et al., 1991, p. 923). Both transactive and relationship-defining memory processes thus assume crucial yet arguably quite distinct functions in relation to resilient adaptation for couples corresponding with functional and identity-maintenance tasks respectively.

Concluding Remarks

Based on the assumption that the couple's mutuality and shared identity are integral to couple-wellbeing, both in daily life and during times of hardship, I have sought to articulate aspects of the 'we' that are instrumental to couple resilience. This discussion was informed by dialogic dialectics as well as intersubjectivity theory, while incorporating theoretical and empirical work from social and narrative psychology, sociology, relationship science, and couple therapy. Conjoint identity processes as well as their expression were examined. These included self-other identity formation and maintenance, mutual attunement and responsiveness, co-constructed meaning and narrative, and partner languaging that references their collectivity – all of which are deeply rooted in, and expressions of, the couple's intersubjective world. In seeking to clarify these more elusive features of couple life, I have tended to isolate the relationship dyad from the broader family and socio-cultural systems in which the couple is profoundly embedded and equally as indebted to for its identity and 'self'-definition. Just as, "We [individuals] are inter-subjects. Our actions and thoughts are not reducible to us alone…" (Crossley, 1996, p. 173) So too, the couple is irreducible within its own collective social network.

The other reductive property that should be acknowledged here is the decision I made to take language and communication between partners as the window though which to examine couple intersubjectivity as it pertains to resilience. Speech acts such as collective pronoun use and the stories and memories couples share are only snapshots in time of process and content features of the couple's intricate "interworld" (Crossley, 1996). Moreover, in emphasizing language and meaning including cognition, there has been an implied prioritization of the verbal over *both* the physical

and the less tangible aspects of couple experience. So much of the 'we' is implicit and unspoken in that it's just there. And apart from a qualifying mention of the importance of the un-*said* and the non-*verbal* aspects of verbal communication, there has been very little acknowledgement, let alone direct study, of the embodied, sensorial, and temporospatial dimensions of intersubjectivity and how these features pertain to couple adaptation (see as exceptions Fergus, 2011; van Nes, Runge, & Jonsson, 2009). By the same token, the methods discussed in this chapter are among the best currently being offered in our attempt to capture or tap into this sense of a 'we' and an 'us' – a phenomenon that is so common to couple experience on the one hand, and yet so steeped in complexity, creativity, and mystery on the other.

The final point I wish to make concerns the 'elephant in the room' of this essay – that is, couples for whom their sense of we-ness is more tenuous. What are the implications for these couples in relation to resilience? For example, self-other knowledge without mutual or altruistic intent, may be used exploitatively or manipulatively, or it may serve as a signal to a conflict one knows is about to unfold but that one simultaneously elects *not* to preempt. These are examples of intersubjectivity 'gone awry' if you will, or of intersubjective processes that are not used in the best interest of the couple or the 'we.' What about the partner who cares deeply for the other but for whom relational competence is not a strong suit? How do these couples inform our theorizing about we-ness vis-a-vis couple resilience? Moreover, who are "these couples?" Is it not more normative than otherwise to have periods where partners are more and less unified in their relationship, as the couple rides the developmental course *of* the relationship? My point here is that we-ness is not absolute and to the extent that I may have suggested so in this chapter would be an oversimplification. The literature to date suggests that the couple requires a certain degree of adversity to abrade against in order to fortify further and such resilient reintegrations beget greater resiliency. However, resilient processes and outcomes are also punctuated by moments of profound vulnerability and uncertainty in relation to the stressor and sometimes in relation to the other. Complexities such as these await further elucidation as we move forward in our study of the interaction between we-ness and resilience in couples.

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Part II
Resilient Processes and Applications to Specific Populations

Chapter 3
Resilience in Lesbian and Gay Couples

Arlene Istar Lev

There has been increased academic, political, and clinical interest in lesbian, gay, bisexual, transgender and queer (LGBTQ) people in past few decades, producing greater visibility and amplified media attention to the issues impacting the lives of sexual and gender minorities. This has resulted in a general trend towards progressive changes in public policy, culminating in greater numbers of out gay and lesbian couples forming permanent and legal partnerships, increased service provision for LGBTQ youth, and broader application of civil rights, like housing and employment protections for transgender people. Despite this generally improved social and political climate for LGBTQ people, there is a surprising dearth of in-depth research specifically focused on how same-sex couples create and sustain long-term relationships (Hunter, 2012). Oddly enough, research on gay and lesbian couples has lagged behind other areas of LGBTQ research for example, lesbian and gay parenting (Goldberg, 2010), and transgender identity development (Lev, 2004).

Until recent decades, LGBTQ people have lived closeted, furtive lives in oppressive, restrictive, and often dangerous social and political realities. Historically, they have experienced bias-related violence, discrimination in public policy including the inability to form legal partnerships or secure employment protections, as well as prejudice in the form of daily invalidating microaggressions. Yet, they have also been able to form and maintain healthy, functioning, stable families and create vibrant communities, suggesting the development of unique protective factors that function within these oppressive conditions.

Within the field of psychology, lesbian and gay intimacy has been viewed as "other," outside of the mainstream, external of what was considered normal and

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common. In the not so distant past, the very nature of homosexual attraction was viewed as pathological, and gender nonconforming behavior is still currently considered a diagnosable mental illness. Even though lesbian and gay people seek out therapy in higher numbers than heterosexuals (Cochran, Mays & Sullivan, 2003), research confirms that heterosexist microaggressions continue to be (re)enacted within the clinical relationship (Shelton & Delgado-Romero, 2011). Even among progressive clinicians, LGBTQ identities are considered "alternative," outside of normative family life and experiences (Walsh, 2011), and a side-bar to mainstream discussions within academia and clinical discourse.

Attempts at eliminating bias against LGBTQ people through education, academically and clinically, often lead to inclusion practices that are "added-on", i.e., a family therapy course discusses same-sex couples as an addendum lecture at the end of the course, instead of infusing the material throughout the course. Green and Mitchell (2008) ask their readers to imagine authoring an article entitled "Therapy with Heterosexual Couples." The title implies that the material will not be sufficiently covered in other chapters and that the information can be adequately described in one chapter, without resorting to stereotypes about straight people. The study of LGBTQ couples and families, an emerging and complex area of research and clinical exploration, is too often relegated to a postscript, an academic footnote. The reader is encouraged to recognize this dilemma in the overview that follows.

LGBTQ identities are too often "lumped together" conflating the issues facing gay men and lesbians, and merging the concerns of bisexual people of both sexes. Complex issues of transgender, transsexual and gender nonconformity are all placed under one umbrella, a sort of "pan-queerism," that minimizes salient differences in identity and community affiliation. LGBTQ is a useful way to describe broad (and necessary) political alliances, in the same way the term "people of color" describes diverse cultural communities, crossing national borders, as well as racial and ethnic identities. These are, however, inadequate terms – academically and clinically – as a way to understand the individuals and communities of people who are conflated into these larger categories; indeed, it whitewashes the salient particulars of these identities. Even discussing lesbian *and* gay couples under one rubric does a disservice to the complex and specifically gendered differences in coupling patterns, community affiliation, and cultural identities.

In this chapter, the focus is explicitly on lesbian and gay couples (the "L" and the "G" of LGBTQ), referred to as "same-sex" couples. However, it is to be remembered that many bisexual people are in same-sex relationships, where they are often invisible *as* bisexual people; of course, the same is true for bisexuals in heterosexual partnerships, a fact rarely mentioned when writing about heterosexual couples. People who are bisexual can have unique issues when partnering in same-sex relationships, including questions of affiliation, identity management, coming out, and challenges due to the "mixed orientation" within the couple, with notable differences between men and women.

Addressing the specific concerns impacting transgender people in relationships is also outside the parameters of this article, however, it is to be remembered that transgender people can identify as heterosexual, gay/lesbian, or bisexual in identity,

and some lesbian and gay couples (like some heterosexual couples) may have a transgender member. Depending on the direction, trajectory, and goal of a gender transition, a transgender person can be in relationship that is defined as either "gay" or "straight." For example, if a man is involved with a woman they are identified as heterosexual, and if the man later transitions and begins living as a woman the couple would then be identified as lesbian; neither of those terms may best describe how the couple views their own relationship. Transgender people are members of relationships that are labeled both "same-sex" and "opposite sex," and within a post-modern world of "sex changes" and "queer identities," the term sexual orientation becomes an inadequate term to fully describe coupling patterns, identities, and shifts in physical sex and gender expression (Lev & Sennott, 2012; Malpas, 2006).

The term *same-sex* will be used to describe lesbian and gay coupling, not the phrase "same-gender"; this is done consciously and purposefully. Sex describes human anatomy (as male and female); gender describes roles, mannerisms, societal expectations, clothing choices, and how people express their gender (as men and women). Some lesbian and gay people (like some heterosexuals) exhibit cross-gender expression, therefore not all same-sex relationships are actually same gender relationships (Lev, 2004). For example, some lesbian couples identify as being in butch/femme relationships, where one partner expresses a more masculine gender, although both identify as female. Although technically these are same-sex couplings, there are complex gendered patterns that may be important to acknowledge and explore that have been largely ignored in the literature (Laird, 1999; Lev, 2008).

The fields of LGBTQ studies and the specific focus on LGBTQ couple and family development is newly emerging and not yet incorporated into larger areas of psychology and marriage and family therapy. Although the knowledge base remains sparse and insufficient, nascent emerging research reveals that despite the impact of severe social oppression and ostracism directed towards sexual minorities, same-sex couples create and sustain loving relationships within strong communities that can withstand personal hardships and invalidating social and political environments.

"We-ness" in a Sea of Other-ness

Resilience research has historically focused on individuals, particularly individual children, living in unusual, high-stress, chaotic conditions. Walsh (1996) has encouraged a radically new way to view resilience, by "… shifting focus from individual traits to interactional processes that must be understood in ecological and developmental context" (p. 261). Resilience research interrogates the questions of why some people are emotionally incapacitated by persistent stress, and repeated micro-aggressions whereas others appear to emerge stronger, with increased resources (Unger, 2011; Walsh, 2011). The focus has broadened from only studying children to examining adults, and from adults to couples and families; additionally resilience research currently looks at normative development in daily life, not only unusual stress-inducing situations. Walsh suggests that familial and intimate relationships

can serve to provide "psychosocial inoculation" and actually fortify resilience (Walsh, 1996, p. 261). Relational resilience is not simply one's capacity to withstand adversity, but requires the skills to utilize, adapt, and integrate the tools and resources available, and to do so within an interdependent network that supports and sustains the process (Unger, 2011).

This idea of *relational resilience*, resilience that speaks to the "we-ness" of couples and focuses on their strengths and the process of how people mature and develop as both individuals and within couples in the face of adversity, is the bedrock of fully understanding the bonds created within LGBTQ families. Although therapy practice that is affirming to sexual minorities has developed within a strengths and empowerment prospective (see Bieschke, Perez & DeBord, 2007), the research on resilience has only recently being applied to LGBTQ couple and family building (Bigner & Wetchler, 2012). The social science study of queer folk has often focused on individuals and their identity, ignoring the role of intimacy and community which can serve as protective factors (Giammattei & Green, 2012).

Walsh (1996, 2011) has critically examined the very concept of family normalcy and shown how families that differ from the norm tend to be viewed as flawed and defective (and perhaps view themselves that way too). The myth that there is an ideal family is steeped in assumptions that are racially and culturally biased as well as heterosexist (Ashton, 2011). Atypical family structures are often labeled dysfunctional despite a growing body of research showing that "family processes matter more than family form for healthy individual and family functioning" (Walsh, 1996, p. 266). Processes that are actually typical and protective *within* alternative family structures are often judged as deficient when measured against values that are assumed to be universally normative. Harvey (2012) refers to the "hidden resilience" of LGBTQ youth, who exhibit behaviors that appear to be socially problematic, but actually serve as protective factors. For example, flamboyance, extreme gender rigidity, or desires to pass can be ways to cope with marginalized identities and struggles to develop a solid self-esteem in a condemning world. Opportunities to understand the specific resiliencies of lesbian and gay couples are too often lost because of the biased perspective of the observer who is outside of, and misinformed about, queer cultural contexts.

In many ways lesbian and gay couples are similar to heterosexual couples (Kurdek, 1993), but there are also complex differences and specific strengths born of their unique cultural context. Green says, "Heterosexuality and homosexuality are *not* logical opposites. Counterposing one against the other inevitably exaggerates their differences and minimizes their commonalities" (2012, p. 181). Lesbian and gay couples face additional stressors that heterosexual couples do not have to face, and one of those stressors is the constant comparison to heterosexual couples and values that are assumptively heteronormative.

Heteronormativity is an ideology (often unconscious) that presumes heterosexuality and promotes gender conventionality and views those values as superior to alternative forms of sexual orientation, gender expression, and family formation (Giammattei & Green, 2012; Lev, 2010). The process of de-centering heteronormativity and honoring alternative ways of creating family is at the root of how lesbian

and gay couples, as well as other sexual minorities, develop resilience and build stable families. Lesbians and gays may be functionally and structurally similar to opposite-sex couples, yet same-sex couples must make meaningful sense of the adversity they face, as cultural beings who can balance multiple interactive concerns including the environmental context of various LGBTQ communities, and their own ethnic, racial, and familial cultures.

The Alchemy of Adversity

LGBTQ identities have been formed within hostile environments, and building relational permanency requires negotiating complex social dynamics of coming out, dating, coupling, and immersion into queer cultural milieus as well as managing "degree of out-ness" with family of origin, cultural communities, and work environments (Ashton, 2011). The development of a stable same-sex "we" infers a long term developmental process from adolescence through maturity in which a positive gay or lesbian individual identity is forged in the face of societal condemnation.

Lesbian and gay people move through the same stages of the developmental lifecycle as heterosexual people but experience numerous challenges and complications unique to their minority status (Ashton, 2011). Managing social stigma and discrimination caused by homophobia is one of the most significant challenges for LGBTQ people. This means they have to cope not only with external oppression but the complex ways that minority groups internalize and come to believe the negative messages about themselves (Green & Mitchell, 2008). Living in a homophobic culture where heterosexuality is assumed and rarely questioned, same-sex couples have had to negotiate the challenges of their own coming out processes in order to forge an intimate committed relationship with one another. To come "out" presumes that one is first of all "in" something, and what LGBTQ people are in is the assumption that they are straight; heterosexuality is the socially presumed default. Being out, even if in the most minimal ways, is necessary in order to find sexual or romantic partners.

Coming out does not simply mean recognizing one's own sexual desires and preferences, but also includes coming out to others and finding and sustaining affiliations that nurture what is often a despised social identity. Coming out is a process complicated by one's social position regarding age, race, ethnic and religious heritage, geographic locality, access to queer communities, and the anticipated and actual reaction of family and loved ones (Green, 2011).

The psychosocial stages of coming out delineates a common sequence of processes and dynamics that LGBTQ people experience in developing an integrated identity (Ashton, 2011). For some people, this process begins as a child or teenager, and for others it does not begin until middle age or later, sometimes after people are heterosexually married. Negotiating adversity and potential rejection during the coming out process can be difficult, particularly for those who are young and dependent on families that are not supportive, as well as those whose cultural or religious communities view homosexuality as a moral failure (Harvey, 2012; LaSala, 2010).

Young people coming out in childhood and adolescence are immersed in the values and belief structure of their parents or caregivers; they are dependent on them for not only food and shelter, but emotional nurturance. Unlike other minority groups, LGBTQ people are seldom reared in families who experience the same minority identity, therefore parents may be uneducated and poorly prepared to assist their children in healthy identity development. Research suggests that it is common for parents to initially be rejecting towards their LGBTQ children (D'Augelli, Hershberger, & Pilkington, 1998; Harvey, 2012; LaSala, 2010, Ryan et al., 2009, 2010). This leaves many LGBTQ youth without parental assistance to navigate their emerging sexual and gender identities and early explorations into the LGBTQ communities.

