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The Effects of Trauma on Intimate Relationships: A Qualitative Study with Clinical Couples

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Abstract

Research traditionally has focused on the development of symptoms in those who experienced trauma directly but overlooked the impact of trauma on the families of victims. In recent years, researchers and clinicians have begun to examine how individual exposure to traumatic events affects the spouses/partners, children, and professional helpers of trauma survivors. The current study examines qualitative interview data from 17 individuals, analyzed using a retroductive methodology to identify how intimate relationships are affected when there is a history of trauma exposure. The following primary themes were identified: increased communication, decreased communication, increased cohesion/connection, decreased cohesion/connection, increased understanding, decreased understanding, sexual intimacy problems, symptoms of relationship distress, support from partner, and relationship resources. Areas for future research and clinical implications are identified.

Traumatic events have received substantial clinical and empirical focus in the past 25 years. Although traumatic experiences have been survived by people for centuries, scientific knowledge of trauma has increased in recent history. Much of the literature on trauma and posttraumatic stress focuses on the individual effects of trauma on the primary victim—the person who *directly* experienced the traumatic event (Herman, 1997; van der Kolk, McFarlane, & Weisaeth, 1996). The predominant focus in the trauma literature has been on the treatment of posttraumatic stress disorder (PTSD; American Psychiatric Association [APA], 2000), a disorder that by definition focuses on the intrapersonal effects of traumatic events on the individual trauma survivor. Currently in the traumatic stress field, the definition of trauma almost exclusively encompasses the *DSM-IV-TR* (APA, 2000) criteria for PTSD; thus, *trauma* has become synonymous with *PTSD*. However, some in the field have challenged this definition, suggesting an alternative model beyond the *DSM-IV-TR* description of trauma (Brewin, Carlson, Creamer, & Shalev, 2005). Shalev (2005) indicated that a stressful event becomes traumatic when it is emotionally and personally meaningful, cognitively incongruous, and when it affects human bonds and networks, suggesting that "trauma should not be seen as affecting individuals but as affecting humans in their context."

The literature that describes a couple and family systems approach to trauma primarily involves secondary traumatic stress theory (Figley, 1983; 1998), adult attachment theory (Johnson, 2002), and the relational approach to trauma treatment (Sheinberg & Fraenkel, 2001). Several terms have been used to describe these secondary effects, like compassion fatigue (Figley, 1995, 2002), vicarious traumatization (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), burnout (Figley, 1998), trauma transmission (Baranowsky, Young, Johnson-Douglas, Williams-Keeler, & McCarrey, 1998), and witnessing (Weingarten, 2003, 2004).

The theory of secondary traumatic stress contends that being in close contact with and emotionally connected to a traumatized person becomes a chronic stressor, and family members often experience symptoms of traumatization (Arzi, Solomon, & Dekel, 2000; Figley, 1983, 1995; McCann & Pearlman, 1990; Solomon, Waysman, Levy, et al., 1992). The basic premise behind secondary trauma theory is that individual stress symptoms are communicable, and those who are close to the trauma survivor can be "infected" with the trauma symptoms (Catherall, 1992; Figley, 1995). Often the problems experienced by people close to a trauma survivor "mimic" (Coughlan & Parkin, 1987) the trauma symptoms in the survivor. This may result from an internalization process, where family members identify so closely with the experiences of the victim that they begin to internalize the trauma symptoms of the victim and experience their own stress reactions (Maloney, 1988). These effects are considered "secondary" because they occur in those who have not been directly traumatized by the event. Frequently, these effects may resemble PTSD symptoms (Bramsen, van der Ploeg, & Twisk, 2002; Nelson & Wright, 1996), but may be less intense (Maltas & Shay, 1995).

