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ORIGINAL ARTICLE

## Whose fault is it? Blame predicting psychological adjustment and couple satisfaction in couples seeking fertility treatment

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### ABSTRACT

Infertility bears psychological and relational consequences for couples who face this problem. Few studies have examined the role of self- and partner blaming to explain psychological and relationship adjustment in couple presenting with a fertility problem. This study used a dyadic approach to explore the links between blaming oneself and one's partner and both partners' symptoms of depression and anxiety, and couple satisfaction in 279 couples enrolled in fertility treatments. Partners were questioned about the extent to which they blamed themselves and their partner for the fertility problem. They also completed the Dyadic Adjustment Scale and the Index of Psychological Symptoms. Path analyses based on the Actor-Partner Interdependence Model showed that self-blame predicted anxiety and depression symptoms in both men and women. Men's self-blame also predicted their own lower relationship satisfaction, whereas women's self-blame predicted more depression and anxiety in their partner. Partner blame in women predicted their own and their partner lower relationship satisfaction. Women's tendency to blame their partner also predicted their own depression symptoms. Clinical implications of these findings are discussed.

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### KEYWORDS

Anxiety; blame; couple;  
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### Introduction

Infertility, defined as the inability to conceive a child after 12 months of regular unprotected sexual intercourse [1], is a worldwide problem. A recent meta-analysis revealed that prevalence rates for current infertility in women aged 20–44 range from 3.5% to 16.7% in developed countries [2]. Several literature reviews have described the psychological and relational challenges encountered by couples who present with a fertility problem and who are seeking fertility treatment [3–7]. Although empirical findings reveal that members of couples who are undergoing fertility treatment as a group tend not to differ from the general population in terms of their psychological symptoms [4,7], approximately half of these individuals describe the experience of infertility and its treatment as being the most stressful event of their lives [8,9]. Furthermore, 20–30% of individuals who are using assisted reproduction technology report clinically significant distress symptoms [10–12].

With respect to relationship satisfaction, results are equivocal. Although some studies found that couples seeking fertility treatment as a group tend not to differ

from general population norms [13–16], others reveal lower relationship satisfaction and relational stress as a result of infertility and treatment [17–19]. Findings also point out that negative relational impacts may coexist with positive consequences of infertility on the relationship (i.e. strengthening the relationship) [19–21]. Hence, whereas infertility and treatment may translate into relationship distress in *a priori* vulnerable couples, it may rather serve as the basis for increased commitment and relational strength in other couples. The association between infertility and relationship satisfaction is thus not a linear one, and more research needs to address factors associated with variations in relationship satisfaction in the context of infertility.

Péloquin and Lafontaine [4] proposed a conceptual model of clinical anxiety in the context of infertility and suggested that intrapersonal (e.g. coping strategies, mental health status), interpersonal (e.g. romantic attachment and dyadic coping strategies) and contextual factors (e.g. medical factors) would contribute to explain infertility-related distress. Several empirical studies support this model and show, for instance, that coping strategies are associated with infertility-

related distress as well as lower relationship satisfaction in both partners [13,22–25]. Very few studies, however, have examined blame as a coping strategy and its association with adjustment in the context of infertility [13,24–27] and with the exception of one study [13], these studies did not use a dyadic approach to examine the link between blame and both partners' psychological symptoms and relationship satisfaction. The current study investigated the role of blame to explain psychological symptoms and relationship satisfaction in a large sample of couples seeking fertility treatment. Using a dyadic approach, we examined whether blaming oneself or one's partner for the fertility problem would be related to anxiety and depression symptoms, as well as lower relationship satisfaction in both partners.

### *Self- and partner blame in infertile couples*

Infertility is a medical problem diagnosed in one or both members of the couple, which has the potential to prevent the achievement of an important life goal for the couple, namely having a child. Infertility may be due to functional, hormonal or genetic factors, but also to lifestyle characteristics, such as advanced age and obesity [28–30]. It is possible that the inability to conceive a child brings about self-blame or the blame of one's partner, as a way of channelling negative emotions such as sadness, anger, powerlessness and the sense of loss that are common in infertile couples. Examining whether infertility-related blame is associated with psychological symptoms and relationship satisfaction thus seems relevant in this population.