Ryan and her colleagues at the Family Acceptance Project have found that rejecting behaviors from family were associated with significantly poorer psychosocial outcomes, including higher rates of depression, increased substance use, and unprotected sexual activities (Ryan, Huebner, Diaz, & Sanchez, 2009, 2010). This is supported by decades of research revealing high incidences of suicidal ideation, school drop-out rates, homelessness, drug and alcohol abuse, and victimization for LGBTQ youth (D'Augelli, Grossman, & Starks, 2006; Harvey, 2012; LaSala, 2010; Nuttbrock et al., 2010).

LGBTQ people experience daily microaggressions due to their sexual orientation and/or gender expression including institutionalized discrimination, vilification of their sexual desires, denial of their chosen familial bonds, and endless derogatory marginalization in social discourse and media portrayal (Meyer, 2003; Nadal et al., 2011; Sue, 2010). This is reflected in elevated signs of mental health problems in adulthood, including increased depression, anxiety, substance abuse and other stress-related disorders (Cochran et al., 2003; Hatzenbuehler et al., 2010; Meyer, 2003; Nuttbrock et al., 2010) due to invalidating social environments. It is clear that the psychological consequences of coming out are potentially detrimental, influencing self-esteem as LGBTQ people internalize these messages of social condemnation and rejection; this is especially true for those who are young, vulnerable, and marginalized (Harvey, 2012).

The qualities of attachment and parental nurturance in childhood are known to be important for psychological health, but it might also influence how young people experience coming out. Research has shown that difficulties in childhood attachment may negatively impact coming out processes and lifelong self-acceptance. Mohr and Fassinger's research (2003) describe how low levels of parental support were associated with higher anxiety, and that people with difficulties accepting their own sexual orientation were more likely to exhibit a pattern of attachment anxiety and avoidance behaviors. In turn, patterns of avoidance were associated with lower levels of self-disclosure in daily life and individuals who are more out typically report less stress and fewer symptoms of depression or anxiety (Vaughan & Waehler, 2010).

It is undeniable that discrimination, bias, and microaggressions directed towards one's identity can be debilitating (Meyer, 2003; Nadal et al., 2011; Sue, 2010). There is also, however, evidence that developing skills to manage the stress of being a sexual minority might also be facilitative and can enhance coping strategies. It has

been suggested that unique strengths are developed by successfully adapting to the significant adversity inherent in coming out as lesbian or gay. Strength related growth, or coming out growth, describes how negotiating the processes of coming out and managing oppressive circumstances can transform the experience of minority stress into opportunities for enhanced growth and assist in the development of stable identities (Bonet, Wells, & Parsons, 2007; Vaughan & Waehler, 2010). Coming out to others can positively influence how people perceive and experience themselves as gay or lesbian people, and also improves their perception of, and relationships with, other gay-identified people (Vaughan & Waehler, 2010). Some of the benefits of coming out growth include: increased honesty and authenticity, lower use of drugs and alcohol, higher levels of social support and community integration, lower levels of depression, anxiety, stress and other mental health challenges, increased levels of self-disclosure and self-acceptance, and better skills at coping with oppression and negative societal hostility (Bonet et al., 2007; Vaughan & Waehler, 2010).

Although research has shown that families of origin are often initially rejecting, it also confirms that family relationships shift and grow as adolescents and their families discover and accept an emerging gay and lesbian identity (LaSala, 2010). Families have their own coming out process that must be negotiated and as they struggle with shame, guilt, and confusion, they must also make meaning of the same negative social messages about homosexuality with which their children have contended. This process can bring families together and serve as bridge for increased communication and a strengthening of family bonds. Ryan and her colleagues (2009, 2010) have demonstrated that lessening familial rejecting behaviors and increasing family acceptance will significantly improve outcomes and increase self-esteem.

Negotiating coming out is a lifelong process, not a single act of disclosure, and LGBTQ people are repeatedly in situations where they must make choices of what to let others know about their sexuality, their identity, and their families. The resilience necessary to cope with repeated societal microaggressions emerges from nurturing relationships with families of origin as well as negotiating adversity within the confines of a heteronormative and invalidating cultural environment. Successfully coming out is a necessary preparation to finding and joining with a same-sex partner, and the competence developed by coming out to families that are often initially rejecting, as well as confronting societal bias, may contribute to increased skills at partnership building.

Same-Sex Couples: Challenges

Green (2004) suggests that there are “three interrelated risk factors for lesbian and gay couples forming a partnership: (1) homophobia (external and internal); (2) lack of a normative and legal template for same-sex couples; and (3) lower levels of family social support” (p. 290). The challenges of homophobia and lack of familial support were discussed above; the focus here is the lack of a normative legal

template. Without a relational template for same-sex couples, Green (2004) says, there is no "preordained prescription for what being a same-sex couple means" (p. 291). Same-sex couples need to negotiate what has been for heterosexuals very basic and assumed (and gendered) tasks, i.e., who pays for the date and who takes out the garbage, as well as complex psycho-emotional processes, i.e., who initiates sex, and which partner will get pregnant and carry the couple's child. Green says that the lack of a relational template creates relational ambiguity (2008, 2011).

Relational ambiguity is a concept expanded from Pauline Boss's theory of "boundary ambiguity." Boss defined boundary ambiguity as "a state in which family members are uncertain in their perception of who is in or out of the family and who is performing what roles or tasks in the family system" (Boss & Greenberg, 1987, p. 536, as quoted by Green & Mitchell, 2008, p. 667). Relational ambiguity is at the heart of any discussion about relational resilience in same-sex coupling since there has been no cultural script or set of rules for how lesbian and gay couples "should" be a couple, or present themselves to the society. Patterson and Schwartz (1994) say that couples must be able to "telegraph to others the shape and seriousness of their commitment. They must invent some 'marital' rules, borrow others, and pick some to avoid" (p. 4). In other words, it must be an active process, and one that is not just internal to the partners, but also involves ongoing communication with their family and social world.

Same-sex couples have had to create healthy boundaries around the relationship, in the absence of culturally proscribed ones. Historically there have been legal constraints on establishing protective boundaries around the relationship, leaving the relationship less secure financially, legally, and emotionally. Lesbian and gay couples have long desired to secure their relationships, although this has only recently become possible with changes in law and policy which have increasingly made same-sex marriage possible in many countries and U.S. states. Hatzenbuehler and colleagues (2010) examined how the lack of institutional recognition can influence mental health for LGB people, and they found that LGB individuals living in states with constitutional amendments banning gay marriage experienced increased rates of psychiatric disorders. Research shows that couples who had civil unions have more financial and familial intertwinement of their lives, and lesbian couples were less closeted about their sexual orientation (Solomon, Rothblum, & Balsam, 2004). The cost of relational ambiguity is high and increased civil rights clearly serves as a protective factor.

In order to resolve relationship ambiguity, same-sex couples have historically had to engage in a complex dialogue about their commitment, as well as manage issues of power and roles. What is accomplished easily with a marriage certificate for heterosexual couples must be established through wills, powers of attorney, health care proxies, etc., at great expense and with necessary forethought for the gay and lesbian couple before marriage equality laws. The communication necessary to negotiate partnerships can be a great boon to the relationship, when this process is successful. However, when it is not successful, the lack of legal bonds can be devastating. This is, of course, rapidly changing as lesbian and gay couples are now legally allowed to marry in many states.

Relationship ambiguity is poignantly illustrated by Allen's (2007) personal narrative of having her lesbian partner end their relationship, refusing to allow her contact with a child she had parented since birth and raising the question of how one can divorce when there is no recognition of marriage. When her and her partner broke up, her partner took their son; she had no legal standing as a non-biological parent, creating a painful, relentless sense of loss, with no hope of legal or political redress, creating what she referred to as the "structural ambiguity of being a politically and legally invisible family" (p. 181). In a heterosexual relationship, her rights as a parent would have been protected, regardless of her ex-partner's desires. The cognitive dissonance of both being a family and yet not having the power to protect those you love or determine the direction of your future together speaks to the ambiguity of relationship status within same-sex coupling and its impact on family-building.

Without legally protective and socially affirmed rituals, when does a relationship move from dating to something more serious, and when does a relationship in trouble cease to be a relationship? When boundaries are permeable, how are they negotiated? Heterosexual relationships are governed by a set of social and legally sanctioned rituals from buying engagement rings, to owning a house and putting both spouses' names on the deed, to complex laws dividing property when there is a divorce. Surely not all heterosexual couples follow these patterns, and some vocally rebel against them, but until relatively recently same-sex couples who wanted to embrace these rituals were blocked by laws that have not recognize their union as legitimate, and by the potential social discomfort caused when they shop for an engagement ring, or new house, within a heteronormative and often blatantly homophobic culture. Additionally, family members, as well as shopkeepers may or may not honor these attempts at creating security in their relationship, and might even resort to minimizing or mocking responses. The couple, as individuals as well as a unit, must confront societal homophobia as well as their internalized fear of rejection or exposure. Indeed, due to ambiguity of rules, it may not be easy to decide *who* buys an engagement ring *for whom* in relationships where gender roles have not been firmly established and rigidly adhered to by socialized male/female constraints! Clearly, relational ambiguity can be a potential minefield of stress and adversity, yet the creative solutions to address this ambiguity are one of great strengths of same-sex relationships. Undoubtedly, the excitement over marriage equality and the Supreme Court decision that the Defense of Marriage Act (DOMA) is unconstitutional, fosters a more supportive social environment for same-sex couples and resolves some relationship ambiguity enabling them to feel more secure, psychologically as well as legally.

Same-Sex Couples: Strengths

Relational or couple resilience infers that a couple is successfully coping with adversity and research shows that lesbian and gay couples are remarkably similar to heterosexual couples in terms of how they manage their daily lives and address

conflicts within their relationships (Kurdek, 1993). Same-sex couples organize their lives in similar ways as heterosexual couples in the sense that they date, move towards greater intimacy, and begin a process of pair-bonding (Ashton, 2011). They celebrate milestone events like anniversaries, they move in together, set up housekeeping, and plan on having children (Bigner & Wetchler, 2012; Goldberg & Allen, 2012). Like all other couples they manage stressful events like illness or infidelity, and eventually they face aging issues together (Dziengel, 2011; Genke, 2004; Witten & Eyler, 2012).

Quam and colleagues (2010) found that a majority of older same-sex couples lived together and/or owned a home together, and had shared bank accounts and credit cards. Research shows that financial interdependence, commitment rituals, and securing legal ties to one another in the absence of marital contracts was part of lesbian and gay coupling for decades, long before the explosion of media attention and increased social acceptance (Bryant & Demian, 1994).

Lesbian and gay couples describe a high level of relationship quality, satisfaction and stability (Bryant & Demian, 1994; Connolly, 2005; Gottman et al., 2003; Green & Mitchell, 2008; Hunter, 2012; Kurdek, 2005). They tend to resolve conflict constructively, have high rates of communication, and place great value on intimacy and closeness. Jonathan (2009) studied communication patterns in same-sex couples and identified that lesbian and gay couples showed a high attunement to one another's needs, referred to as an attuned-equality pattern. Same-sex couples were attentive to fairness and justice, engaged in conscious relationship strategies, including shared decision-making, and careful conflict management. There was an ongoing evaluation of the relationship and a willingness to re-negotiate when conflict arises. Additionally, male same-sex couples reported increased autonomy, and female same-sex couples reported high intimacy and equality (Gottman et al., 2003).

In most heterosexual relationships gender plays an important role in determining both daily tasks, and psycho-emotional relational rules regarding communication patterns and childrearing practices; indeed gendered expectations permeate every area of marital life. Gender is also a salient factor for same-sex couples, but since gender dynamics are not based in heterosexual (and heterosexist) rules (Hunter, 2012) the role of gender has often been under-explored and perhaps sometimes completely misunderstood.

In gay and lesbian partnerships gender is a relational task that is negotiated depending on numerous variables, including personality and interests, sub-cultural community patterns and values, and may be re-negotiated depending on the shifting needs of the individuals and family through the course of the lifecycle (Connolly, 2005; Green & Mitchell, 2008; Jonathan, 2009). Since neither partner enters the relationship with an expectation that their social roles will be based along gender lines, both men and women are "allowed" to explore both traditionally masculine and feminine roles. No one is designated as "the person who takes out the garbage," or "the one who will get pregnant," these relational tasks must be discussed and negotiated, reflecting a high need for communication and conflict resolution.

Contemporary research has consistently shown that same-sex couples exhibit a value of equality and shared power in how they organize their daily lives. Lesbian

and gay couples are active participants in co-creating their relationship. There is an interactional pattern of closeness, a strong desire to create an equality of power, and openness of communication (Green, 2011); this is especially true in lesbian relationships (Connolly, 2005). Connolly (2006) refers to a dynamic of mutuality, a strong "personal dedication to the relationship" (p. 151). Couples often develop an "us-against-the-world" perspective (Connolly , 2006, p. 151), which can assist in couple cohesion, the sense of being a "united front" (ibid) against oppression and discrimination.

Decision-making regarding household labor becomes a mutual task, and in the majority of same-sex couples the household responsibilities are divided relatively equally between the partners (Jonathan, 2009; Kurdek, 2005; Quam et al., 2010; Solomon, Rothblum, & Balsam,, 2004). In families with children, child-rearing chores and parental responsibilities are also equally shared in lesbian and gay couples (Goldberg, 2010, 2012). Interestingly, it is also true in lesbian relationships where gender roles are explicitly butch/femme identified; Levitt, Gerrish and Hiestand (2003) discovered that although gender was a salient factor in how these couples identified and expressed themselves, housekeeping duties were *not* divided along traditional gender lines. As Lev (2008) has said,

> Examining domestic chores and parenting styles, or even power dynamics and communication styles, may not accurately measure the way that gender operates within same-sex couples, and for butch/femme couples it may actually mask the way that gender roles are understood and interpreted within the relationship. If research about gender roles assumes a power differential attached to the gender expression, the "equality" within the lesbian couple may hide important aspects of how gender functions in the relationship that is neither traditional (i.e., based in hetero-normativity) nor hierarchal. (p. 138)

Within heterosexual coupling, gender role expectations have symbolized complex power dynamics between the members of the couple. Examining gender in same-sex couples may require a different lens, a less heterosexist lens, to determine the meaning of behavior. Gay and lesbian couples are able to explore gender, "play" with gender, express gender, without it necessarily being attached to traditional gender roles, or societal rules. The stay-at-home mom may be a dad who lifts weights and bakes cookies. It is not that gender is absent in gay and lesbian couples; it may simply reflect different cultural patterns. It is necessary to deconstruct the meaning of gender and roles, without heterosexist assumptions. For example, the closeness in lesbian relationships has often been mislabeled as "fusion," instead of seeing the deeper intimacy between two women as a potential strength of their female coupling (Green, 2011; Macdonald, 1998; Spitalnick & McNair, 2005).