Several authors have described the secondary effects traumatic events have on children (Barnes, 1998; Steinberg, 1998), spouses and partners (Arzi et al., 2000; Bramsen et al., 2002; Lev-Wiesel & Amir, 2001; McCann & Pearlman, 1990; Nelson & Wampler, 2000; Nelson, Wangsgaard, Yorgason, Higgins Kessler, & Carter-Vassol, 2002; Nelson & Wright, 1996), therapists (Figley, 2002; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), emergency and medical professionals (McCammon & Allison, 1995), direct and indirect witnesses (Weingarten, 2003, 2004), and others who work and interact with trauma victims/survivors on a personal level. The dilemma with the secondary traumatization hypothesis is that there is limited empirical support for the theory. Much of the literature on secondary traumatization gives brief

mention of this concept, citing clinical support and providing a necessary conceptual framework for understanding the secondary effects of trauma (Figley, 1983; McCann & Pearlman, 1990; Miller & Sutherland, 1999; Nelson & Wright, 1996).

Secondary Traumatic Stress in Couples

Quantitative Research

The empirical work by Solomon and colleagues (Arzi et al., 2000; Dekel, Goldblatt, Keidar, Solomon, & Polliack, 2005; Mikulincer, Florian, & Solomon, 1995; Solomon, 1988; Solomon, Waysman, Avitzur, & Enoch, 1991; Solomon, Waysman, Belkin, et al., 1992; Solomon, Waysman, Levy, et al., 1992) has focused on the effect of combat trauma on the spouses/partners of veterans. These authors found combat stress reaction (CSR) and PTSD in husbands to be related to greater somatization, depression, anxiety, loneliness, hostility, and impaired marital, family, and social relations in wives. Research by Riggs, Byrne, Weathers, and Litz (1998) indicated that over 70% of the PTSD veterans and their partners reported clinically significant levels of relationship distress, compared to only 30% of the non-PTSD couples. PTSD-positive couples reported significantly more relationship distress, difficulties with intimacy, and relationship problems than the PTSD-negative couples. Lev-Wiesel and Amir (2001) found that approximately 1/3 of partners of Holocaust survivors reported secondary traumatic stress symptoms, with levels of anger and hostility, paranoia, and interpersonal sensitivity in Holocaust survivors related to increased levels of secondary trauma symptoms in their spouses and decreased marital quality in the relationship.

Research conducted by Nelson and Wampler (2000) reported that clinic couples with an abuse history reported lower marital satisfaction and higher individual distress symptoms for both partners than those couples in which neither partner reported an abuse history. However,

further research conducted by Nelson (1999) addressed the impact of traumatic experiences on dyadic relationships by comparing individual symptoms and relationship impairment measures between three clinical groups: veteran couples, childhood sexual abuse survivor couples, and a control group of couples. Although the results indicated differences between groups on individual stress and trauma symptoms, there was not a significant difference in relationship impairment between the groups. Thus, this research provided some support for secondary traumatic stress theory, as the partners of trauma survivors experienced increased individual symptoms, but the results did not support the premise that couple relationships are negatively affected by a history of trauma.

Qualitative Research and Clinical Literature

In addition to this limited quantitative research, few qualitative studies are available in the literature on the systemic effects of trauma in couples. The published literature that is available focuses predominately on the partners of war veterans (Dekel et al., 2005; Lyons, 2001; Maloney, 1988; Verbosky & Ryan, 1988) or childhood sexual abuse survivors (Reid, Wampler, & Taylor, 1996; Wiersma, 2003). This research describes the individual or secondary effects on the partners of trauma survivors, rather than a description of the interpersonal or systemic patterns that may occur between partners. Nelson et al. (2002) and Nelson Goff and Smith (2005) provided a clinically based framework (2002) and theoretical model (2005) to describe the interpersonal patterns that may be characteristic of trauma couples; however, these models, although based on empirical literature, have not been empirically supported.

There are several limitations currently in the literature on the systemic effects of trauma in couples. First, although some of the literature reviewed here indicates support for secondary trauma in partners of trauma survivors, the results are mixed. Second, current literature has not

identified the specific systemic effects of trauma on interpersonal or relationship functioning in couples; thus, an empirical description of trauma in couples is missing. Finally, most of the research in the trauma field includes participants with homogenous trauma histories (e.g., all participants experienced childhood sexual abuse), yet clinical descriptions (i.e., PTSD symptoms described in the *DSM-IV-TR*; APA, 2000) identify similarities across survivors of different types of traumas in terms of individual symptomatology. Thus, research does not include a broad description of the systemic effects of trauma comparing participants with diverse trauma experiences. The current study is an attempt to address the current limitations in the field by providing an empirical description of the systemic and relationship effects of trauma exposure and traumatic stress symptoms in couples with exposure to various prior traumas.