A recent qualitative study based on interviews with infertile couples showed that it is not uncommon for the infertile individual to express self-blame, experience guilt and consider leaving their partner so that their partner may conceive a child with another person [21]. Quantitative research shows that women are more likely than men to blame themselves for the couple's infertility [31–34], whether they received the infertility diagnosis or not. Using self-blame as a coping mechanism is associated with more infertility-related stress and lower well-being in both men and women and with lower relationship satisfaction in woman [26,34]. It is also related to more depression symptoms in both men and women of couples undergoing *in vitro* fertilisation (IVF) [24] and couples with definite involuntarily childlessness [27]. No study investigated the association between self-blame and anxiety symptoms in the context of infertility.

Rare are the studies that have examined the occurrence of partner blame in the context of infertility. Compared to women, men would be more likely to hold their partner responsible for the fertility problem when their partner received the infertility diagnosis [31]. Although no study specifically examined the association between blaming one's partner for the fertility problem and psychological or relationship adjustment, a study found that attributing the infertility to someone else's behaviour was associated with greater general distress [35]. This is coherent with findings from a review showing that blaming others for threatening events is related to poorer adaptation [36]. Whether blaming one's partner for the fertility problem is associated with increased psychological or relationship distress is unknown.

### *Dyadic perspective on partners' adjustment*

Most studies have examined infertility-related adjustment from an individual perspective. Studying the contribution of both partners to understand both individuals' adaptation in the context of infertility and its treatment is far less common. Infertility is undeniably a couple reality and because both partners are closely involved in the fertility treatment process, bidirectional influences of partners on each other are likely. The use of a dyadic approach thus appears crucial in this context. Only one dyadic study used the couple as the unit of analysis to investigate the link between taking responsibility for the problem as a coping mechanism (i.e. self-blame) and adjustment in infertile couples using assisted reproduction technology [13]. Couples in which both partners accepted high degrees of responsibility reported the highest level of fertility-related stress and lowest level of relationship adjustment compared to other couples. The effect of partner blame was not examined in this study.

### *Goal of the current study*

The present study examined whether individuals' self-blame and partner blame are related to their own and their partner's depression and anxiety symptoms, as well as relationship satisfaction in a large sample of couples seeking fertility treatment. Self-blame and partner blame were expected to be related to more psychological symptoms and lower relationship satisfaction (actor effect). Partner effects of self- and partner blame onto psychological symptoms and relationship satisfaction were also examined, although no hypotheses were put forward *a priori* for lack of empirical basis supporting possible predictions.

## Methods

### Participants and procedures

Results from this study were derived from secondary analyses of an existing database of a broad research programme comparing psychosocial adjustment to infertility, high-risk pregnancy and normal pregnancy. The current study only used a subsample of couples seeking fertility treatment. A total of 279 couples with fertility problems were recruited by their gynaecologist at their first visit in two fertility clinics in a large French-speaking Canadian city. They were recruited consecutively for a period of 5 years (duration of the grant) and all efforts were made to reach the largest possible sample size. Couples were given a consent form and completed a series of questionnaires in the presence of a psychologist who was part of the research team. Partners completed questionnaires independently. Ethical approval was obtained from the institutional ethics review board.

### Measures

#### Fertility-related blame

Two items were created to assess the extent to which participants blamed themselves and their partner for the fertility problem (“Do you blame yourself for the infertility?”; “Do you blame your partner for the infertility?”). Each item was rated on a 4-point Likert-type scale (1 = not at all; 4 = a lot).

#### Psychiatric symptoms index (PSI) [37]

This 29-item measure assesses four domains of psychological distress: depression, anxiety, cognitive disturbances and hostility. Participants are asked to rate the frequency of symptoms in the past 7 days on a 5-point Likert scale (0 = never; 4 = very often). Items are summed and converted to a 100-point scale to form global subscale scores. High scores reflect more severe psychological symptomatology; scores of 30 and above fall within the clinical range [38]. The PSI French translation was standardised on 16,000 French–Canadian individuals and showed adequate convergent and discriminant validity [38]. For the current study, only the depression and anxiety subscales were used. Both subscales showed good internal consistency in men ( $\alpha = 0.80$  and  $0.75$ , respectively) and women ( $\alpha = 0.85$  and  $0.84$ , respectively).