Research on sexuality is particularly susceptible to a heterosexist analysis. Many studies have shown that lesbians tend to have less frequent genital sex when compared to heterosexual or gay male couples. This is often stated as a "problem," ignoring the equally compelling information that lesbians express higher satisfaction in their intimate sexual relationships (Green, 2011; McDonald, 1998). If researchers perceive that sexual frequency trumps sexual satisfaction, then lesbians are seen as having a deficit in their sex lives. In a similar vein, research has also shown that non-monogamy and open relationships are more common in gay male relationships

(Bryant & Demian, 1994; LaSala, 2004; Spitalnick & McNair, 2005). Within the context of a heterosexual lens, a lack of fidelity would likely be viewed as a lack of commitment, but research does not show that gay male couples are less committed or happy in their relationships. When examining coupling patterns and gender, same-sex couples should not be judged within the same value orientation as heterosexual couples, but rather with a queer cultural lens. Negotiating complex areas of gender and sexuality actually requires high levels of communication and sophisticated skills of conflict resolution, which may indeed be a strength, a hidden resilience, for gay and lesbian couples.

It is possible that same-sex couples have an advantage to being reared in same gender role as their partners. They may be similar to one another in important ways, and this similarity may increase closeness, cohesion, egalitarianism, and emotional expressiveness, especially for women. This may lead to great attunement during conflict since they approach disagreements from a position of peer equality and humor (Gottman et al., 2003) which may assist the couple in re-bounding from adversity with great ease (Connolly, 2005, 2006).

Strength in Numbers: LGBTQ Community

As part of the process of coming out, most gay and lesbian people recognize that they are different in important contextual ways from heterosexual peers and also similar in core ways to other LGBTQ people, so they seek out communities that will affirm and mirror their emerging identities. Seeking out community and finding resources, social services, and support has been instrumental in assisting people in developing a positive queer identity. From facing the negativities of oppression and minority stress, through the process of reframing and reinventing, LGBTQ people have created an affirming cultural community, which helps sustain long-term friendships, intimate relationships, and creates an environment for family building. Green (2011) says, "it evolved over many decades as part of a secret society that protected its members against physical, economic, legal, and social threats to survival and well-being" (p. 176).

Like all communities, the community that gay and lesbian people have built has its own cultural norms and behavior patterns. It has served as a safe harbor for queer people who have most often been raised by heterosexual parents within straight culture. Living without formal recognition for same-sex pair boding, a vibrant culture has arisen that borrows from the mainstream culture, but is willing to also stretch into new ways of building intimacy and family. LGBTQ people have built communities, with its own set of meta-rules and patterned ways of communication. It is common, for example, for LGBTQ people to remain close to ex-lovers, and build families based not on blood, but love and commitment. For those who have been ostracized from their families of origin, the LGBTQ community often replaces the family that has been rejecting or abandoning and becomes an extended family, providing nurturance, support, and a place to celebrate holidays, or seek our comfort

in trying times. There is also great variety of intimate relationship arrangements that are acceptable within the LGBTQ community, including open relationships and polyamory (Green & Mitchell, 2008; LaSala, 2004).

Research consistently shows the importance of the LGBTQ community in the lives of lesbian and gay couples (Dziengel, 2011; Genke, 2004; Green, 2011; Vaughan & Waehler, 2010). Involvement in the LGBTQ community was also found to predict high levels of coming out growth (Bonet et al., 2007; Vaughan & Waehler, 2010), because being with other queer people increases individual self-esteem and challenges isolation. Additionally, the LGBTQ community has become a powerful political voice advocating for marriage equality, and empowering queer people to demand equal treatment and fight oppressive laws.

The LGBTQ community is also a place to meet others for dating as well as finding mutual supports for socializing. This is especially true for those who live more rurally, or in more insular religious or cultural communities; the Internet has been instrumental in creating support for LGBTQ people who are more isolated (Giammattei & Green, 2012). Involvement in the LGBTQ community has been essential for creating supports for people living with AIDS, as well as coping with other illness and aging issues (Dziengel, 2011; Genke, 2004; Witten & Eyler, 2012). In this sense community-building is a source of resilience, a mutual aid relationship, where those coming out seek out the community while developing their identity and their continued engagement in the community creates a lifeline for those who follow.

Same-sex couples have role models within the larger community to mirror their experiences. As the LGBTQ community has grown, multiple communities and identities for sexual minorities have expanded, and possibilities for post-modern coupling and sexual expression have also broadened. The experience of being around others who can affirm relationships that are outside of the heteronormative culture, creates a “narrative coherence” (Walsh, 1996, p. 267), that mirrors ones personal experience, helps to normalize them, and then creates an environment to make meaning of shared identities and relationships.

Relational Resilience in a Changing World

The process of de-centering heteronormativity, and developing supportive communities, has given lesbian and gay couples the ability to re-vision their relationships, and create unique family forms. The nature of same-sex coupling allows for greater diversity in how families are organized around gender, and influences greater flexibility in all areas of life from household chores to sexual intimacy. Relational resilience is born from adversity; many of the unique family forms have been forged from surviving difficult conditions.

Lesbian women and gay men forming intimate partnerships need to negotiate complex interactions within society including: discrimination and bias in the form of blatant and sometimes violent homophobia; invisibility due to ubiquitous heterosexism

and misinformation about queer identity and communities; and harsh gender role socialization and societal punishment of gender transgressions. Additionally, they must manage equally complex psychological and intrapersonal processes including struggles regarding coming out and identity self-disclosure as well as issues of relational ambiguity, forging a functioning couple identity without culturally proscribed roles or legal boundary containment.

There are also specific tasks in individual relationships that must be successfully negotiated in order to form stable, loving relationships that can withstand normative and out-of-the ordinary crises. For example, partners might come out at different ages or stages in the lifecycle, or come from different religious or cultural backgrounds, and might not be comfortable with similar levels of disclosure about their relationship. They might have to face illness or infertility or unemployment. Lesbian and gay couples must develop the protective factors necessary to confront the normative interpersonal challenges that impact all couples regardless of their sexual orientation.

In recent years, public policy has shifted and these changes have created many benefits for the LGBTQ community. For example, adoption by out lesbian and gay people has become socially sanctioned by major national child welfare organizations, and more municipalities have instituted discrimination protections in housing and employment for transgender persons. Same-sex marriage, viewed as a pipe-dream a mere decade ago, has gained traction and become a legal fait accompli in many countries and in increasing numbers of U.S. states. However, it is easy to forget while these changes are celebrated that most U.S. states still do not allow same-sex marriage, or have protections for queer families in housing or employment and most LGBTQ people still face complex adverse social situations. Bias-related violence remains an ongoing threat, even in progressive urban environments.

The tide, however, has clearly turned from the closeted, fearful homophobia common only decades ago. Green and Mitchell (2008) cite D'Augelli and colleagues (2006) research showing that young lesbian and gay teens plan to marry and have children when they are older, something an older generation of LGBTQ could not have imagined envisioning as young people. There is tremendous hope for the future of lesbian and couples, building on long history of creating relationships in hostile and negative environments.

Research continues to show that same-sex couples value communication, and develop a strong sense of "we-ness" and mutuality, which are protective factors against both external oppression, and relational ambiguity. As LGBTQ people increasingly secure legal rights and become integrated in positive ways into mainstream culture, the challenge is to maintain the unique relational resiliencies developed within queer communities and retain the lessons learned while living as outlaws.

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Chapter 4
Sexual Resilience in Couples

Andrea M. Beck and John W. Robinson

Joan looks at her husband and sighs to herself. "Why can't it be like it was?" she thinks. "It used to be close and intimate when we made love. We used to have such a good sex life. Since his surgery, it all seems so unnatural, sometimes even forced. I feel sad; sometimes I feel it might be easier to just forget it."

Rick looks down, avoiding his wife's gaze. He too longs for how sex was before he had his prostate cancer. "Why is it all so complicated and why can't we go back to the way things were?" he wonders. "She hardly seems interested in touching me anymore, and even if she did, it would probably turn out badly. It's so frustrating, and sometimes it feels easier to just forget it. Perhaps, we should try a vacuum erection device. That might help me get a better erection."

Why is it that some couples are resilient and weather a storm in their sexual relationship, coming through it with their sexual relationship intact, while others find their relationship stuck? This is the question we address in this chapter on couples' sexual resilience.

Sexual Resilience in Couples

Couples go through many stages and seasons in their relationships, whether the relationship is short- or long-term. Many events and experiences in a couple's life can affect their sexual relationship. Some couples are able to weather these storms and maintain or restore a satisfying sexual relationship, while other couples find the difficulty insurmountable and feel sexually dissatisfied, often grieving the loss of their past sexual relationship for many years.

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Psychologists have long recognized the abilities of humans to adapt to and overcome adversity. Individuals, families and communities are able to rebuild their lives even after devastating tragedies. Resilience is the ability to withstand stress, regain strength, adapt, and find solutions to life's challenges and setbacks. Being resilient does not mean going through life without experiencing stress and pain. All people face challenges, and all people feel grief, sadness, and a range of other emotions after adversity and loss. Resilience refers to the capacity to work through the emotions and effects of stress and painful events.

A specific type of resilience, manifested in couples as well as individuals, is sexual resilience. Sexual resilience, as we have come to understand and define it, is a term used to describe individuals or couples who are able to withstand, adapt, and find solutions to events and experiences that challenge their sexual relationship. Although any experience that places stress on a couple can have unexpected effects on the sexual relationship, the most common challenges to sexuality include the birth of the first child, where the demands of parenting often eclipse the sexual relationship between partners; the onset of a physical or mental illness, such as cancer, diabetes or depression; an emotional blow to the relationship, such as betrayal or hurt; lack of relational intimacy, such as becoming absorbed by other priorities such as career; and changes associated with aging, such as vaginal dryness or erectile dysfunction.

Sexual resilience is a term that we use to describe couples who are able to adapt to challenges to their sexual relationship in ways that maintain or restore a satisfying sexual relationship. These couples are able to assess their current sexual relationship, find and implement potential solutions, and adapt to the challenges at hand. Sexually resilient couples are those who have faced significant challenges and were able to come out on the other side equally or more satisfied with their sexual relationship.

Although challenges to couples' sexual relationships are ubiquitous, few resources exist to guide couples through the process of working through these difficulties. Even when accessing services from a professional with specialized training in sexuality, whether a physician, counselor, or psychologist, few theoretical frameworks exist to guide the professional in carrying out their work. There is a paucity of evidence-based models of sexuality that provide a unifying theory upon which to base one's work with couples on matters of sexuality. What does exist in the literature are suggestions for addressing sexual problems. Missing, however, is a comprehensive theory that is able to provide insight into couples' sexual resilience.

Existing Models of Couple Sexual Functioning and Intimacy

The Good-Enough Sex Model

Until recently, the most comprehensive model of sexuality has been the "Good-Enough Sex" model of Metz and McCarthy (2007). Although the authors present several guiding principles of healthy sexuality, the most fundamental postulate is that couples need to have realistic expectations of their sexual encounters- accepting

mediocre, dissatisfying, or dysfunctional sexual experiences as "good-enough sex," rather than expecting that every sexual experience will be highly satisfying. Adopting realistic expectations helps couples to avoid negative feedback loops, whereby one dissatisfying sexual experience causes distress that creates a negative expectation for all future sexual encounters.

Most of the work carried out by Metz and McCarthy focuses on the concept of sexual desire, or the dysfunction that occurs when one or both partners experience inhibited sexual desire (McCarthy, Ginsberg, & Fucito, 2006). In fact, the authors argue that desire and satisfaction are the key factors in maintaining a healthy sexuality. They even provide a prescription for increasing desire that entails integrating intimacy, non-demand pleasuring, and erotic scenarios with positive, realistic sexual expectations. Sexual resilience is achieved by not avoiding sex or feeling self-conscious, and by maintaining a flexible sexual relationship.

Although the authors acknowledge that sexual dysfunction is generally multi-causal, the only specific cause of sexual dysfunction offered is the existence of unrealistic expectations in one or both partners. Thus the Good-Enough Sex Model does not provide a framework for understanding the development of inhibited sexual desire, sexual avoidance, self-consciousness, or a rigid sexual relationship, apart from unrealistic sexual expectations.

The Sexual Health Model

The Sexual Health Model (Robinson, Munns, Weber-Main, Lowe, & Raymond, 2011) was originally developed in the context of safe sex practices, specifically HIV prevention, but has more recently been applied to the treatment of a variety of sexual dysfunctions, including orgasmic and desire disorders. The authors' treatment program promotes and teaches ten essential components of sexual health, which include: (1) the ability to talk openly and explicitly about sex, (2) understanding the impact of one's gender and cultural heritage on sexual identity, attitudes, behaviors, and health, (3) having a basic knowledge and acceptance of one's anatomy, sexual response, and sexual functioning, (4) knowing and taking care of one's body, such as getting regular medical care, (5) addressing barriers to sexual health, such as sexual abuse and mental health issues, (6) having a healthy body-image through the acceptance of a wide standard of beauty, (7) appreciating the role of masturbation and fantasy in healthy sexuality (i.e., masturbation and fantasy are normal and healthy, rather than deviant, immoral, or unhealthy), (8) having a positive attitude toward sexuality, including the ability to be assertive about one's sexual desires, (9) addressing conflicts in the relationship that interfere with intimacy, and (10) being able to integrate and assume congruence between one's sexual behaviors and values, and one's spiritual, ethical, and moral beliefs. In terms of sexual resilience, Robinson and colleagues would argue that any event or experience that challenges a person's ability to successfully negotiate one of the ten components of sexual health could compromise that person's sexual health.

The Flexible Coping Model

Originally developed in response to a dearth of research and intervention strategies for addressing sexual concerns for those with chronic illness and those with cancer, the Flexible Coping Model (Reese, Keefe, Somers, & Abernethy, 2010) posits that the level of flexibility a person has in regard to his or her definition of sexual activity and the centrality of sexual function and activity, will directly affect how the person responds to sexual challenges. First, individuals who have rigid and narrow definitions of sexual activity, for example, that sexual activity is seen as synonymous with intercourse, may respond to an event that compromises their ability to engage in intercourse with helplessness and avoidance. In this case, treatment would focus on helping the individual to expand his or her definition of sexual activity, as well as to engage in a wider variety of sexual activities. Conversely, a person whose definition of sexual activity includes intercourse, non-intercourse sexual activities, and non-sexual intimacy, is more likely to appraise sexual challenges as manageable and to cope more successfully. A person who relies heavily on the importance of sexual functioning within their self-concept will likely struggle more than a person who views sexual functioning as less central. Treatment strategies, then, would focus on helping the individual set more realistic and attainable goals.

The Sexual Self-Schema Model

Anderson and colleagues proposed the model of sexual self-schemas (Andersen, Cyranowski, & Espindle, 1999). Sexual self-schemas are argued to be generalizations about the sexual self that guide sexual behavior and influence the processing of sexual information. Sexual self-schema is typically measured using the Sexual Self-Schema Scales, which contain a series of trait adjectives (such as “cautious” or “loving”) and result in the categorization of individuals into one of three main dimensions. For women, the dimensions include passionate/romantic, open/direct, and embarrassed/conservative (Andersen, 1999; Carpenter, Andersen, Fowler, & Maxwell, 2009). To determine a total score, items from the first two factors are summed and items from the third factor are subtracted. For men, the Sexual Self-Schema Scale is made up of three similar, but not identical, dimensions including passionate/loving, powerful/independent, open/liberal, and the total score is determined by summing all three factors (Andersen, 1999; Andersen et al., 1999). On both, low scores represent a negative sexual self schema while high scores represent a positive sexual self schema.

Although the sexual self schema model posits that a positive self schema is a protective characteristic that provides a person with resiliency in the face of sexual dysfunction, the Sexual Self-Schema model itself has a broader range (Andersen, 1985, 1994, 1999). This model predicts that those individuals who have a positive sexual self-schema will adjust to sexual dysfunction better than those who have a negative self schema (Andersen, 1999; Carpenter et al., 2009). Interestingly, the authors also hypothesize that negative sexual self schema may be related to lower levels of passionate love and anxious or avoidant romantic attachments.