Methodology

Qualitative Methodology

To provide context for the research process, it is important to note that data collection, analysis and reporting were conducted using a team-based approach. The research team consisted of the faculty primary investigator (PI), the primary qualitative methodologist (QM), doctoral and master's-level graduate students, and undergraduate students who were all members of the *Trauma Research, Education, and Consultation at Kansas State University* (TRECK) *Team*. The study reported here is part of a larger study of trauma in couples conducted by the TRECK Team, which included three separate primary research questions. In the current study, only data from Research Question #2 are reported: *In what ways are the couple's interpersonal functioning affected when there is a history of trauma exposure (interpersonal/systemic secondary traumatic stress symptoms)?* The other research questions focused on primary and secondary trauma symptoms in both partners (Research Question #1) and the mechanisms by

which systemic functioning may be affected by trauma (Research Question #3).

A broad definition of "traumatic events" was used for the study, in order to collect data on a variety of traumatic experiences and to not limit the type of data that was included. The participant couples were recruited through a university-based counseling center in the Midwest. The couples, who were receiving therapy services at the center, received one free therapy session for their participation in the research. All participants were at least 18 years of age and reported they had been in a committed relationship (dating, married, cohabiting) for at least one year. After completing the informed consent forms, the participants completed quantitative questionnaires and semi-structured qualitative interviews. The research procedure was approved by the University Institutional Review Board.

The current study included 10 couples in which at least one partner reported exposure to a past traumatic event. Data from one couple was omitted due to questionable validity and another female partner's qualitative interview did not record, resulting in 17 usable individual interviews (Data from all 18 participants are included in the description of the sample, below).

Although participants were recruited as couples, each partner was interviewed separately by the PI and graduate student members of the research team at the university clinic. Each interview was audiotaped and transcribed verbatim by the undergraduate research assistants. The open-ended, semi-structured qualitative interviews consisted of 30 questions and focused on the long-term interpersonal impact of trauma on the couple relationship (e.g., *How is your relationship most affected by: your past trauma experiences or your partner's past trauma experiences?*), intrapersonal effects of trauma exposure on both partners (e.g., *Has your partner ever experienced any traumatic events? How is your partner most affected by his/her past trauma experiences? How are you most affected by your partner's trauma?*), and current dyadic

functioning (e.g., *How would you rate your ability to talk to your partner about the events that happened in your past?*) (The first author may be contacted to request more specific information about the steps of the procedure and the specific qualitative questions used in this study).

A phenomenological perspective was utilized in this study in that the goal was to understand the lived experiences of the couples regarding the effects of trauma on their interpersonal functioning. Following the completion of the interviews, a retroductive method of qualitative analysis was used, which involves a continuous cycle of induction and deduction. More specifically, a typical form of analytic induction begins with the analyst using deduced hypotheses from previous literature or theory to analyze the data. Then, the analyst inductively analyzes the data by allowing new themes to emerge, while viewing those themes within the original deductive framework. This analysis was deemed most appropriate because this method allows the use of secondary trauma theory as a basic framework from which to view the data but also offered the flexibility to permit new themes to emerge so that gaps in the literature could be filled.

Beginning the process of retroductive analysis, a codebook of themes based on secondary trauma theory and previous findings in the literature was established. Then, content analyses of the interviews were performed by the research group, which consisted of the faculty mentor, two doctoral students, and two undergraduate students. In order to enhance the verification and validity of the analysis, analyst triangulation (Patton, 2002) was utilized during the process of the content analyses. First, each group member independently identified patterns within the data that corresponded with the themes from the codebook. Next, the group converged and established a consensus regarding the coding of the data. Throughout the analysis process of each interview, the group also decided if any new themes emerged from the data and added those to the codebook, when necessary.