#### Dyadic adjustment scale (DAS) [39]

This 32-item scale assesses relationship satisfaction. Items are evaluated on various Likert-type scales and

summed to create an overall index of relationship adjustment (ranging from 0 to 151). The clinical cut-off point is 100, with higher scores indicating better relationship adjustment and satisfaction. The French translation showed adequate internal consistency and good discriminant validity for clinically distressed couples [40]. The alpha coefficient in this sample was 0.90 for men and 0.89 for women.

### Statistical analyses

#### Preliminary analyses

Data were analysed using SPSS 22.0 (Chicago, IL). All variables were screened for normality using the Kolmogorov–Smirnov test and visual inspection. When applicable, non-linear transformations were applied to correct for non-normality. Anxiety and depression variables were positively skewed and were subjected to a square root transformation. Except for women’s self-blame, the three other blame variables were positively skewed. No non-linear transformation corrected for this non-normality. We therefore decided to keep the untransformed variables despite non-normality. To check for possible gender differences, a repeated-measures MANOVA was conducted on both partners’ blame, anxiety, depression and relationship satisfaction variables (dependent variables), where gender served as a repeated measure for the couple. A Bonferroni correction was applied to maintain the overall alpha level at 0.05 (0.05/5 analyses = 0.01) when examining the results of each individual ANOVA. Preliminary correlational analyses between demographics and study variables (relationship satisfaction, depression and anxiety) were conducted to identify potential control variables. Spearman correlations were calculated between measures of blame, couple satisfaction and psychological symptoms among men and women to examine preliminary bivariate relations among variables.

#### Main analyses

To test associations among the two blame variables and couple satisfaction, depression and anxiety in both partners, we conducted path analyses (with maximum-likelihood estimation and nonparametric bootstrapping in AMOS software) based on the actor–partner interdependence model (APIM) [41]. This statistical approach (a) addresses the non-independence of dyadic data by treating the couple as the unit of analysis; (b) integrates both actor effects (i.e. the effect of an individual’s blame on his or her own couple satisfaction) and partner effects (i.e. the effect of an individual’s blame on the partner’s couple

satisfaction) in a single analysis; (c) enables the testing of gender differences in actor and partner effects; and (d) reduces the overall number of analyses conducted [41]. Although no specific indices can be used as absolute criteria for assessing the goodness of fit of a model, the inspection of several indices guided our assessment of the fit of the model to our data, as suggested by Kline (2015): the standardised root mean square residual (SRMR) goodness of fit index (values of 0.08 or less suggest a good fit), the comparative fit index (CFI; values greater than 0.90 suggest a good fit), and the root mean square error of approximation (RMSEA; values of 0.08 or less suggest a model that fits well) and its 90% confidence interval [42].

Residual terms from men's and women's variables were allowed to correlate within couples to account for the non-independence of partners' data. That is, both partners' blame variables were included in a single couple model, allowing all possible correlational paths between the four blame variables. A correlation was also specified between partners' outcome variables. Direct paths were then drawn from individuals' blame variables to their own (actor effects) and their partner's couple satisfaction, depression and anxiety (partner effects). For power consideration, paths were removed from this model based on preliminary correlations between variables. Paths for which the preliminary correlation was  $\leq 0.10$  were removed from the model to reduce the number of parameters to be estimated and increase statistical power. Non-parametric bootstrapping was used to calculate 95% confidence intervals for standardised path coefficients. When results appeared to differ between men and women, men's and women's paths were constrained to be equal, in order to test for significant gender differences using a chi-square difference test. No significant gender differences were found in any of the results.

Interpretation of gender differences must thus be done with caution.