To date, the studies that have been carried out to test the sexual self schema model have been correlational in nature (Carpenter et al., 2009). There is limited empirical support that a positive self-schema predicts better sexual adjustment, and the interactions between partners are not taken into account.

The Physical Pleasure: Relational Intimacy Model of Sexual Motivation (PRISM)

The models presented thus far are effective in articulating many components of healthy sexuality, such as having a sex-positive perspective, realistic expectations, and flexible attitudes toward sex. However, in our clinical work with couples experiencing sexual dysfunction after treatment for prostate cancer (PrCa), we found that these models did not fully explain why some couples are able to adjust and continue to enjoy sex while others are not and thus stop having sex altogether. After treatment for prostate cancer for example, most men experience some loss of erectile function that makes penetrative sex difficult, if not impossible, without the use of pro-erectile aids (i.e., intracaversonal injections, vacuum erection devices or oral medications like Viagra, Levitra, Cialis and Staxyn). We and others have found that even if couples find an erectile aid that gives a man an erection sufficient for penetration, half of these couples stop having sex within a year (Matthew et al., 2005; Schover et al., 2002).

The PRISM Study of Sexual Resilience

To better understand what distinguishes couples who adapt successfully (i.e., resilient couples) from those who do not, we conducted in-depth interviews with both successful and unsuccessful couples. Ten heterosexual couples who successfully maintained satisfying sexual intimacy and seven couples who had not maintained satisfying sexual intimacy after prostate cancer treatment were interviewed for the study and analyzed using a qualitative coding procedures. The result is the Physical Pleasure – Relational Intimacy Model of Sexual Motivation (PRISM; Beck, Robinson, & Carlson, 2013).

Methods

After recruitment and informed consent, couples were interviewed in-person with their partner. A few day later, each partner was interviewed individually. In total, 51 interviews with 17 couples made up the data set. To enhance participants' recall of events and experiences, interviews followed a chronological format, whereby specific time points were used as benchmarks to cue participants' memories (Geiselman, Fisher, MacKinnon, & Hollan, 1986). Specifically, participants were

asked to describe their sexual relationship before the diagnosis of prostate cancer, after diagnosis but before treatment, during the time soon after treatment, and currently. The strategies that the couples used to maintain sexual intimacy were specifically queried. As each interview was reviewed, the researcher took note of new themes to inquire about in subsequent interviews. The interviews were audio-recorded and subsequently transcribed verbatim.

Interviews were analyzed according to the qualitative procedure of grounded theory, as outlined by Strauss and Corbin (1998), allowing the theory to emerge rather than forcing a theory based on preconceptions. The constant comparative method was used whereby the researcher allowed the theory to emerge by generating themes based in the data and delineating their relationships by comparing categories systematically. The grounded theory analysis resulted in the generation of one foundational theme and three important secondary themes. To identify the foundational and secondary themes, all interviews were first coded line-by-line, and a comprehensive list of themes was generated. These initial themes were then organized into hierarchies, in which specific categories were subsumed under more general categories. This helped to clarify the relationships between the themes, as well as winnow out the themes that were only distally or not at all related to the research question.

The researcher then asked specific questions of the data in order to highlight those themes that most directly addressed the research question, "How are some couples able to maintain satisfying sexual intimacy after prostate cancer, while others are not?" First, the researcher asked, "What are the characteristics or qualities associated with satisfied couples? How would I describe satisfied couples?" From this question, the three secondary themes of *acceptance*, *flexibility*, and *persistence* were chosen as most reflective of those couples who were able to maintain sexual intimacy after prostate cancer.

In order to explain why some couples were able to have the characteristics of acceptance, flexibility, and persistence, while other were not, the researcher asked, "What is the difference between couples who were accepting, flexible, and persistent, and those who were not?" Based on this question, the theme of *value placed on sex* was chosen as the foundational notion best explaining the fundamental difference between those couples who were satisfied with their sexual intimacy and those who were not.

Study Findings

The main finding, which also forms the core of the PRISM model, is that peoples' sexual values affect the way in which they respond to events that challenge their sexual functioning. From a values-based perspective, the two main – although not the only- reasons people have sex are for (1) physical pleasure and (2) relational intimacy. Valuing sex for physical pleasure means that people are motivated to engage in sexual activity because they enjoy the sensorial and physiological feelings associated with sexual activity. In this case, sex is experienced as a release, as

physically satisfying, as pleasurable, and as a source of physical gratification. People who value sex for physical pleasure engage in sex because it feels good physically.

Valuing sex for relational intimacy means that a person is motivated to engage in sexual activity because they enjoy the feeling of being emotionally close to their sexual partner. In this case, sexual intimacy is experienced as a connection with a valued other person, as intimate, and promoting a sense of well-being and romance. People who value sex for relational intimacy often described finding enjoyment out of the quality time they spend together when engaging in sexual activity and feel connected on an emotional level. These individuals seek out sexual experiences to connect with their partner.

An individual may value sex for both physical pleasure and relational intimacy. Thus these constructs are not mutually exclusive, but rather thought of as two separate dimensions. The relative value that a person places on sex for physical pleasure and/or relational intimacy can be understood as existing on a continuum from low to high; the interaction of these two continuums creates a dimensional matrix by which an individual's motivation to engage in sex can be plotted (Fig. 4.1). Thus these constructs are not mutually exclusive, but rather thought of as two separate dimensions. The model postulates that the relative value predicts sexual satisfaction following a challenge to their sexual relationship.

People who place a relatively low value on sex for physical pleasure and a relatively low value on sex for relational intimacy (Quadrant 3 in Fig. 4.1) most commonly feel indifferent or apathetic toward sex. They have little motivation to pursue sexual activity, as they tend not to find sex highly rewarding, either physically or emotionally. In the context of an intimate relationship, these individuals engage in sex primarily for the sake of their partner. When faced with sexual challenges, both men and women may find it exceedingly difficult to generate and sustain the motivation required to address and overcome sexual difficulties.

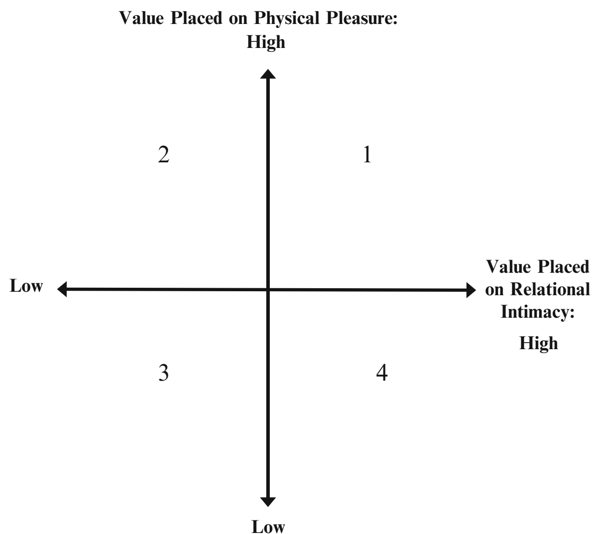

Fig. 4.1 Dimensional matrix of the value placed on sex

People who place a relatively high value on sex for physical pleasure and a relatively low value on sex for relational intimacy (Quadrant 2) engage in sexual activity primarily because of the physical gratification associated with sex. The main goal of sex is to have intercourse and experience orgasm. When paired with a partner who is willing and able to engage in sexual activity, these individuals often have healthy and satisfying sexual lives. When faced with sexual challenges however, these individuals most commonly become frustrated. Because these individuals place a relatively low value on sex for relational intimacy, sex with reduced physical pleasure, or in the absence of intercourse and orgasm, is unsatisfying. While they may be highly motivated to restore intercourse and orgasms, they often lack the flexibility to redefine their sexual relationships, to experiment with and place value in sexual activities other than intercourse and orgasm, to incorporate sexual aids, and/or to persevere through many months or years of sexual dysfunction.

People who place a relatively low value on sex for physical pleasure and a relatively high value on sex for relational intimacy (Quadrant 4) are motivated to engage in sexual activity primarily to feel emotionally close to their partner. These individuals often describe their partner as their best friend and maintain that intimacy in general is extremely important for the health of their relationship. They tend to be less concerned about the physical outcomes of sexual encounters (i.e., whether or not intercourse or orgasm occurred) but highly value the time spent together to focus on their partnership. For this reason, these individuals may respond to sexual challenges with less distress than those who place a high value on sex for physical pleasure. On an individual level, they are not overly concerned about specific sexual dysfunctions, but are motivated to find alternative ways of continuing to be sexually intimate with their partner, which may or may not include intercourse. These individuals often have a flexible attitude about the definition of sexual activity and are willing to experiment and take sexual risks with their partner.

People who place a relatively high value on sex for physical pleasure and a relatively high value on sex for relational intimacy (Quadrant 1) are motivated to engage in sex because it feels good and to emotionally connect with their partner. These individuals often engage in frequent and highly satisfying sexual activity with their partner. They also tend to describe sexual intimacy as important for the health of their relationship. When faced with sexual challenges, participants who highly value sex for both physical pleasure and relational intimacy are often tenacious about maintaining sexual intimacy. While they are willing to expand their definition of sexual intimacy, experiment, and take risks with their partner (and are able to derive sexual pleasure from these activities), they are also highly motivated to seek out, practice, and persevere with solutions to sexual dysfunction. These individuals often express a "just do it" attitude toward approaching and solving sexual difficulties.

Although the model is dynamic, assuming that couples' sexual values shift over time, Fig. 4.2 represents the researchers' estimations of each participant's relative value placed on sex for physical pleasure and/or relational intimacy. It is important to note that this graphical representation is an estimation based on the impressions

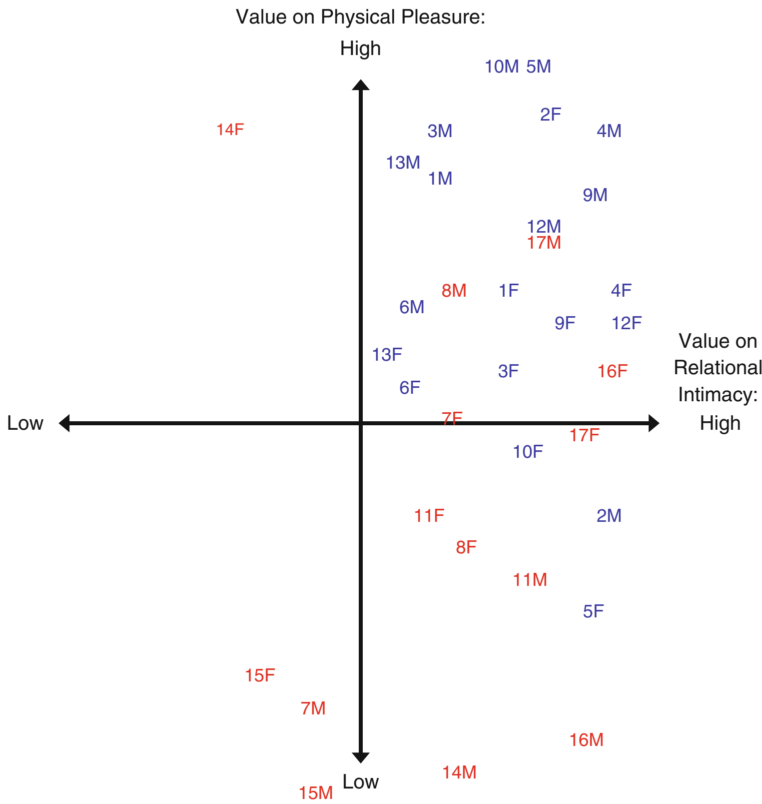

Fig. 4.2 Graphical representation of participants' relative value placed on sex for physical pleasure and relational intimacy. *Note*. Numerals represent couple identification numbers; "*M*" denotes male partner; "*F*" denotes female partner; *red* denotes those dissatisfied with current sexual intimacy; *blue* denotes those satisfied with current sexual intimacy

of participants' sexual values gleaned during the interviews. It represents the values of participants at one specific time-point and does not reflect the changes participants likely experience over time. Note that participants who reported satisfaction with their current sexual intimacy are denoted in blue, while participants who reported dissatisfaction with their current sexual intimacy are denoted in red.

An important aspect of the PRISM model is that the value that a person places on sex is dynamic, changing throughout a person's life based on sexual messages and sexual experiences, including events that challenge the sexual relationship. The interview data showed that individuals that struggle with sex, sometimes for many months or years, are able to restore satisfying sexual relationships after an honest assessment and reworking of their sexual values based on the new perspectives they gained from their experiences.

In addition to the fundamental importance of sexual values, the PRISM model found that several characteristics are often present in individuals and couples who are able to navigate challenges to their sexual relationships and maintain satisfying sexual intimacy (Beck et al., 2013). These characteristics include acceptance, flexibility, and persistence.

Acceptance Acceptance can be defined as the act of taking or receiving something offered. In the PRISM study, satisfied couples overwhelmingly acknowledged that it was important to take what they were given; in fact, this was an essential element of developing successful sexual relationships after being faced with an event that challenged the sexual relationship.

First, participants spoke of the importance of accepting the current situation. In other words, participants felt it was necessary to logically assess the situation they had found themselves in and, based on that assessment, develop realistic expectations about their current and future sexual relationship. The main sentiment was that continuing to rail against the current situation was a waste of emotional energy. When a person is able to set aside the frustration and the resentment, and instead accept the situation as it is, then one gains the intellectual and emotional resources needed to consider solutions and alternative ways of maintaining the sexual relationship. In this way, the PRISM model's notion of acceptance both accommodates and extends the ideas presented in the previous models: realistic expectations in the Good-Enough Sex Model, accepting one's sexual functioning (component 3) and addressing barriers to healthy sexual functioning (component 5) in the Sexual Health Model, and reducing the centrality of sexual functioning in the Flexible Coping Model (Metz & McCarthy, 2007; Reese et al., 2010; Robinson et al., 2011).

The PRISM model also extends the notion of acceptance by pointing out that because people often experience their sexuality in the context of a relationship, acceptance is also important in terms of one's own and one's partner's reactions to the sexual challenges and their feelings about potential solutions. First, an individual needs to acknowledge and accept their own feelings. For example, in the PRISM study, one woman had difficulty acknowledging that she was not satisfied with relational intimacy alone, but craved the physical pleasure associated with sex. Second, a person may need to work at accepting their partners' reactions to the sexual challenges and feelings. Whether one's partner is depressed and withdraws emotionally, is unrealistically optimistic about the future of the sexual relationship but complacent about taking action, is zealous and relentless about finding solutions, or seems unfazed by the experience, understanding and accepting a partner's feelings is a necessary but often challenging process.

Like the Good-Enough Sex Model (Metz & McCarthy, 2007), the participants in the PRISM study also needed to accept that emotional and physical sexual satisfaction was not all-or-nothing. In other words, successful couples were able to accept a sexual encounter that was "fair" or "moderate" as worthwhile and enjoyable. These couples seemed inherently to view sexual functioning as dynamic and fluctuating, with some sexual encounters better than others, but all meaningful and

worthwhile. This type of acceptance is particularly helpful in preventing hopelessness: a disappointing sexual encounter is not evidence that all future sexual encounters would be equally unsatisfying.

Flexibility Flexibility can be defined as the willingness or ability to modify or adapt. As understood in the context of the PRISM model, flexibility is the willingness to modify one's actions and reactions in the service of maintaining a satisfying sexual relationship. In order to successfully maintain satisfying sexual intimacy, couples must be willing to modify their old ways of having sex. This requires individuals and couples to experiment with new sexual activities and new sexual scripts. For example, couples may have to experiment with assistive aids, figure out how to have sex in a comfortable way, schedule sex rather than initiate spontaneously, and use manual stimulation or oral sex more frequently.