After reaching consensus for the interview coding, the group utilized NUD*IST Version

N6 (Richards & Richards, 2002), a software program designed for qualitative research, for purposes of data organization only. In the final stage of the analysis, the group then read the NUD*IST N6 reports, consisting of the selected data from the transcripts that was organized according to the identified themes, in order to assess the substantive significance of the themes. Substantive significance is the method by which qualitative findings are evaluated for scientific merit, similar to that of statistical significance for quantitative data (Patton, 2002). Then, to conclude the analysis, the group identified the strongest of the themes, based upon breadth and depth, and identified theme exemplars, quotes that particularly capture the essence of each theme (Patton, 2002). Thus, substantive significance was determined through the use of several methods of triangulation (e.g., multiple coders and team consensus) and through consensual validation by group members.

In the current study, 13 initial variables were identified, which consisted of variables that were matched for both increased and decreased symptoms (e.g., increased and decreased communication; increased and decreased relationship distress). Variables were regularly revised throughout the analysis process, resulting in a final total of 29 variables. The final themes described here consisted of the 10 most frequently identified and most salient themes, based on individual member coding and research group consensus. Table 1 provides a summary of the study variables.

Participant Characteristics

The total sample included 9 males and 9 females. The age range for the participants was 21-52 (M=34.89, SD=10.20), with 7.37 years as the average length of their relationship (SD=9.13; range=1 month to 23 years; 1 month was the length of marriage for couples who had been together as a couple longer but recently had been married). Seven of the nine couples were

currently married, with one couple dating and one couple who was separated. Except for one male participant (Asian/Pacific Islander) and one female participant (American Indian/Alaska Native), all other participants were European American. Eleven of the 18 participants (61%) were employed full-time, with 10 of the 18 (56%) reporting an annual income under $40,000.

As mentioned previously, participants were not limited by type of previous traumatic events; however, participants were asked to identify their primary or most traumatic experience for the quantitative and qualitative questions. The ranges for traumatic events experienced by participants are described in Figure 1.

Insert Figure 1 about here

Results

Qualitative Interview Results

The qualitative data analysis resulted in 10 primary themes: increased communication, decreased communication, increased cohesion/connection, decreased cohesion/connection, increased understanding, decreased understanding, sexual intimacy problems, symptoms of relationship distress, support from partner, and relationship resources. The participants' data were categorized using these themes across all 17 interviews. The themes were used to compare across the interviews, which resulted in some dichotomy (e.g., both increased and decreased communication). Thus, within the same interview, the participant may have described situations or experiences of increased communication, as well as situations when they experienced communication problems or reduced communication. This resulted in participants' responses being classified in more than one theme, even themes that could be considered on a continuum, which are divergent or opposite in scope. In some instances, these themes may be directly related to the past trauma experiences; however, due to the nature of the qualitative interviews, some of

the participants' responses may have been describing relationship characteristics, in general, not necessarily a result of their previous trauma experiences. Trauma-specific examples are included to provide an understanding of our classification and interpretation of the data.

The primary themes will be described below, including the total number and gender of the participants for each theme, supporting quotes, and participant code numbers for each quote (e.g., 1M = Couple #1, male partner; 4F = Couple #4, female partner). The first six themes include the continuum or dichotomous areas of increased and decreased communication, increased and decreased cohesion/connection, and increased and decreased understanding.

Increased Communication

One of the most salient themes from the participant interviews was increased communication, which was described by all 17 participants (9 males and 8 females). The participants reported both positive communication patterns related specifically to their or their partner's trauma experience (trauma-specific communication), as well as reporting general relationship skills that demonstrated support between partners and provided an environment receptive to sharing emotions, talking through problems, working to improve communication skills, and a willingness to seek outside help (e.g., therapy) to enhance communication. When asked specifically about how they learned about their partner's trauma or whether their partner knew about their own trauma history, participants directly stated "*she/he told me*" (2F, 4F, and 10M) or "*we're able to talk to each other about it*" (5F). There was a clear indication from participants that they experienced improved communication directly resulting from open, clear communication about past trauma experiences. As Participant 5M stated when asked how his partner supports him in his trauma experience:

Probably just by communicating, uhm more than anything else, just talking about what's

happened and continuing to talk about the situation.