## Results

Women averaged 31.03 years of age ( $SD = 4.42$ ; ranging 18–41) and men averaged 33.36 years of age ( $SD = 5.32$ , ranging 24–50). Approximately half of the couples were married (57.3%) and partners had been cohabiting for an average of 5.65 years ( $SD = 3.71$ ; ranging from less than 1 year to 19 years). The majority of participants were French speaking (84.4%; English = 6.5%; other = 6.8%). Women's average annual income was \$27,100 CAN ( $SD = 14,140$ ) and men's average annual income was \$39,300 CAN ( $SD = 22,300$ ). Most couples presented with primary infertility (74.8%) and 9.3% presented with secondary infertility. The remaining couples (15.7%) were childless, but one or both partners had children from a previous relationship. Other demographic and medical variables, originally recorded in participants' medical file, were not available for the current secondary analyses.

### Preliminary analyses

Table 1 presents means and standard deviations for all study variables. Descriptive analyses showed that partners were generally highly satisfied with their relationship ( $M = 120.54$ ;  $SD = 13.19$ ), with only 6.1% of participants reporting clinically significant relationship distress. Furthermore, although most participants reported normal levels of anxiety ( $M = 16.86$ ;  $SD = 13.71$ ) and depression symptoms ( $M = 19.51$ ;  $SD = 15.55$ ), a minority reported clinically significant levels of anxiety (15.9%) and depression (21.1%). Results showed that women reported more anxiety

**Table 1.** Correlations, means, and standard deviations for measures of blame, couple satisfaction and psychological symptoms among men and women ( $N = 279$  couples).

Variables	1	2	3	4	5	6	7 <sup>a</sup>	8 <sup>a</sup>	9 <sup>a</sup>	10 <sup>a</sup>
1. Self-blame M		0.05	0.27 <sup>b</sup>	0.15 <sup>b</sup>	-0.18 <sup>c</sup>	-0.12 <sup>b</sup>	0.12 <sup>b</sup>	0.03	0.20 <sup>c</sup>	0.05
2. Self-blame W			0.13 <sup>b</sup>	0.30 <sup>c</sup>	-0.06	-0.10	0.11	0.24 <sup>c</sup>	0.14 <sup>b</sup>	0.28 <sup>c</sup>
3. Partner blame M				0.16 <sup>b</sup>	-0.11	-0.12 <sup>b</sup>	0.06	0.09	0.05	0.06
4. Partner blame W					-0.18 <sup>c</sup>	-0.32 <sup>c</sup>	0.02	0.13 <sup>b</sup>	0.03	0.24 <sup>c</sup>
5. Couple satisfaction M						0.69 <sup>c</sup>	-0.20 <sup>c</sup>	-0.12	-0.32 <sup>c</sup>	-0.17 <sup>c</sup>
6. Couple satisfaction W							-0.12 <sup>b</sup>	-0.25 <sup>c</sup>	-0.15 <sup>c</sup>	-0.33 <sup>c</sup>
7. Anxiety M								0.29 <sup>c</sup>	0.69 <sup>c</sup>	0.23 <sup>c</sup>
8. Anxiety W									0.23 <sup>c</sup>	0.72 <sup>c</sup>
9. Depression M										0.26 <sup>c</sup>
10. Depression W										
<i>M</i>	1.49	2.08	1.15	1.24	120.41	120.68	14.48	19.24	15.81	23.22
<i>SD</i>	.81	1.07	.47	.54	13.39	13.02	11.10	15.57	12.80	17.13