Second, successful coping requires flexibility in communication with one's partner. Many of the couples in the PRISM study had been intimate for decades and, prior to the challenges imposed by prostate cancer treatment, were used to a sexual routine that required very little explicit verbal communication. After treatment, however, it became imperative that partners verbalized their experiences before, during, and after sexual activity. In the absence of explicit communication, partners can be in danger of having unnecessary fears, experiencing discomfort, and misunderstanding their partners' feelings.

It is, again, clear that the PRISM model can accommodate the ideas presented in the existing models. The notion of flexibility, as outlined above, is congruent with the Flexible-Coping model, as well as component 1 of the Sexual Health Model (being able to talk openly and explicitly about one's sexual needs and desires) (Reese et al., 2010; Robinson et al., 2011).

Persistence Persistence is the act of continuing steadfastly in some purpose despite barriers or opposition. In the search for solutions to sexual challenges, sexually satisfied couples are incredibly persistent in obtaining information about possible solutions, approaching professionals for support, and experimenting and practicing with new ways of having sex until some satisfactory solution is found. For example, many of the dissatisfied couples in the PRISM study tried just one or two assistive aids only once or twice before giving up, while the satisfied couples were tenacious about trying an assistive aid many times in order to become comfortable and proficient with its use.

When considered in terms of an attitude, persistence appears to be made up of patience, determination, and perspective taking. Couples who are able to maintain sexual intimacy are patient, even when solutions to sexual problems take years to implement. They are determined that a sexual challenge was not going to stop them from enjoying one another sexually and they are able to engage in self-talk that helps them restore perspective when the challenges become particularly tiresome and difficult.

Summary of the PRISM Model

Sexual values can be integrated with the secondary themes of acceptance, flexibility, and persistence. Couples who strongly valued sex for relational intimacy were the ones who were most likely to exhibit these characteristics and successfully adapted to the challenges associated with prostate cancer treatment. Valuing sex for relational intimacy was what sustained couples, giving them the strength to accept their current functioning, remain flexible, and persist in finding solutions to events that challenged their sexual functioning.

This integrated theory of sexual resilience can be illustrated through a metaphor of a couple on a sailboat. The couple is navigating the sailboat out of a storm. On the hull of the sailboat is the name *Relational Intimacy* because, fundamentally, valuing sex for relational intimacy buoys sexual relationships through storms. There are three sails on the boat, one each for acceptance, flexibility and persistence, to illustrate that the couple's use of these attributes determines the specific direction or nature of their journey through sexual challenges.

Revisiting Sexual Motivation in View of Resilience

In general, research on sexual motivation is largely concerned with describing what motivates organisms to physically desire sexual activity, particularly intercourse. In other words, these theories concern themselves with the appetitive sexual drive. Many theories have been proposed, which include a plethora of components including approach/avoidance, appetitive/consummatory motives, excitatory/inhibitory brain processes, and those involving sensory/cognitive components (see Pfaus, 2008 for review). What these theories fail to explain, however, is why many people engage in sexual activity in the absence of the physical appetite for sex. In addition, these theories lead to the notion that low sexual desire is unnatural or unhealthy. An advantage of the PRISM model is that it can accommodate a broad range of levels of sexual desire that occur in healthy individuals and couples. This includes both individuals and couples that may happen to have a low desire for sex or feel that sex is not an important component of their relationship, in terms of fulfilling relational and/or physical needs.

The notion that people are motivated to engage in sexual activity for reasons beyond a desire to satisfy a sexual hunger has been strongly advocated (Basson, 2000, 2001, 2008). Basson has argued that, although the sexual response cycles developed by Masters and Johnson (1966) provided a substantial foundation for the understanding of the sexual response, the notion that sexual activity is consistently preceded by sexual desire is flawed and does not adequately account for the many motivators for engaging in sex. Instead, Basson posits that people may also engage in sexual activity for relational intimacy reasons, including emotional closeness, bonding, and commitment.

The fundamental reason that having high intimacy-based motivation helps couples maintain satisfying sexual intimacy may be that these couples are less invested in the physical outcome of sexual encounters than those who rely predominantly on sexual appetite as their primary motivation for engaging in sexual activity. Hence, these couples are more able to accept the challenges that arise, are flexible regarding solutions, and persist in continuing to engage in sexual activity despite difficulties. For these couples, because a primary reason for having sex is to experience relational intimacy, even if a sexual encounter is physically unsatisfying, the experience is still seen as emotionally satisfying and, therefore, not experienced as a failure. For this reason, these couples are more likely to experience resiliency rather than become caught in a negative feedback loop, where, in the event of a physically disappointing experience, all future sexual encounters are approached with the expectation of failure.

Dissatisfied couples, on the other hand, often wait for their own spontaneous sexual desire to arise before initiating sexual activity, or alternatively, wait for an invitation from their partner. The problem is that decreased physical desire is common during challenging times, and desire may rarely occur for both partners at the same time. Second, when the physical desire is present, the difficulties encountered in terms of sexual dysfunction (such as erectile dysfunction or dyspareunia) can eclipse the sexual appetite. In addition, couples who are motivated by physical desire are much more invested in the physical outcome of the sexual encounter and much more distressed in the face of physical challenges. In this way, a negative feedback loop occurs in which disappointing sexual encounters reduce the frequency and intensity of future sexual desires.

The Dynamic and Dimensional Nature of the PRISM Model

Individuals and couples invariably bring their pre-existing relationships, including sexual, into the experience of sexual challenges. Prior to these experiences, some individuals valued sex primarily for relational intimacy, while others primarily valued sex for physical pleasure. Some couples come into a challenging experience with good dyadic adjustment and strong constructive communication skills, while other couples are already experiencing tension and mutual avoidance. Facing sexual difficulties with a high value placed on sex for relational intimacy, with strong dyadic adjustment, and with effective and open communication skills primes a couple to respond well to sexual challenges. Our findings suggest that facing sexual difficulties with little value placed on sex for relational intimacy, with tenuous dyadic adjustment, and/or with an avoidant style of communication, may increase the likelihood of experiencing struggles in response to the sexual challenges. However, these trends likely do not automatically preclude couples from learning how to maintain or re-establish satisfying sexual intimacy. As the study findings suggest, some couples are able to overcome these challenges if motivated enough to maintain sexual intimacy. Based on this research as well as clinical observation, we have come to conclude that for some couples, the sexual challenge, when handled

well, can become a vehicle not only for improving sexual intimacy but also for addressing longstanding relationship issues and for deeper emotional healing.

An important aspect of the dynamic and dimensional nature of the PRISM model is that it accounts for the process of adjustment that couples experience after sexual difficulties. Because an individual's experience is dynamic, so too is his or her placement on the model. As individuals struggle with their new and challenging sexual relationship, they may go through a process of self- and partner-reflection as a way of searching for solutions. This may include a re-evaluation of their motives for engaging in sex. Through this process, some people who initially struggled may be able to develop a new appreciation of relational intimacy. Although some couples may remain entrenched in their maladaptive communication styles and weak dyadic adjustment, other couples that are initially frustrated may progress and became more satisfied over time.

The PRISM model reflects and can accommodate these movements, as couples learn to value relational intimacy through practice. Although the degree to which individuals and/or couples are able to adjust their sexual values is not known at this time, the interview data suggest that change is possible and that couples appear to be able to move within the model. Several couples, in describing their sexual experiences before, during, and after prostate cancer, made comments that suggested that their sexual values had changed over time. This was sometimes due to relationship factors (e.g., the individual had changed partners, and the newer partner's values influenced a change in their sexual values). At other times, a change in sexual values was an outcome of searching for new perspectives and solutions for the couple's struggling sexual relationship. Further research on and clinical application of the PRISM model will provide more information about the degree to which sexual values are modifiable.

Another important aspect of the dimensional nature of the PRISM model is that it allows for the assessment of degree. That is, those who happen to fall into the same general category or quadrant are not assumed to have the same level of that particular value. For example, two couples may express satisfaction with their current sexual relationship, and both may place a relatively high value on sex for relational intimacy and for physical pleasure. However, the model allows for the two couples to differ in degree. One couple may fall into the far reaches of the upper right quadrant, while the other couple may settle near the axes. Furthermore, individual partners within the same couple may differ in their sexual values. Discordant values (e.g., apathy vs. high motivation) may contribute to more struggles. Fundamentally, the PRISM model can account for variations in appraisal of the sexual experience (i.e., not everyone is satisfied, frustrated, or apathetic to the same degree).

Clinical Implications

The field of sexuality lacks a comprehensive model to guide effective clinical interventions. For example, current intervention programs designed to improve couples' sexual satisfaction after prostate cancer have yielded disappointing results

(Canada, Neese, Sui, & Schover, 2005; Chambers, Ferguson, Gardiner, Aitken, & Occhipinti, 2012; Collins et al., 2013; Giesler et al., 2005; Manne et al., 2011; Schover et al., 2011). These interventions emphasize strategies for restoring erections and thus for increasing physical pleasure. The PRISM model suggests that the reason these interventions produce disappointing results is that they may inadvertently encourage couples to value sex mainly for physical pleasure (Canada et al., 2005; Schover et al., 2011). This idea is also supported by the literature suggesting that those couples who re-negotiate their sexual practices and are willing to incorporate more non-penetrative activities (Reese et al., 2010; Wittmann et al., 2009) or even non-traditional penetrative activities (e.g., strap-on dildo; as described in Warkentin, Gray, &Wassersug, 2006), into their sexual repertoire, are likely to succeed in maintaining satisfying sex.

The PRISM model helps us understand the relationship between flexibility and a couple's shared values. When couples first try new ways of being sexual, for example by using a pro-erectile aid like a PDE5i, they usually find that sex is not as physically pleasurable as before. Couples who value sex predominantly for physical pleasure can become demoralized when they find sex to be less physically pleasurable. Couples who also value sex for relational intimacy find sex with less physical pleasure to still be rewarding because they value the time spent being physically intimate.

We have started to use a values clarification exercise based on the PRISM model in our clinical work with couples experiencing sexual dysfunction subsequent to prostate cancer treatment with promising results (Hampton, Walker, Beck, & Robinson, 2013). The PRISM model appears to have an appeal for couples by helping them to clarify their own sexual values and better understand those of their partner. We now return to the couple we introduced at the beginning of this chapter to illustrate the model's clinical utility:

Joan and Rick sought counseling after struggling with their sex life for over 2 years after Rick's surgery for prostate cancer. They had married in their mid twenties. Now, with their three children out of the house and without the stress of work, they looked forward to enjoying each other's company, especially sexually.

Joan and Rick were a fairly typical couple. While they both enjoyed sex over the course of their relationship, it was never a central part of their marriage. Consequently, they were both surprised to find how their sexual difficulties were disrupting their relationship in such profound and pervasive ways. Rick had completely lost the ability to get an erection after his surgery. To their amazement, Rick was still able to get sexually aroused and reach orgasm (albeit dry) without an erection. Their surgeon said that Rick's erections would improve with time and if they didn't, he would prescribe Viagra. Rick's erections had improved but even with Viagra he couldn't reliably get an erection hard enough to have enjoyable intercourse. Despite their best efforts to find a way to enjoy intercourse like they did before surgery, they couldn't. Their love making changed. Now, if Rick got an erection they hurried to have intercourse before he went soft. Rick felt that he was letting Joan down by not being able to perform and became hesitant to approach her even though he longed just to be held by her. Joan didn't want to put pressure on Rick, so she held back on giving Rick anything more that perfunctory hugs and

kisses for fear he would think she was wanting intercourse. Their hearts ached for one another. They felt desolate and demoralized as individuals and as a couple because they couldn't see a way to make things better.

The counselor gave Joan and Rick the following instructions:

Print out 2 copies (see Figure 4.1*) of the* ***P****hysical* ***P****leasure t* ***R****elational* ***I****ntimacy Model of* ***S****exual* ***M****otivation (PRISM) form, one for each of you.*

On your own, first think about how much you value sex for physical pleasure. Put an ***X*** *on the* ***vertical*** *line to indicate the degree to which you value sex for physical pleasure. If you highly value sex for physical pleasure put your X close to the top of the line. If you don't value sex for physical pleasure put your* ***X*** *closer to the bottom of the line.*

Do the same thing thinking about how much you value sex for relational intimacy. This time draw your ***X*** *on the* ***horizontal*** *line.*

Draw lines to connect the two lines and write your name where the two lines intersect.

Now do the same thing guessing how your partner filled out the form and put your partner's name beside the point.

Show each other how you filled in the form.

When the couple saw how the other filled in the grid, the couple's dispirited demeanor changed to one of excitement as they began to talk directly to one another rather than to the counsellor. Rick saw that Joan greatly valued sex for relational intimacy but only minimally valued sex for physical pleasure. Joan saw that Rick valued sex highly both for physical pleasure and relational intimacy, but relatively less so for relational intimacy.

Joan reminded Rick that sex had never been all that physically pleasurable for her and since menopause even less. She went on to say that for her, sex was a special time when they shut out the world and just focused on one another trying to make each other feel special. She teared-up when she saw how much Rick valued sex for physical pleasure, "I now understand why the loss of your erections troubles you so much. And I now understand that you keep trying to make sex more physically pleasurable for me because that's what you value most about sex."

Rick explained that he did value sex for relational intimacy, but because he actually felt closer to Joan when they were listening to a beautiful piece of music or hiking in the mountains, sex was less important for him as a way of being emotionally intimate with Joan. For him, there was nothing that physically felt better than sex. Rick sighed "I have to accept that sex will never feel the way it did before surgery." He went on to say how he now realized that his single-minded efforts to make sex more physically pleasurable for both of them resulted in their focusing more on helping him have an erection and having intercourse, and less and less on one another.

Having the exclusive goal of trying to make sex more physically pleasurable left both of them feeling desolate and disappointed after sex. With this insight, they then began to talk about how they could start to focus more on one another and re-establish a sense of intimacy in their love making.

Application of the PRISM Model to Other Populations

While the PRISM model was developed based on research with couples after prostate cancer treatment, the theory need not be restricted to this population. It is possible that the model may be applicable to a variety of couples who have experiences that present a challenge to healthy sexual functioning. The model may also be able to potentially predict outcomes for couples just facing a sexual challenge, as the PRISM model suggests that the main motives for engaging in sexual activity (for physical pleasure and/or relational intimacy) are likely a determining factor in the successful maintenance of satisfying sexual intimacy in the face of general challenges.

The PRISM model's potential wide-ranging applicability may be due, in part, to its relatively general nature in that it does not pre-suppose prostate cancer (PrCa)-related struggles per se. It is likely that the model is applicable to a wide range of individuals and couples struggling with many types of sexual challenges, either primary sexual dysfunction or sexual dysfunction secondary to other problems such as cancer, other health issues, disability, mental health challenges, and even relationally-based difficulties.

For example, the PRISM model may be applicable to other cancer populations. Breast cancer itself, as well as its treatment, is associated with sexual dysfunction for women (see Henson, 2002, for review; Krychman & Katz, 2012). With the presence of diminished libido, pain with intercourse, depression, fear of rejection, or fatigue, the motivation to engage in sexual activity for physical pleasure may place a heavy burden on women, who may react by shying away from sexual encounters with their partner. However, with the reconsideration of sex as an activity whose goal is to relate intimately with one's partner, rather than perform physically or experience physical pleasure, sexual activity may become less threatening to women, and they may be more likely to continue their sexual relationships.