For some participants, their increased communication with their partner was seen as an *active* process, in which they clearly communicate about their previous trauma experience or that they viewed as directly related to their trauma:

> *Because of the [trauma] situation, I've communicated a lot more. I had a lot more inner feelings coming out and that's because of the traumatic situation, we've been forced to but, communicated a lot more rather than just…holding it [in].* (5M)

However, for others, their communication was less direct, or more *passive*, indicating more nonverbal cues or ways of communicating with their partner:

> *He's gotten good at reading me, uh, he can tell when I'm upset…* (Interviewer: Now does he know those things because you've told him what you need? Or is it more he's trying different things and finally gotten to the point where he knows?) *Yeah, he just figured it out (laughs). (*Interviewer: Ok, so it's not something that you've said, "This is what I need from you"?) *No*. (1F)

Decreased Communication

Interestingly, although increased communication was identified as a key theme in all interviews, decreased communication also was described by many of the participants (n = 15; 8 males and 7 females) as a pattern in their relationships, particularly related to the trauma. There appeared to be general patterns of incomplete communication, miscommunication, unsatisfactory communication, or a lack of communication described by participants, which appeared to create a sense of disconnection between partners.

This decreased communication pattern was interpreted as either *passive avoidance* or *active avoidance*. With passive avoidance, participants indicated a limited or incomplete

awareness by partners due to the trauma survivors' decreased communication about their trauma experiences. One participant stated, *"He probably doesn't even know I have trauma"* (2F). When asked how his wife is most affected by her past traumatic experience, her husband stated:

> *……(7 secs) I don't know. Only that she……(7sec) I don't know because I think it just let her know that anything can happen…And you know I don't know, I don't know to tell you the truth.*

Some participants reported more *active* efforts to avoid discussing their trauma history, like hiding emotions, stating that they do not want to talk about the trauma, or engaging in behaviors to avoid discussing their past trauma experiences: *"I don't talk to him much about it. I just tell him it bothers, I mean, that things happened, and it still sometimes bothers me, but specifically what happened, or anything, I don't*" (4F). When participants had experienced multiple traumatic events, they sometimes "compartmentalized" their trauma experiences, selecting certain traumas (e.g., less critical or key traumas) to discuss with their partners, while avoiding directly discussing other experiences.

Increased Cohesion/Connection

Participants (*n* = 13; 7 males and 6 females) reported experiencing a sense of increased cohesion or connection in their relationship with their partner. Some participants described actively connecting with their partner through their trauma experience, expressing a sense that their past trauma exposure brought them closer as a couple. For some couples, this involved a mutual or shared trauma experience:

> *My wife and I have come closer together, uhm, and to talk about some things and communicate more openly about things. The trauma has brought us closer [more] than troubled. I know that's for sure, uh, it's brought us closer together.* (5M)

Other participants reported increased connection through their own individual trauma experiences:

> *I guess just that when he talks, when it comes up and he talks about it, I can feel how much pain he has*. (2F)

Participants also described a general relationship connection to their partner, by indicating a sense of having a "friendship" or being a "team" as a couple, developing their general attachment and commitment to their relationship. Participant 10M exemplified this team effort in his relationship: *"…we both try to take care of things like equal amounts, not one of us has an extra amount of stress or extra amount of responsibilities we're trying to, to take care of things, you know, 50-50*." His partner stated: "*We know what we want from a marriage and that we have to work together to make it.*" Thus, increased cohesion in the relationship was described by several participants, which included connection through their trauma experiences or as a more general characteristic of their dyadic relationship.

Decreased Cohesion/Connection

Similar to the previous increased and decreased communication themes, cohesion/connection also was described as a dichotomous theme. The theme of decreased cohesion was described in 10 interviews (5 males and 5 females) as a general loss of connection between partners and a more active distancing by partners. In describing disconnection, participants reported feeling a lack of caring from their partner, a sense of isolation, and a loss of love in their relationship. These patterns appeared to result from the trauma, as well as just a general relationship trajectory that may or may not have been trauma-based. One couple described an extreme example of this disconnection in their marriage:

> *It's like having a roommate, that's how I would describe it...we don't really have a*

relationship ...there just wasn't a connection there. (6F)

I'd just say it's strained and it's not really a relationship it's more like roommates now...How is my relationship affected? We don't, we don't have one. (6M)

Beyond the experience of losing a connection or experiencing a decrease in cohesion, participants also described an "active distancing" by partners, using terms like "*distant*" (4F, 6M, 9M), "*disconnect*" (2M), "*push away*" (2F, 4F), and "*pulling back*" (1F).