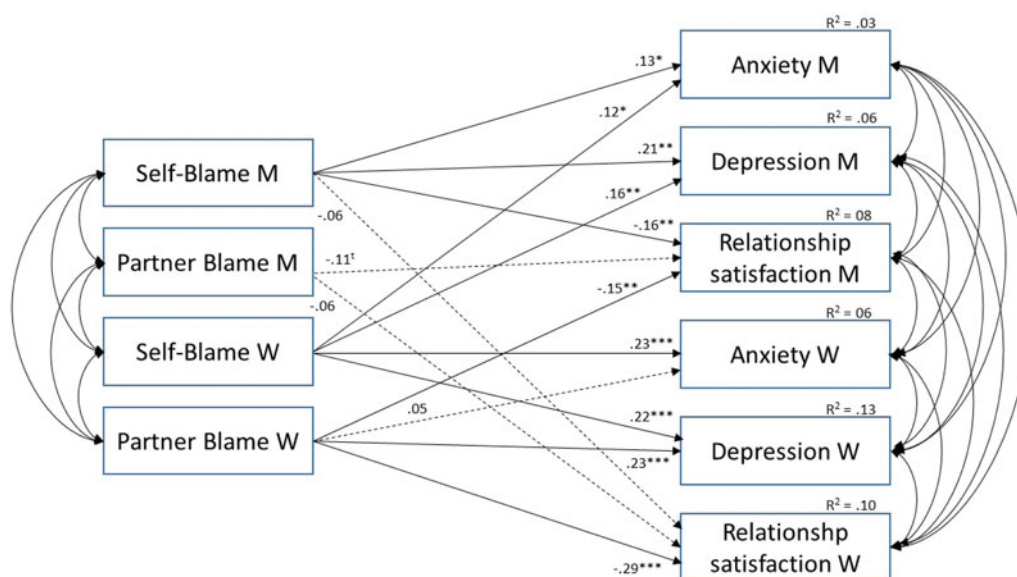
Note: M = Men; W = Women.

<sup>a</sup>A square root transformation was performed due to significant positive skewness; untransformed means and standard deviations are presented here.

<sup>b</sup> $p < 0.05$ .

<sup>c</sup> $p < 0.01$ .





**Figure 1.** Self-blame and partner blame predicting psychological adjustment and relationship satisfaction in men and women. Note: M=Men; W=Women. Standardised regression coefficients are shown. Dashed lines represent non-significant paths. <sup>†</sup> $p < 0.10$ ; \* $p < 0.05$ ; \*\* $p < 0.01$ ; \*\*\* $p < 0.001$ .

( $F(1,268) = 38.32, p < 0.001, \eta^2 = 0.13$ ) and depression symptoms ( $F(1,268) = 54.61, p < 0.001, \eta^2 = 0.17$ ) than men. Participants generally reported low self-blame and partner blaming, but compared to men, women were more likely to blame themselves for the fertility problem ( $F(1,268) = 48.78, p < 0.001, \eta^2 = 0.15$ ). Men and women did not significantly differ on partner blaming ( $F(1,268) = 5.28, p = 0.022$ ).

Weak associations were observed among study variables, age, cohabitation duration and annual income. Because all correlations were small in magnitude ( $r < 0.18$ ) [43], these demographic variables were not controlled for in the main analyses.

Table 1 also presents Spearman correlations between measures of blame, couple satisfaction and psychological symptoms among men and women. All significant correlations were in the expected direction. There were significant correlations between men's and women's self-blame and partner blame. Similarly, except for a non-significant correlation between men's couple satisfaction and women's anxiety, all other outcome variables (couple satisfaction, depression and anxiety) were correlated among men and women, highlighting the non-independence of data in couples.

### Main analyses

The proposed model appeared to fit the data well, as suggested by adequate fit indexes ( $\chi^2(10, N = 279) = 4.56, p = 0.918$ ; SRMR = 0.023; CFI = 1.000; RMSEA = 0.000, 90% CI (0.000, 0.023)). Results show that self-blame in men negatively predicted their own

couple satisfaction, and positively predicted their own depression and anxiety. Self-blame in women positively predicted both their own and their partner's anxiety and depression symptoms. With respect to blaming the partner, it predicted women's own lower relationship satisfaction, but not men's. Partner blame in women also predicted lower relationship satisfaction in their male partner. Women who blamed their partner reported more depression symptoms, but partner-blame was unrelated to anxiety symptoms. No significant gender differences were found for any of the effects; apparent gender differences need to be discussed with caution. Results, including effect size (standardised coefficient paths and  $R^2$ ), are shown in Figure 1. Confidence intervals for the standardised path coefficients are shown in Table 2.