The PRISM model may also be applicable to individuals with chronic illnesses (e.g., diabetes), disabilities (e.g., spinal cord injury), or age-related changes and diseases (e.g., cardiovascular disease, hormonal changes). These types of health challenges cause stress, as well as specific sexual side-effects, such as erectile dysfunction and vaginal dryness. The PRISM model has potential utility with such populations as well, as these individuals can continue to find value in and benefit from sexual activities with their partner, even when their disability precludes them from performing the full range of activities normally associated with sex (i.e., intercourse, orgasm, etc.). When the physical pleasure aspect of sex is viewed as an enjoyed, but not essential, component of sex, couples no longer need to rely on perfect sexual functioning to engage in satisfying sex. Physical pleasure can come to be seen as "icing on the cake", while relational intimacy is the cake itself.

Moving even further from the realm of health challenges, it may be possible to adopt the PRISM model as a lens through which to understand and assist individuals who are struggling with sexual challenges secondary to other experiences, such as the birth of a child, relationship breakdown, or chronic stress. Asking individuals

or couples to reflect on the reasons they value sex and to determine in what ways their current sexual relationship is meeting their needs, and failing to meet their needs, could allow the couple to begin renegotiating their sexual repertoire to create a relationship that is more satisfying to both. As some of these examples suggest, we believe that the PRISM model is inclusive and nonspecific enough to generalize to a wider population and to have clinical utility for a range of sexual challenges.

Future Research Directions

Future research stemming from the PRISM model could take several forms and follow a variety of paths. First, similar studies could be carried out with other populations to test whether the model appears valid for other types of people struggling with other types of sexual challenges. For example, similar studies could be carried out with homosexual couples after PrCa treatment or with couples after other types of cancers, health concerns, or disabilities. In addition, it is possible that the relative value one places on sex may change with age and stage of the relationship, and this could also be tested.

The model's predictive validity could be tested by interviewing couples before a known challenge, such as PrCa treatment, and having individuals place themselves on the model pre-treatment. Using this information, it may be possible to predict couples' likely outcomes, given the specific sex-related struggles of the specific challenge. Couples actual outcomes could then be compared with their predicted outcomes. The model would certainly gain strength and validity if it could be shown to hold up to this type of prediction.

Another future research endeavor would be to develop a measure that could place individuals and couples on the model of sexual values. The measure could be tested first on PrCa populations for reliability and validity. Once a valid and reliable measure was created, normative data could be gathered and generated for non-PrCa populations. Taking this line of research further, given a valid and reliable measure, one could then test the measure on other populations of individuals struggling with sexual challenges, to test whether the model appears valid for other populations.

If the model constructed and presented here is able to stand the test of time, given research and debate, it is possible that one could develop a psychotherapeutic intervention in order to help couples maintain sexual intimacy and thus demonstrate sexual resilience in the face of sexual challenges. This intervention would be theoretically based on the model and tested using pre-post measures of one's sexual values. Specifically, one could test whether those in the intervention group were more successful at maintaining sexual intimacy than those in the control group. One could also test whether individuals can and do modify their sexual values with intervention.

Summary

Our initial research question was, how are some couples able to demonstrate sexual resiliency and maintain a satisfying sexual relationship after the challenge of prostate cancer treatment, while other couples are not? The PRISM model was developed using grounded theory methodology. The model suggests that those couples who value sex for relational intimacy will be more likely to maintain or re-establish satisfying sexual intimacy, when faced with a challenge to their sexual relationship. Acceptance, flexibility, and persistence are characteristics most commonly associated with couples who successfully negotiated the challenges to their sexual relationship.

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Chapter 5
Dyadic Adaptation to Chronic Illness: The Importance of Considering Context in Understanding Couples' Resilience

Kristi E. Gamarel and Tracey A. Revenson

The concept of resilience is typically defined as positive adaptation under adverse circumstances (Luthar, Cicchetti, & Becker, 2000). This definition derives from work in human development that focused on how children could develop normally or even thrive under adverse family and social circumstances, including poverty, neglect, abuse, and chronic illness (e.g., O'Leary, 1998; Werner & Smith, 1977). More recently, research on resilience among adults continues to examine positive life changes under adverse situations, focusing on both outcomes and process (Bonanno, 2004; Danoff-Burg and Revenson, 2000; Joseph & Linley, 2005; Lepore & Revenson, 2006; Park & Helgeson, 2006; Tedeschi, Calhoun, & Cann, 2007; Tennen & Affleck, 1998). This phenomenon also has been referred to as stress-related growth, posttraumatic growth, thriving, and benefit-finding.

In truth, no single definition fully captures the construct of resilience. Resilience has been conceptualized as an outcome when it is viewed as an endpoint of stress and coping processes. It has been conceptualized as a personality attribute or coping resource (Aspinwall & Taylor, 1997; Carver, Scheier, & Segerstrom, 2010). And it has been conceptualized as a process involving dynamic interactions between risk and protective factors that can be within (e.g., biology, personality) or outside (e.g., social support) of the person (Bonanno, 2004; Luthar et al., 2000; Masten & Coatsworth, 1995; Rutter, 1985, 1999). Whichever approach is adopted, researchers have increasingly examined this phenomenon in the context of adverse health conditions, particularly cancer (Park, Lechner, Antoni, & Stanton, 2009).

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In this chapter, we expand the construct of resilience to the dyadic or interpersonal realm, specifically to couples that exhibit resilience in the face of a particular medical challenge: HIV disease. We couch resilience in a dyadic coping framework (Revenson, Kayser, & Bodenmann, 2005), in which each partner's stress appraisals and coping effects mutually influence individual and couple-level outcomes. We chose HIV disease as an exemplar because unlike many other illnesses (e.g., cancer), the consequences of coping with the illness affect partners' health and well-being; that is, dyadic coping not only affects psychological adjustment to the illness but also physical health: the virus can be transmitted between partners if dyadic coping is not effective.

Scholars have increasingly noted the difficulty of individual-level HIV prevention interventions, and called for research that examines the social, relational and structural contexts of people's lives that sustain risk behavior or promote optimal health behaviors (Beyrer et al., 2012; Diaz & Ayala, 2001; Huebner, Mandic, Mackaronis, Beougher, & Hoff, 2012). As a large proportion of HIV risk behavior occurs within the context of a primary romantic relationship (Davidovich et al., 2001; Dolcini, Coates, Catania, Kegeles, & Hauck, 1995; Marin, Tschann, Gomez, & Kegeles, 1993; McCoy & Inciardi, 1993; Reilly & Woo, 2004; Sullivan, Salazar, Buchbinder, & Sanchez, 2009; Weinhardt et al., 2004), researchers have sought to examine how relationship dynamics contribute to risk behaviors, both within and outside the primary partnership among same-sex male couples (Hoff, Beougher, Chakravarty, Darbes, & Neilands, 2010; Mitchell, Harvey, Champeau, & Seal, 2012; Prestage et al., 2008). In this review, we first focus first on definitions of dyadic coping. Then, we systemically review the literature on dyadic coping among same-sex male couples in which one or both partners has HIV disease. We conclude with a roadmap for future investigations, arguing for a greater attention to the questions of mechanism and context that are critical for examining dyadic resilience and health among gay male couples affected by HIV.

Dyadic Resilience and Dyadic Coping

Our conceptualization of dyadic resilience starts with Lepore and Revenson's (2006) tripartite model of three related – yet distinct – definitions of resilience in the face of stress and adversity: Recovery, Resistance, and Reconfiguration. *Recovery* is similar to standard definitions of adaptation to stress (Stanton, Revenson, & Tennen, 2007). When a stressor disrupts a person's normal state of functioning, the individual appraises and copes with the stressor with the goal of returning to pre-stressor functioning. *Resistance* (called recovery by Bonanno, 2004) is used to describe individuals who appear not to be severely affected by a stressor and maintain their "normal" functioning during and after a stressor. Resistance is seen by some as pathological as individuals do not visibly exhibit distress (see Bonanno). *Reconfiguration* is where individuals confronting adversity are able to reconstruct the experience in terms that either change their world views or reframe the stressor

to fit into an existing world view (Janoff-Bulman, 1992). In all three definitions, resilience is not conceptualized as a static personality trait (i.e., a person is resilient or not); instead, it is a dynamic process in which people, or in our case couples, may show better adjustment outcomes at different times.

A good deal of research shows that when one member of a couple faces a serious chronic illness, both partners are affected (Bodenmann, 2005; Revenson & DeLongis, 2011). In some cases, the well-partner's mental health is affected to a greater degree than the patient's (Fagundes, Berg, & Wiebe, 2012; Manne, Badr, Zaider, Nelson, & Kissane, 2010; Milbury, Badr, & Carmack, 2012). Among couples affected by chronic illness, a supportive intimate relationship may protect against the social and psychological stressors of illness that give rise to poor mental and physical health outcomes (Stanton et al., 2007). Moreover, relationship variables are important and independent predictors of optimal coping efforts and positive health outcomes, over and above the presence of general perceived social support (Berg & Upchurch, 2007; Bodenmann, 2005).

Although a central component, the concept of dyadic coping involves much more than the transaction of social support. Individuals whose partner has chronic illness "occupy a dual role in the coping process: as a primary provider of support to the ill partner, helping him or her cope, and as a family member who needs support in coping with the illness-related stressors she or he is experiencing" (Revenson, 2003, p. 533). At the same time, although a large number of studies, including prospective population studies, have established strong associations between intimate relationships and health outcomes, increases in social support are not always protective (Revenson & DeLongis, 2011). For example, unwanted social support can produce relationship conflict, maladaptive coping, increased negative affect, and poorer disease progression (Revenson & DeLongis).

In the context of chronic illness, scholars have suggested that couples who are able to adopt a dyadic perspective or "we" orientation in relation to illness demonstrate an increased capacity to cope (Badr, Carmack, Kashy, Cristofanilli, & Revenson 2010; Berg & Upchurch, 2007; Fergus, 2011; Skerrett, 1998) and what we might call greater resilience. In synthesizing the existing literature on couples adaptation to chronic illness, Fergus (2011) noted that the variety of ways couples potentially interact as they manage illness-related stressors have been termed many different constructs, including "dyadic coping" (Bodenmann, 2005), "communal coping" (Lyons, Michelson, Sullivan, & Coyne, 1998), "coping congruence" (Revenson, 2003), "collaborative coping" (Berg et al., 2008), "joint platform" (Salander & Spetz, 2002), and "we-ness" (Skerrett, 1998). However, the comparable feature across these constructs is the recognition that illness is a shared health threat that affects both partners and that coping (e.g., managing or minimizing distress or accepting circumstances) is a joint responsibility rather than individual efforts (Fergus). There is also some evidence that when couples cope in a congruent fashion (using either similar or complementary coping strategies), adjustment to illness is increased (Revenson, 2003), although the nature of the coping is key: In a study of metastatic breast cancer patients and their partners, congruence in coping was beneficial when it was focused on joint problem solving and not mutual avoidance (Badr et al., 2010).

Dyadic Coping with HIV Disease

Theories in relationship science and dyadic coping offer useful frameworks for understanding the mechanisms of couples' coping with illness by examining how partners' cognitions, emotions and behaviors mutually influence each other while being interdependent (Bodenmann, 2005; Lewis et al., 2006; Mermelstein & Revenson, 2013). More recently, a call has been made to broaden approaches to HIV prevention efforts to address not only social, psychological, behavioral, and biological factors, but also examine the interpersonal factors that are associated with HIV transmission and adaption to illness (El-Bassel & Remien, 2012; Karney et al., 2010). Until recently, few HIV researchers focused on couples (Burton, Darbes, & Operario, 2010). Also ignored are relationship factors, such as intimacy and trust, and the sociocultural context, such as social stigma or heterosexism.

In our review of research on "dyadic resilience", we decided to address key questions about how social support, relationship factors, and dyadic coping could help us understand resilience among same-sex male couples in which one or both partners are living with HIV and to use that research evidence to understand dyadic resilience more generally. In this context, dyadic resilience is broadly defined to be inclusive of couples' resources, dyadic coping efforts and the ensuing mental and physical health outcomes as well as relationship "health". We conceptualize dyadic resilience as an iterative process in which couples draw on their resources and past dyadic coping strategies in the face of a recurring stressor or a new stressors to ensure positive dyadic outcomes (Dunkel Schetter & Dolbier, 2011).

What might resilience look like among same-sex male couples where one or both partners are living with HIV? We believe that resilience may involve the ability to remain emotionally close and mutually supportive despite the potential of HIV transmission and other stressors such as HIV stigma and gay-related discrimination. Within HIV serodiscordant couples, this would also include maintaining sexual intimacy, open communication, and relationship quality while having to navigate safe sex practices. We were interested in reviewing existing literature to examine whether and how relationship factors served as potential dyadic resilience resources. We were also interested in the degree to which the sociocultural context of HIV shaped dyadic resilience.

Methods of the Systematic Review To answer these questions we conducted a systematic review of the literature. Briefly, articles were identified through searches conducted on MEDLINE, PubMed, PsychInfo, CINAHL, and Social Sciences Index using a combination of the following search terms as key words and in abstracts: *HIV or AIDS* or *Acquired Immunodeficiency Syndrome* and *couples* or *family characteristics* or *caregivers* and *gay* or *homosexual*. The initial search yielded 206 unique articles published from 1986 to 2012. Articles were included in the review if they were original research; collected data from both members of a couple; and couples were biological males in a romantic relationship with another biological male in one or both of the partners had HIV/AIDS. Only 27 (13 %) articles met these criteria. It is worth noting that multiple articles were published

from the same data set. In total, only 16 articles were unique studies and the remaining 11 used data from 4 data sets (but examined different research questions). We coded the studies along multiple dimensions including study approach (whether the study used a theoretical framework and what it was), relational variables (duration, partners' HIV serostatus), study design (cross-sectional or longitudinal, intervention or observational, qualitative or quantitative), and outcome (sexual risk behavior, medication adherence, psychological adjustment). Aspects of the socio-cultural context, when available, included measures of HIV stigma, heterosexism, and minority stress (Meyer, 2003).

This systematic search yielded a relatively small body of literature comprised of studies that were largely cross-sectional, self-report and including couples that varied widely in relationship duration (3 months to 27 years). Thus, a few caveats are in order: First, although all 27 articles included data from both members of the couple (an inclusion criterion), less than half (13 or 48 %) analyzed the dyad as the unit of analysis, and only four used a statistical analysis technique such as the actor partner interaction method (APIM) that accounts for intradyadic interdependence among the measures. About two-third of the studies (18) combined couples of different serostatus (i.e., discordant, concordant negative, and concordant positive) in analyses and over half (19) failed to include information about the length of time since the HIV diagnosis.

Organization of the Review The broader literature examining couples coping with chronic illness suggests that partners mutually experience the stresses of one partner's illness, and that relational factors may moderate the relationship between stressors and health outcomes. Couples draw on the quality of their relationship to engage in effective dyadic coping (Berg & Upchurch, 2007; Coyne & Smith, 1991; Hagedoorn et al., 2000). Examining the outcome of sexual risk behavior, treatment adherence, substance use and psychosocial adjustment, we divided the review into three sections that address: (1) social support and community integration; (2) intimacy, trust, and commitment; sexual agreements; and (3) power and equality. Whenever possible, we note whether the samples are seroconcordant or serodiscordant and whether serostatus affects the findings. After reviewing the literature, we examine how these processes contribute to dyadic resilience.