It is easy for me to disconnect before anything bad happens. (2M)

There were lots of times that he would do things and say things that almost seemed like he was just trying to push me to leaving. (2F)

This disconnection is similar to the attachment problems in trauma survivors described by Johnson (2002). Participants in the current study described this active distancing as trauma-related, with most demonstrating insight into their own reactions and attempts to achieve that distance in relationships:

I think that [partner's name] [is an outsider] too. I think she just can't get into it and pull me out of it so I do think that she may be on the outside, but I'll tell you how I do that, it's, I have, I've done that all my life is not let people in...I normally see everybody as an outsider. (2M)

And um, I think maybe he's felt like we were a little bit distant because I wouldn't tell him exactly what happened [about my sexual abuse experience as a child]. … Because it's kind of like there's a wall there, I don't go there at all. (4F)

Increased Understanding

Several participants (*n* = 9; 6 males and 3 females) indicated that their partner's

"understanding" them or their trauma experience was important. A key element of increased understanding included knowledge of the partners' past trauma experiences, the ability for partners to recognize trauma triggers and reactions, and being able to connect current symptoms to past experiences. Trauma survivors reported a general belief that their partner understands them and their experiences, which they indicated demonstrated a sense of showing support:

> *I think it helps too, to talk about stuff that happened. 'Cause it, I don't know, makes me feel better to know that he understands better what happened, so he can understand why I'm so upset. Why it affects me the way it does. It helps a lot.* (1F)
>
> *Yeah, he really does, he really understands that when I'm like {makes a noise} he understands I need my space, he understands what I need.* (8F)

Partners of trauma survivors also indicated that there were moments of them understanding their partner that were critical in their relationship:

> *But then everything kind of came together like because she would do things that, wouldn't make sense to me. But it was because of what happened to her in the past, and then when I found out what he did, then I realized why she was acting the way she was.* (1M)

Decreased Understanding

Some participants (*n* = 7; 3 males and 4 females) also described a "lack of understanding" or decreased understanding as well, both in their self-awareness of the effects from their trauma experiences and in their partners' awareness or level of understanding. Participant 2M stated: "*there's just something there that unless you experience it, you just don't connect with it.*" Both primary trauma survivors and their partners indicated not understanding one another, particularly related to the past trauma experiences. Participants stated, "*I don't think she even understands*

[my past trauma]" (2M); "*I don't think she understands what I feel sometimes about it*" (3M); and "*I don't know if he could really understand that it, because I think he'll think it's more him, like something he did when it's not*" (4F).

Although not explicitly described by participants, the researchers identified some statements by participants that suggest a lack of awareness or realization that they do not understand; in other words, the participant does not know s/he does not understand the impact of the past trauma experiences on the partner. For example, when asked how her partner is most affected by what he went through during a war experience, Participant 8F stated:

> *I have no idea. I really have no idea...I mean, I don't see it yet. I guess because I don't know what affects him, then I don't know what, how, you know what I'm saying, like I'm not sure what it is that affects him yet.*

The lack of clarity in answers to inquiries about the impact of a partner's trauma history, as well as direct statements of not understanding, suggest a lack of awareness by partners about the effects of previous trauma on themselves, their partners, and their relationship.

The next two themes focus on specific relationship issues or problems: increased sexual intimacy problems and increased relationship distress. Although the original classification codes included the opposite themes (*decreased* sexual problems and *decreased* relationship distress), these themes were not found to be salient; thus, they were eliminated from the final reported results.