### Discussion

This study used a dyadic design to examine the extent to which self- and partner blame were associated with symptoms of depression and anxiety, as well as relationship satisfaction in a large sample of couples seeking fertility treatment. Corroborating previous research [11], results show that a non-negligible minority of participants reported clinically significant psychological symptoms or relationship dissatisfaction. With respect to psychological distress, 15% fell within the clinical range for anxiety and 21% reported clinically significant depression symptoms. These results confirm that clinical symptoms are likely to occur in this population and are worthy of interest by medical and mental

**Table 2.** Nonparametric bootstrapped 95% confidence intervals for standardised path coefficients.

Variables	Couple satisfaction M	Couple satisfaction W	Anxiety M	Anxiety W	Depression M	Depression W
1. Self-blame M	[-0.273, -0.039]	[-0.165, 0.045]	[0.011, 0.230]		[0.090, 0.332]	
2. Self-blame W			[0.000, 0.217]	[0.101, 0.338]	[0.043, 0.263]	[0.096, 0.331]
3. Partner blame M	[-0.221, 0.020]	[-0.362, 0.022]				
4. Partner blame W	[-0.255, -0.056]	[-0.384, -0.184]		[-0.092, 0.162]	[0.080, 0.364]	

Note: M = Men; W = Women.

health professionals. In terms of couple satisfaction, 6.1% of couples reported clinically significant distress. The fact that few couples reported relationship distress is expected provided that most of these couples are sufficiently well functioning to envision having a child. Yet, although small, this percentage needs to be noted because these couples are to become parents if fertility treatments are successful. The birth of a child is known to be related to decreased relationship satisfaction in most couples [44,45] and to heighten relationship problems in couples presenting relationship difficulties before birth [46].

When examining preliminary gender differences in our results, women were more likely than their partner to both blame themselves the fertility problem. These results replicate previous findings showing that women are more likely to take responsibility for the fertility problem than men [31,47]. Women also reported more anxiety and depression symptoms than men, and these results also concur with previous research in infertility [3,4]. Women may be more likely to experience distress as a result of infertility and in the context of treatment, possibly because different meanings are attributed to maternity and paternity. Maternity may be more strongly linked to women's identity [48]. Other contextual factors may contribute to explain this gender difference, however, including treatment invasiveness, pain, and hormonal medication side effects likely to amplify women's emotional reactions in the context of infertility [48,49].

With respect to the association between blame and adjustment to infertility and its treatment, our analyses first showed that men and women who blame themselves for the fertility problem present more depression and anxiety symptoms, replicating results from prior research in infertility [24,25] and mental health in general [50,51]. It is possible that blaming oneself for the couple's conceiving difficulties, instead of blaming contextual/medical factors, contributes to increase psychological distress through feelings of defectiveness and powerlessness. Studies conducted in other areas of research have showed that attributing negative situations to internal factors (i.e. self-blame), as opposed to external factors, contributes to poorer adjustment [52–54].

Self-blame in women was also related to more depression and anxiety symptoms in their male partner. This is coherent with the study conducted by Peterson et al. [13] showing that men in couples in which both partners exhibited low levels of responsibility for their infertility reported lower infertility-related stress than men in couples where the woman reported high levels of responsibility. When the woman takes responsibility for the problem, her partner may feel powerless or inadequate in reassuring or consoling her or containing her distress, which may in turn result in men experiencing more depression or anxiety symptoms in the context of infertility.

Findings also reveal that when the man blames himself for the fertility problem, he also experiences lower relationship satisfaction. This is in line with results from Peterson et al. [13] study showing that couples in which both partners exhibited low levels of responsibility for the fertility problem reported higher marital adjustment than couples in which the man felt responsible for the couple's infertility. Men who blame themselves for the fertility problem may experience guilt, avoid discussing the fertility problem with their partner or become more distant in their relationship, which may then contribute to explain his reduced relationship satisfaction. An alternative explanation might reside in the association between infertility and a possible threat to masculinity in men. Men reporting self-blame may be more likely to perceive themselves as being "less than a man", which may translate into guilt and shame and negatively impact their perception of their relationship. Corroborating this hypothesis, a previous study found that infertile men who endorsed the view that fatherhood is strongly related to masculinity reported more psychological and relational distress than those who did not hold such view [55].

With respect to blaming the partner, we found that women who blamed their partner for the fertility problem reported more symptoms of depression. It is possible that blaming one's partner for the couple's inability to conceive a child may be related to anger, feelings of injustice or powerlessness, which could then explain their increased depression symptoms. Perceptions of low personal control was related to more distress in a study of infertile couples [56].