Social Support and Community Integration

Although less than half of the 27 articles used a theoretical framework, the 12 articles that did were studies of how social support affects sexual behavior, adherence, or psychological adjustment. Social support often has been used as an umbrella term for a number of aspects of social relationships (Revenson & DeLongis, 2011). Reflecting this, the articles in our review used vastly different definitions and measurements of supportive relationships. HIV-specific social support refers to functional elements of social support, such as reminding, encouragement, informational and emotional support exchanges from close relationships (Wills & Ainette,

2012). Because they experience rejection and discrimination, many gay men may not be able to turn to their families and communities of origin to obtain support (Fergus, Lewis, Darbes, & Butterfield, 2005). As a result, gay men have historically created "families of choice" to develop a positive sense of identity and well-being. Similarly, integration into and identification with the gay community has been posited to "foster a positive sense of identity that may counter the mental and physical health effects of heterosexism and homophobia" (Fergus et al., 2005, p. 152). Gay community integration has been assessed within the broader literature to include a variety of activities such as "participation in specific gay or bisexual functions or activities; belonging to gay or bisexual organizations; reading gay books, magazines, and newspapers; patronizing gay shops or businesses; or going to gay bars, dances, or clubs" (Fergus et al., p. 152; see also Kippax et al., 1992; Rosario et al., 2001).

Community Integration Two studies of 59 gay male couples (37 seroconcordant negative, 7 seroconcordant positive, and 10 serodiscordant) suggested that community integration was associated with *increased* sexual risk behavior (Fergus et al., 2005; Fergus, Lewis, Darbes, & Kral, 2009). Frequenting gay bars was associated with greater sexual risk behavior among *both* partners (Fergus et al., 2005). Subsequent analyses found that there was significant actor effect, such that higher level of gay community integration was associated with a 2.3 increased odds of engaging in sexual risk behavior (Fergus et al., 2009). However, this was qualified by a significant interaction such that participants who reported high levels of general social support and low levels of community engagement reported less sexual risk behavior, whereas partners with high levels of support but high levels of community engagement reported a greater probability of sexual risk behavior. It should be noted however, that the measure of support was of perceived support without specifying a source so it is unclear if partner support is protective. Nonetheless, this study suggests that community integration within the gay community may be an important factor for understanding sexual risk behavior among same-sex male couples.

Social Support Studies of social support have focused on different health outcomes. In a qualitative study, Wrubel, Stumbo, and Johnson (2008) examined three different types of support for medication adherence among same-sex male couples: reminding, medication support (monitoring medications, and organizing, ordering and picking up refills), and coaching. The frequency of each type of support reported did not differ by couple HIV serostatus and were described as evidence of caring. For example, one man described how his partner nags him to take his medications stating "That's fine. I'll just get annoyed with him nagging then take it just so he'll shut up [chuckles]" (Wrubel et al., 2008, p. 854). In contrast to this quote, the authors described how many of these support transactions were 'invisible' forms of support (Bolger & Amarel, 2007; Bolger, Zuckerman, & Kessler, 2000) that went unnoticed by the partner. According to research by Bolger and his colleagues, invisible support may be more effective because visible forms of support can produce feelings of dependency and indebtedness. However, these types of support were not linked to outcomes within this study.

Darbes and Lewis (2005) found that after statistically controlling for levels of general support, HIV-specific support from partners around safer sex behaviors was associated with a reduced odds of engaging in risk behavior. This finding did not differ by couples HIV serostatus. However, HIV-positive partners who reported greater levels of general social support had *increased* odds for sexual risk behavior with partners of the same serostatus *outside* the relationship. The authors interpret these findings as a function of serosorting practices, which refers to "a partner selection strategy whereby sexual partners are chosen on the basis of their HIV status" (Eaton, West, Kenny, & Kalichman, 2009, p. 185). By serosorting, one can choose sexual partners of the same HIV status for the primary purpose of having unprotected sexual acts (Eaton et al., 2009). Eaton and colleagues (2009) found that men in sero*con*cordant relationships (i.e., whether both partners were HIV-negative or HIV-positive) were more likely to believe that serosorting reduced HIV transmission risk, compared to men in serodiscordant relationships. As such, there may be different perceptions of health threats and the efficacy of social support based on the couple's HIV serostatus that require future examination.

In sum, few studies examine the relation between social support – broadly defined – and health outcomes for same-sex male couples. There is some evidence that gay community integration may influence risk behavior among men in same-relationships (Fergus et al., 2005). Partners' exchange of domain-specific support in the context of adherence and sexual risk behaviors may serve important functions for the recipient, the provider, and the relationship (Darbes, Chakravarty, Beougher, Neilands, & Hoff, 2012; Wrubel, Stumbo, & Johnson, 2010). Because the studies use different conceptualizations and measures of support, examine different health outcomes, and have small sample sizes that may not be representative, it is difficult to draw strong conclusions. Moreover, it is not clear whether there are differences between seroconcordant and serodiscordant couples, which may be essential for creating interventions to reduce risk behaviors.

Intimacy, Trust, and Commitment

Regardless of sexual orientation or serostatus, a number of studies have found lower condom use reported among intimate partners compared to casual partners. Although HIV prevention efforts tend to emphasize multiple and concurrent casual partners (Grov, Parsons, & Bimbi, 2007; Mimiaga et al., 2009), studies have found that feelings of intimacy, trust and commitment in intimate relationship are associated with greater intra-dyadic risk behavior (Theodore, Duran, Antoni, & Fernandez, 2004) and that serostatus is a key contextual variable in these findings.

The symbolic meaning of condom use may be particularly pronounced among men in serodiscordant relationships. In an early study, Remien, Carballo-Dieguez, and Wagner (1995) examined facilitators and barriers to condom use among 15 same sex male couples, conducting separate focus groups for HIV-positive and HIV-negative partners. Men often described condom use as a barrier to emotional

intimacy, and condoms were seldom used for oral or anal sex. Because the HIV-positive and HIV-negative partners wanted to protect each other from thinking about transmission, communication about condom use was curtailed and actual condom use suppressed in order to circumvent fears about illness progression and transmission risk. In fact, for some men, condom use became a constant reminder of the couple's serodiscordant status. Moreover, positive relationship adjustment was actually found to increase risk behavior, such that some men also reported that as emotional intimacy, security and trust grew with their partner, and as familiarity and length of time in the relationship increased, their perception of transmission risk decreased and unprotected sex increased.

Over a decade later, Nieto-Andrade (2010) examined the association between awareness of transmission risk and sexual behavior in a qualitative interview study of 44 men in serodiscordant relationships. Both HIV-positive and HIV-negative men who felt a greater sense of commitment to their partner *didn't* use condoms with that partner. Specifically, men who reported unprotected sex described their relationship as long lasting and that they were not afraid of becoming infected with HIV. Some men reported that not wearing condoms was a way to minimize relationship conflicts and feel connected to their partners. For some HIV-negative men, not wearing a condom was described as a way of showing love and commitment to their partners and illustrating that they were not afraid of infection. However, approximately one-quarter of both the HIV-positive and HIV-negative men in the study reported that avoiding infection or re-infection was based on commitment to the relationship, and that condom use was a mutual responsibility in which both partners faced the transmission threat together.

Summarizing across these studies we can conclude that although some men conceptualized safe sexual behaviors as a way to show their love and commitment to their partner, the drive for intimacy may overshadow rational decision-making during emotionally heightened sexual encounters. Thus, there may be an underlying belief among many same-sex male couples that condoms are antithetical to intimacy, and that having unprotected sex with their partners connotes an act of intimacy through which they express their commitment to their partner.

Sexual agreements involve the decisions couples make about whether they allow sex with outside partners and the sexual behaviors they engage in together (Hoff & Beougher, 2010; Hoff et al., 1997, 2009). Originally termed 'negotiated safety' (Kippax, Crawford, Davis, Rodden, & Dowsett, 1993), investments in sexual agreements are seen as an important relationship factor associated with reduced sexual risk behaviors among gay male couples (Hoff et al., 2009).

Although investments in sexual agreements are a way for partners to protect one another from HIV transmission (Neilands, Chakravarty, Darbes, Beougher, & Hoff, 2010), they are not often motivated by HIV prevention beliefs. For example, Hoff and colleagues (2009) examined similarities in motivations for sexual agreements across 566 gay and bisexual couples of different HIV serostatus (concordant negative, concordant positive and discordant). The primary reasons for making sexual agreements were to promote honesty and trust. Better relationship quality

(i.e., intimacy, trust, commitment, attachment and equality) was reported by men in monogamous relationships than by men in an open relationship or men whose partners did not hold the same views on their sexual agreement. In fact, men in discrepant relationships had the poorest relationship quality of all the relationship groups, and endorsed greater avoiding and withholding communication. These findings suggest that mutual decision-making and open communication around sexual agreements are important for building trust and honesty, which may reduce transmission risk.

Violations of sexual agreements are not uncommon and have the potential to produce strain on the relationship, placing the couple at risk for HIV and other sexually transmitted infections (Hoff et al., 2009). Hoff et al. (2010) analyzed in-depth qualitative interviews with 39 gay male couples (17 concordant negative, 10 concordant positive, and 12 discordant) about their sexual agreements. For some couples, taking emotional breaks – that is, continuously having sex with new partners without thinking about their partner's reactions created emotional distance – violated "trust, intimacy, and, commitment, and in some cases threatened the longevity of the relationship" (Hoff & Beougher, 2010, p. 782). Other couples who had explicit agreements that allowed sex with outside partners placed conditions on these agreements "to separate physical and emotional intimacy with outside partners or to not have ex-boyfriends as outside partners" (Hoff & Beougher, p. 782). These types of breaks, however, threatened the relationship and increased risk for HIV transmission. Hoff and colleagues (2010) found that of the 25 breaks reported, 21 were disclosed to the partner, perhaps because communication about the break offered a way to renegotiate their needs and desires. In contrast, the few men who did not tell their partner that they had broken the sexual agreement reported emotional distance from their partner. Disclosure and communication about breaks is a critical relational variable to consider in dyadic coping within HIV affected couples, as it has a significant impact on the relationship and sexual health of each partner and of the "health" of the relationship.

Couple HIV serostatus is an important contextual factor in the underlying reasons for sexual agreements. For example, an HIV diagnosis had a major impact on the sexual relationship in a small study of ten gay male couples in serodiscordant relationships (Palmer & Bor, 2001). As a result of the diagnosis, all the couples had explicit sets of rules for sexual agreements, which ranged from open to closed to no sexual activity. Hoff and Beougher (2010) found that men in serodiscordant relationships reported the "most articulate and detailed agreements, including the specific behaviors they could engage in with each other and with outside partners" (p. 785). This suggests that sexual agreements among couples in discordant relationships may constitute a relationship maintenance mechanism. In Palmer and Bor's (2001) study, only two of the HIV-negative men continued to have unprotected anal sex with their partner. These men described unprotected sex within the relationship as a means of redressing the imbalance in the relationship and loss of intimacy in sex. As such, the underlying motivations and details of the agreement may be quite different for serodiscordant couples.

Equality and Power

Early studies suggested that same-sex couples had a more egalitarian division of labor than heterosexual couples (Kurdek, 1993). However, there are other power dynamics to consider within relationships, which may be tied to HIV serostatus. According to social exchange theory (Emerson, 1981), relationship power is based on multiple factors, including dependence of one partner on the other, unequal possession of valued resources (e.g., economic, emotional), and potential alternatives to the current relationship. Relationship power is expressed through decision-making dominance, engaging in behaviors against a partner's wishes, or controlling a partner's actions (Emerson, 1972, 1981).

Only four studies in our systematic review examined power and relational equality and its relation to HIV-prevention or adherence. Men in monogamous relationships reported greater relational equality compared to men in open relationships or those who reported discrepant agreements (Hoff et al., 2009). Additionally, relational equality was associated with higher investment in sexual agreements (Neilands et al., 2010).

A qualitative study of nine gay male couples where one partner was living with HIV examined the meaning of reciprocity as it relates to HIV symptom management in the earlier years of the epidemic (Powell-Cope, 1995). The couples conceptualized symptom management as a form of mutual protection. Most partners strove for an equalitarian relationship, but HIV-positive men described the need to be independent in their self-care and HIV-negative partners worked to protect their partners from feeling dependent on them. Powell-Cope interpreted this behavior as a way to protect the ill partners' self-esteem by creating illusions of independence to offset losses to freedom. As the illness progressed, symptom management moved first into interdependent care where the HIV-negative partners monitored symptoms and then to dependent care where HIV-positive partners described "a loss of independence, humiliation, decreased self-esteem, anger, and depression as they had to relinquish responsibilities to partners" (Powell-Cope, 1996, p. 26). As the illness progressed, couples engaged in mutual protection using strategies to preserve the ill partners' feelings of independence and autonomy through managing the HIV-positive partner's health symptoms, diet, and medical care. This single study suggests that the stress surrounding an HIV diagnosis may create power imbalances within the relationship.

Dyadic Coping Among Couples with HIV

Only two studies within this review explicitly examined dyadic processes. These two studies were guided by interdependence theory, which focuses on social control tactics that aim to influence or regulate another person's behavior

(Lewis et al., 2006). It is assumed that both partners are motivated to try to change each other's health behaviors because each is affected by the other's illness or unhealthy habits (Butterfield & Lewis, 2002). Positive social control strategies, such as direct persuasion or influencing the enactment of desired behavior, have been hypothesized to be related to health-enhancing behaviors. Positive social control strategies contain elements of social support, for example by rewarding a desired behavior. In contrast, negative social control attempts (e.g., nagging or withdrawing affection) involve pressuring a partner into a desired health behavior change, for example, to reduce sexual risk; these tactics are often inefficient or counterproductive (Umberson, 1992). However, this may depend on the outcome (e.g., adherence vs. sexual risk) and one's orientation toward interdependence.

In a study of 60 same-sex couples (11 serodiscordant, 7 seroconcordant positive, 42 seroconconcordant negative), Lewis and colleagues (2006) found that many couples reported using positive social control tactics, such as discussions, presenting information, and asking questions, in relation to medication adherence. In contrast, the same couples described using negative social control tactics (nagging, setting rules and boundaries) when it came to HIV-related health compromising behaviors (e.g., bar hopping and sexual risk behavior). Interestingly, positive social control tactics were mentioned most frequently by those who scored highly on the interdependence measure.

In a qualitative interview study with 20 gay male couples (10 serodiscordant and 10 seroconcordant positive), Wrubel and colleagues (2010) found two opposing orientations towards partner support for medication adherence: *personal responsibility*, characterized by the belief that medication adherence should be the responsibility of the HIV-positive partner and *couple responsibility*, in which responsibility was shared. In a forced-choice question, one quarter of the couples (4 serodiscordant and 1 serodiscordant) described medication adherence as a personal responsibility and 12 couples (6 seroconcordant and 6 serodiscordant) described it as a couple responsibility. Among couples that endorsed personal responsibility, HIV-positive partners allowed themselves to be given emotional support but not practical assistance. Among those who endorsed a couple orientation, five couples described their relationship as one in which one partner was the "boss" or the "daddy-figure", and used positive social control tactics (regular reminding, problem solving, reinforcing) to increase medication adherence. In these couples power struggles were notably absent. More importantly, the dominant partner was not open to receiving support from their partner, and when it was provided it resulted in the dominant partner feeling annoyed and irritated, illustrating a very one-directional way of having the couple take responsibility. The other couples who endorsed a couples' or relational orientation were much more mutual in their provision of support and that mutuality involved different positive social control tactics from the "partner in control" couples (e.g., synchronizing schedules and dividing adherence responsibilities).

Homophobia and Heterosexism as Contextual Determinants of Dyadic Coping

Dyadic coping, along with other health behaviors, is affected by the larger sociocultural context (Revenson, 2003), including gender roles (Helgeson, 2011), ethnicity (Brondolo, Brady, Libby, & Pencille, 2011), and socioeconomic status (Ruiz, Steffen, & Prather, 2012). Sociocultural factors can have both direct and indirect (moderating) effects on health behaviors; for example, gender roles may influence norms about social support provision and expectations for interdependence among partners (Cross & Madson, 1997).

Structural forms of homophobia have defined as a societal level condition that constrains the opportunities, resources and health of gay men (Hatzenbuehler, 2009). Despite advances in LGBT rights, homophobia and heterosexism continue to produce stress in same-sex relationships, which may manifest itself as internalized stigma, concerns about sexual identity disclosure, and social validation. Only one study in our review explicitly examined experiences of heterosexism among same-sex male couples living with HIV and how they affected dyadic coping. Conducting a secondary analysis of interviews with nine couples (five serodiscordant, four seroconcordant positive), Powell-Cope (1998) found that most couples talked openly about experiences of homophobia in the context of caregiving. Couples described fears that being seen with their partner could lead to violence and assault. However, couples' utilized strategies to resist structural constraints imposed by heterosexism, including commitment ceremonies, and being open with family and friends about their couple status.

Although this study did not explicitly examine the link between homophobia and symptom management, these findings suggest that homophobia may affect couples' ability to draw on outside social support in their coping efforts. Although many couples, such as those described in Powell-Cope's small study, engaged in strategies to resist structural constraints, others may have a difficult time overcoming these barriers. This may produce additional strain on the relationship. In addition to the "regular" chronic stressors surrounding an illness diagnosis, same-sex male couples must negotiate social constraints that impinge on their ability to draw on social support resources in their dyadic coping (Fergus et al., 2005, 2009; Palmer & Bor, 2001; Wrubel et al., 2010). Similarly, same-sex couples may come to internalize negative messages about their identities and romantic affiliations, which may have an adverse impact on the quality of their relationships (Otis, Rostosky, Riggle, & Hmrin 2006). Thus, HIV prevention efforts that target more insidious influences, such as experiences of homophobia, may have long-term benefits for dyadic coping.

What Do We Need to Know to Construct a Theory of Dyadic Resilience?

The findings from this review provide minimal but preliminary evidence for the importance of incorporating relational variables and dyadic processes in behavioral HIV research. The studies examined a range of health outcomes among couples of

different serostatuses over a time period that has seen major medical advances in treating HIV disease. Nonetheless, the findings from this review suggest several important areas for understanding dyadic resilience among same sex couples coping with HIV disease, specifically, and chronic physical illness, more generally.

During the 20-year span that this review covers, researchers have focused primarily on social support processes when studying dyadic coping. (This is also true of research on heterosexual couples coping with illness; see Revenson & DeLongis, 2011). While community integration has historically been linked to optimal outcomes, integration into the gay community may have a detrimental impact on risk behavior for same-sex male couples living with HIV (Fergus et al., 2005, 2009). However, provisions of social support may buffer the association between community integration and sexual risk behavior (Fergus et al., 2009). Similar to other populations, social networks, which included support outside the relationship serve as a protective factor in terms of providing HIV-related support and general social support for same-sex male couples living with HIV (Beckerman, 2002; Fergus et al., 2009; Stumbo, Wrubel, & Johnson, 2011).

Relationship variables such as intimacy, commitment, trust, and power are essential to understanding HIV-prevention and adherence, perhaps as much as direct support transactions between members of the couple. Some aspects of relationships may undermine rational decision making in sexual encounters to promote risky sexual behavior, particularly among men in serodiscordant relationships (Nieto-Andrade, 2010; Remien et al., 1995). Shared perceptions of health threats (i.e., viral load suppression and biomedical strategies) may be important factors to examine alongside these relationship factors to fully capture sexual decision making processes. Similarly, sexual agreements are believed to arise out of concerns for sexual safety but this only appears to be the case for men in serodiscordant relationships where there is the very real possibility of HIV transmission within the dyad. As such, sexual agreements appear to foster closeness and connection and may have associations with other health behaviors beyond HIV transmission. However, nonmonogomous sexual agreements have the potential to confer HIV risk, particularly when they are not driven by HIV prevention beliefs or when breaks in those agreements are not openly disclosed and renegotiated to incorporate sexual safety. Power and equality within relationships also influence health behaviors yet few studies have examined how power and inequality impact dyadic processes, such as mutual decision making and its influence on risk behaviors.

The Importance of Context in Understanding Dyadic Resilience Among Couples with HIV Disease

Our literature review suggests some similarities between same-sex and opposite-sex couples in dyadic coping, but also as many differences. It also touches on some of the unique aspects of HIV/AIDS in comparison to other chronic illnesses. Although an examination of these similarities and differences is beyond the scope of this

chapter, it is important to emphasize the unique sociocultural context surrounding same-sex male couples living with HIV/AIDS that is often overlooked. For example, the couple's HIV serostatus is an important contextual variable as it reflects and shapes different health statuses, power differentials, and relationship functioning. Most studies include couples of different serostatuses (concordant positive, concordant negative, and discordant) but ignored these important distinctions or lacked sufficient statistical power to examine these differences, or more importantly, how they interact with other variables predicting dyadic coping and resilience. For the dyadic stressors of an HIV diagnosis, including fear of disease transmission, fear of loss of the partner, and issues of sexual safety to keep both partners healthy, may result in dyadic conflict for the serodiscordant couples (Remien et al., 1995). This conflict, in turn, may impact appraisals of relational quality for both partners, particularly the HIV-positive partners and may influence the couple's ability to maintain safer sex behaviors, treatment adherence and emotional intimacy. Simultaneously, men in seroconcordant relationships may choose particular partners as a risk reduction strategy (Eaton et al., 2009), to provide a sense of security that reduces potential disclosure stigma and fears of rejection (Golub, Tomassilli, & Parsons, 2009). Thus, future research is warranted to disentangle the impact of serostatus on dyadic coping among HIV/AIDS couples.

In our research review, we didn't address the larger sociocultural and political contexts of HIV (Ickovics, Thayaparan, & Ethier, 2000), which is another way that dyadic resilience among this population may be different than heterosexual and gay couples coping with other serious illnesses. Couples living with HIV may be affected by HIV-related stigma (Herek, 1990), which has been shown to create significant barriers to HIV testing, restrict the utilization of prevention services and the adoption of preventative behaviors including HIV medications, as well as produce excess stress on the individual living with HIV (Brooks et al., 2012). HIV-related stigma impacts the "relational, emotional, and physical health of HIV-affected couple members" (Talley & Bettencourt, 2010, p. 84).

Although no studies have explicitly examined the impact of HIV stigma on health outcomes, health behaviors, or dyadic coping among same-sex male couples living with HIV (Talley & Bettencourt, 2010), several studies in this review incorporated the ways in which same-sex male couples manage HIV stigma when examining sexual risk behavior and psychological adaptation, and give us some preliminary clues. Two early qualitative interview studies with same-sex male couples in serodiscordant relationships suggested that internalized HIV stigma may influence sexual functioning for the HIV-positive partner as a result of the guilt and shame that may accompany an HIV diagnosis (Powell-Cope, 1995; Remien et al., 1995). Thus, future research is warranted to examine how HIV stigma influences adaptive communal coping strategies between relationship partners and influences health outcomes.

Most of the studies in the review also overlooked the demographic context of the research, combining participants from different demographic categories (race/ethnicity, socioeconomic status) without openly discussing or examining the possible influence of these demographic categories on relationship factors, dyadic process,

or health outcomes. Given disparities in HIV prevalence, incidence rates, disease progression and AIDS mortality for HIV-positive Latino and African American gay, bisexual and other MSM (CDC, 2008; Diaz, Ayala, & Bein, 2004; Mays, Cochran, & Zamudio, 2004), it was surprising that not one article in this review considered ethnic group membership or socioeconomic status either in terms of relationship variables, dyadic processes or their relation to health outcomes. In fact, three articles did not even include information about the racial/ethnic composition of the sample. Of the studies that included information about race/ethnicity, the majority of samples comprised of largely White men (64–90 %) and even those that were more diverse did not account for race/ethnicity in their analyses. Similarly, only three included an indicator of socioeconomic status in their analyses. Yet these two variables are intricately braided within the context of living with HIV/AIDS and dyadic coping.

Much of the literature implicitly assumes that social discrimination affects HIV-behavior, but has not built this phenomenon into the studies. This is a timely lacuna as researchers have increasingly looked to the compounding effects of social discrimination to explain persistent disparities in health (Krieger, Rowley, Herman, Avery, & Phillips, 1993; Williams, Neighbors, & Jackson, 2003). The potentially damaging effect of racism and financial hardship on individual well-being has been well-documented (Diaz, Ayala, Bein, Henne, & Marin, 2001; Jones, 1992; Schuman, Steeh, & Bobo, 1985). Discrimination may give rise to social practices and policies that restrict employment, housing, education, and other health care opportunities, which can produce negative health outcomes in creating strain and tension within the relationship (Cutrona et al., 2003). Additionally, discrimination can produce negative emotional and stress responses for individuals (Gamarel, Reisner, Parsons, & Golub, 2012; Williams et al., 2003), and influence relationship dynamics (Otis et al., 2006).

In the HIV prevention literature, there have been studies that have examined the compounding effects of homophobia, racism and financial hardship on the sexual health of Black and Latino gay, bisexual and other MSM. Nonetheless, there are many unanswered questions about the ways in which the intersection of discrimination based on sexual identity, race/ethnicity and socioeconomic status impacts the lives of same-sex male couples living with the disease. For example, discrimination and the strategies that couples use to cope with and minimize exposure to discrimination may produce excessive strain on the relationship and give rise to conflict and/or social constraints on disclosure, which may influence health behavior support. Additionally, financial hardship may produce power imbalances within relationships thereby influencing relationship dynamics (i.e., investments in sexual agreements) and dyadic processes (i.e., negative social control tactics), which may lead to maladaptive health behaviors such as sexual risk behavior. Given the high rates of racial/ethnic disparities in HIV, more research is needed to understand the differential impact of racism, financial hardship, homophobia, and HIV stigma on men of color in same-sex relationships living with HIV.

Developing a Theoretical Framework of Dyadic Resilience

The questions guiding this review provide basic and valuable information on same-sex male couples living with HIV but also expose many unanswered questions. We see glimpses of Lepore and Revenson's (2006) tripartite model of resilience: recovery, resistance, and reconfiguration. However, one of the major obstacles to moving this research area forward is the lack of theoretical frameworks to guide research and intervention development. To expand the theoretical foundation of HIV prevention efforts among same-sex male couples living with HIV, we propose a social-relational model that integrates the existing findings on HIV prevention and adherence research on same-sex couples living with HIV with existing models of relationship science.

This social-relational framework is based in both interdependence theory (Rusbult & Buunk, 1993) and dyadic coping perspectives (Bodenmann, Meuwly, & Kayser, 2011; Lewis et al., 2006). Communal coping strategies arise out of a shared stressor that is communicated between the partners, shared desired outcomes, and more constructive communication (Bodenmann, 2005). Using dyadic statistical approaches, this framework can partition variables at the individual and couple-level levels of analysis to determine effects on health behaviors, relationship quality, and ultimately dyadic resilience. As described throughout this chapter, dyadic coping is part of a larger process that unfolds over time and includes reciprocal influences; that is, partners' dyadic coping strategies affect health outcomes, which in turn, shape dyadic resilience and ultimately future coping efforts (Lazarus, 1966).

This social-relational framework suggests that predisposing factors such as perceived threat of HIV transmission and/or disease progression, shared desired outcomes, and more constructive communication styles may influence couples' responses to HIV (Lewis et al., 2006). For example, HIV serodiscordant couples may have different conceptualizations of the threat of HIV on the relationship than seroconcordant couples (Brooks et al., 2012; Remien, Wagner, Carballo-Dieguez, & Dolezal, 1998; Wagner, Remien, Carballo-Diéguez, & Dolezal, 2002), yet no studies have examined shared threats and desired outcomes. Additionally, relationship characteristics such as intimacy, trust, commitment, equality and investment in sexual agreements and sociocultural factors such as discrimination and HIV stigma may influence the couple's ability to engage in optimal dyadic coping strategies, which in turn, may affect health behaviors and maintain the quality of the relationship.

At the heart of this social-relational framework is the premise that couples will engage in a transformation of motivation process whereby a partner moves from a perspective of self-interest to a *we*-focus in the face of a shared threat (Lewis et al., 2006). According to Lewis and colleagues (2006) "*transformation of motivation* is a key construct in interdependence theory that explains how interdependence arises when partners may accommodate to work together cooperatively, and why relationships are so influential on health outcomes" (p. 1373) As a result of this, the couple will engage in dyadic coping strategies to reduce the threat (Lewis et al.). For exam-

ple, research suggests that same-sex male couples living with HIV developed a "couple identity" to resist HIV stigma (Powell-Cope, 1995; Remien et al., 1995). Although no studies within this review examined this process in relation to health behaviors, transformation of motivation could influence partners to "cognitively and emotionally ascribe health events as meaningful for the relationship or their partner (Lewis et al., 2006, p. 1373). Thus, HIV prevention researchers must explicitly examine the significance that specific health behaviors have for relationship maintenance and satisfaction (Rusbult & Van Lange, 2003) as well as study how relationship variables affect dyadic resilience.

Elaborating upon Lewis and colleagues' (2006) formulation, this social-relational framework posits that relationship functioning promotes pro-relationship motivation and behavior (Yovetich & Rusbult, 1994). For example, commitment represents a long-term orientation to the relationship with intentions to persist in the face of stressors (Yovetich & Rusbult). Commitment has been shown to predict persistence in relationships, as well as relationship maintenance behaviors such as willingness to sacrifice and accommodative behavior (Weiselquist, Rusbult, Foster, & Agnew, 1999). The limited findings described earlier suggest that commitment is associated with sexual risk behavior, particularly among serodiscordant couples (Nieto-Andrade, 2010; Remien et al., 1995). However, shared perceived threat and desired outcomes may moderate these associations, such that couples who view HIV as a shared health threat and value reducing transmission risk may engage in dyadic coping strategies to eliminate the threat of HIV.

To capture the dyadic processes laid out in this framework, and take the steps to begin to define dyadic resilience in this context, the study of same-sex male couples living with HIV must move beyond a reliance on studies that are purely descriptive, cross-sectional, or limited to one or two variables. Qualitative studies provide us with an important means for identifying previously neglected variables and potential mechanisms for consideration in quantitative research (Fergus, 2011; Wrubel et al., 2008). However, complex quantitative designs are needed for testing complex theoretical frameworks. One important question that emerged from this review was *how* couples cope with HIV/AIDS over time, as the disease and relationship changes (Revenson, 2003). Prospective, longitudinal designs and daily experience sampling are a potential means of elucidating the dyadic mechanisms through which relationship factors and health status mutually influence each other (DeLongis, Capreol, Holtzman, O'Brien, & Campbell, 2004; Laurenceau & Bolger, 2005).

Our basic argument, which is by no means new, rests on the need to place a greater emphasis on relationship factors and dyadic mechanisms in order to understand health behaviors and dyadic resilience in the context of HIV. Researchers and clinicians have increasingly considered the need for more substantive research on how these processes influence health behaviors and outcomes (Burton et al., 2010; Karney et al., 2010). We would argue that there must be greater efforts to integrate contextual factors into the forefront of these investigations. There is a need to integrate and interpret complex, reciprocal associations between intra- and interpersonal

processes, and health-relevant behaviors, specifically in identifying some of the most complex relationships between discrimination and health for couples. If we want to understand and foster optimal health among same-sex male couples affected by HIV, we must make a commitment to changing the way we think about – and study – the mechanism through which dyadic coping plays a role in gay male couples' well-being if we want to understand dyadic resilience.

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