These findings are also coherent with another study showing that attributing the infertility to someone else's behaviour is associated with greater distress [35].

Finally, our findings show that when the man blames his partner, he tends to report lower relationship satisfaction, whereas when the woman blames her partner, both partners report lower relationship satisfaction. Research also shows that attributing the cause of negative relationship events to the partner is systematically associated with lower relationship satisfaction [57]. When partners blame each other for the problem, this may result in more frustration, hostility and conflicts in the relationship and this climate may not be conducive of intimacy, empathy and mutual support at a time when both partners may be upset and stressed about the fertility process. A recent study demonstrated that angry hostility was associated with both partners' lower marital satisfaction [57].

### **Research and clinical implications**

Overall, this study highlights the relevance of examining blame (self and partner), beyond diagnosis, as a potential risk factor for adjustment difficulties, as it may explain greater variance in adjustment than diagnosis itself. That is, how partners respond to the diagnosis (male vs. female factor) might be a better predictor of adjustment. Our findings also bear clinical implications for mental health professional working with couples undergoing fertility treatment. Our results suggest that beyond knowing which partner received the infertility diagnosis, inquiring about blame attributions is likely clinically relevant as it may inform about potential distress in both partners. A brief two-item blame measure (self, partner) could be used as a screening tool by health professionals, considering how self-blame is related to one's own level of depression and anxiety during fertility treatment, and how partner-blame is related to lower relationship satisfaction. In terms of counselling, therapists should be sensitive to both men's and women's tendency to blame themselves, as it may impede their psychological adjustment during this highly stressful period. Therapist should also carefully address the notion of partner blame, especially for women, as it appears to play a larger role in their own and their partner's relationship satisfaction. The expression of sadness, anger or sense of helplessness that may lie underneath this negative blame attribution, if received with empathy and validation during counselling, could allow the partners to understand and support each other, and possibly decrease relational distance and loneliness

whilst increasing their feeling of intimacy and closeness.

### **Limitations**

The current study presents a number of limitations. First, results rely on self-reports and cross-sectional data only, precluding any inference about causation between variables. For instance, although our analyses suggest that blame temporally precedes adjustment, it may be that underlying depression and anxiety underlie self-blame and that pre-existing marital conflicts are at the root of partner-blame. Research identifying mediators of these associations is also needed to help understanding the mechanisms through which blame might be related to poorer psychological and relationship adjustment. Although we proposed several potential mediators (e.g. shame and guilt, anger, helplessness and low personal control), our study did not assess these variables. Second, in the absence of medical information concealed in medical files and to which we did not have access for this study, it is not possible to identify possible associations between self- and partner blame, diagnosis, treatment and outcome adjustment variables. Third, the sample size was limited to conduct path analyses, hence reducing statistical power and our ability to detect significant associations among variables. As a result of the limited sample size, a pre-selection of the paths to be tested in our final model (based on preliminary correlations) was also necessary. Finally, participation in this study was voluntary. Most couples in our sample presented high levels of relationship satisfaction and may not be representative of all couples seeking fertility treatment. Our study nevertheless included a large sample of couples, comprising both partners, a feature that remains rare in infertility research. More dyadic research of this type is needed in the future to further our understanding of complex relational dynamics and adjustment in infertile couples.

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The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

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#### ► Current knowledge on the subject

- Infertility is related to psychological and relationship adjustment in a significant proportion of couples.
- Self-blame and partner blaming are both related to poorer psychological adjustment, but their role in the context of infertility has been seldom investigated.
- Most studies have examined infertility-related adjustment from an individual perspective, but few dyadic studies considering both partners' perspective have been conducted.

#### ► What this study adds

- Partners' own self-blame for the fertility problem predicted their own depression and anxiety symptoms as well as their own lower relationship satisfaction.
- Self-blame in women predicted their partner's anxiety and depression symptoms.
- Partner blaming in women predicted their own depression symptoms and lower relationship satisfaction, as well as their partner's lower relationship satisfaction.