Increased Sexual Intimacy Problems

Increased sexual problems were reported by 10 participants (5 males and 5 females). This theme can be described as a disconnection or distancing that affects a particular area in the couple's sexual relationship. Participants described two key aspects: a lack of sexual desire and

sexual intimacy that is affected by past trauma, both sexually-based traumas (e.g., childhood sexual abuse) and other types of traumatic experiences (e.g., recent traumatic events). For example, 5F described decreased sexual desire after a recent traumatic loss:

> *…the difference obviously is that I don't feel like loving him, you know, and they ask the questions about sexual relations* [from the study's quantitative questionnaire]*– there's no desire for that right now. I mean it's not even thought about because my mind is so preoccupied about everything that has happened…I don't have a strong desire to be close to him right now.*

Other participants expressed intimacy problems by avoiding sex because it became a reminder of previous sexual trauma endured. As Participant 4F stated: "*…being intimate, sometimes I'll want to stop somewhere because I'll, it feels like I'm going through it again.*" Participant 4M shared what he has told his wife to reassure her: "*I don't want to feel like I'm raping you or whatever, you know, well the point is to make love to you*" (4M). Although this theme was described by just over half of the participants, participants clearly and directly described the negative effects on their sexual relationship, particularly related to a lack of sexual intimacy.

Increased Relationship Distress

The theme of increased relationship distress was described by 13 participants (6 males and 7 females). Some participants described feeling stress in their relationship because of interactions they had with their partners that were reminders or "triggers" of past traumatic experiences. As Participant 2F (who experienced domestic violence in a previous relationship) stated:

> *Um… just that you know, there's, there's that split second where I don't know if he's*

> [current partner] *gonna hit me, I, you know, I, even though consciously I can say, "No, he would never do that." But subconsciously there's always that fear.*

Other participants described relationship distress as being less directly related to the traumatic experiences, but which could involve reactions like the secondary partner being angry or frustrated due to the effects of the previous trauma that they observe in their partners:

> *I have to be really careful…with things that I do or say. I feel like I'm walking on eggshells a lot of the times. I felt like a lot of things are tests…that could very well spark a huge argument depending on my answer. So it's a, it keeps me on my toes a lot, it makes me a, it makes me a little anxious about certain situations.* (9M)

Finally, some couples appeared to experience a rigid "style" of interpersonal conflict in their relationship, demonstrated by patterns of intense conflicts, unresolved conflict, lack of communication, and anger primarily expressed by trauma survivors. Several participants described conflict in their relationships, including "*blowing up*" (3M, 6M), "*screaming*" (6M), "*uncontrolled anger*" (6F), and "*heated discussions*" (3F). Other participants described verbal abuse and throwing objects during arguments. As Participant 9M stated, "*most of our conflicts don't get resolved, they just get ignored.*" Some conflict appeared to be trauma related, resulting from flashbacks or other trauma symptoms: "*Usually I would take out, everything that I was feeling, um, and I would have flashbacks from my previous relationship. I would take it all out on [partner's name]"* (1F). The conflict described by most participants appeared to be a general destructive pattern in their relationships, which may or may not have been a result of their previous trauma exposure: "*We get in arguments a lot but it's just stupid stuff…every time we fight I guess he is afraid that I'll leave him"* (4F).

The final two themes, support from partner and relationship resources, also were found to

be highly salient. These themes reflect the resilience or positive aspects that couples may experience after trauma exposure, indicating that the relationship may play a role in coping with past trauma.

Support from Partner

Several participants (*n* = 15; 9 males and 6 females) reported experiencing increased support from their partner as a key strength in their relationship. A primary aspect of support involved a sense of their partner "being there" to support them. Partners stated, "*he knows that I was there for him*" (3F), "*she's always been there*" (3M), and "*he's there emotionally and physically for me when I need him*" (8F). In addition, participants reported that an important part of feeling supported was their partners' being positive, optimistic, reassuring, validating, encouraging, and patient. When asked whether her partner is an insider or outsider to what she experienced, Participant 8F stated:

> *I think maybe I would say insider because how it affects me, it affects him...and so in that sense, I would say he is inside the problem as well, but he's able to, you know, help me deal with it each time.*

Relationship Resources

Several participants (*n* = 16; 9 males and 7 females) described resources they experience in their relationships that help in coping with their trauma experiences. Some of these resources can be seen as "internal" to the relationship, like shared responsibility, a sense of equality, a sense of commitment, and having a partnership in the relationship. A key internal component that was described by several participants was patience: "*You have to have a lot of patience and you have to understand what they went through*" (1M). Participants also described resources outside the relationship, such as attending therapy or preventative efforts to intervene and

improve their relationship. However, as Participant 1F stated, in describing how her partner supports her, the support trauma survivors find in their relationships often is key to dealing with current symptoms and past experiences:

> *He's helped a lot. I mean it's one thing to go to therapy, and it's another thing to have someone who really helps you. That supports you, tells you when you're like flipping out again, or you're having another, nightmare or flashback, you know it's okay, you know it's not your fault, and like talk to you and listen to you.*

Discussion

The current study focused on identifying how intimate relationships are affected in couples when there is a history of trauma exposure in a partner. Qualitative data from 17 participants were analyzed using a team-based, retroductive analysis approach, which resulted in 10 primary themes: increased communication, decreased communication, increased cohesion/connection, decreased cohesion/connection, increased understanding, decreased understanding, sexual intimacy problems, symptoms of relationship distress, support from partner, and relationship resources. These results provide a unique empirical description of the specific patterns and issues that trauma survivors and their partners reported in their couple relationship.

Review of the Results

In much of the previous empirical research on the interpersonal effects of trauma in couples, negative or impaired relationship patterns have been described; however, the current results clearly did not support the assumption that the relationships of trauma survivors are inherently impaired or problematic. We provided participants with the opportunity to describe both relationship strengths as well as problem areas, contrary to previous literature, which would

suggest that distress variables might be more salient in the interview data. Although we approached the data analysis this way, it was feasible that if problems predominated the relationships of trauma survivors, then the problem or distress variables would dominate the results. However, the final results indicated that a "continuum" existed with several of the variables (e.g., increased and decreased communication, increased and decreased cohesion, understanding/lack of understanding, relationship distress and relationship resources); thus, the final themes included a relatively equal mix of relationship strengths and problems.

The range of relationship variables somewhat reflects the variability in relationship satisfaction in the sample. Some participants generally indicated strong, positive relationships, while others indicated relationships that suggested more serious problems (e.g., separation, past violence). However, even "distressed" participants described positive aspects of their relationships, and participants who described their relationships as satisfied to very satisfied reported a range of relationship problems, as well.

This finding fits with Nelson Goff and Smith's (2005) model of systemic trauma in couples, and it lends more specific information about how couple functioning may be affected when there is a history of trauma. Nelson Goff and Smith (2005) described issues related to attachment, satisfaction, stability, adaptability, support/nurturance, power, intimacy, communication, conflict, and roles as key factors in systemic functioning in trauma couples. Some of these variables were identified as key themes in the current study (e.g., attachment/connection, support, intimacy, communication, and conflict); however, this study did not confirm all of the variables described in the previous model. New variables (e.g., understanding), as well as the continuum found in several variables provide an interesting addition to the research on trauma in couples. These results also suggest the need to recognize

the range of issues, which include strengths and resources, with which trauma survivors may present to therapy.

The results of the study indicate that the interpersonal relationships of trauma survivors may have characteristics that are uniquely trauma-based. Although this study did not include a comparison group of couples without a trauma history, several observations may be made from the current results. First, although some of the primary themes, like communication, cohesion, understanding, and support, could be considered characteristics of dyadic relationships, in general, many of the participants clearly described experiences that were unique to their relationship because of their or their partner's past trauma experiences. It is difficult to distinguish what characteristics are directly trauma-based and which are simply a normal part of relationships, whether the partners have experienced previous trauma or not. However, 23 out of the 30 total qualitative interview questions directly asked about their own or their partner's previous trauma history. Also, the quantitative survey, which was not included in the data reported here, directly addressed exposure to previous traumatic events and current trauma symptoms, and the qualitative interviews referred back to the specific traumatic event(s) reported by the participants. The analyses focused on identifying the interview themes, based on variables from current literature on trauma in couples. Although some variables were confirmed in the current study, resulting in a good degree of saturation in the research themes, future research including a comparison group of couples without a reported trauma history is needed to confirm that the current themes are unique to couples with a history of trauma.

In addition, the specific qualities identified in the results are not dissimilar to general characteristics of couple relationships. It is generally understood that good communication, understanding, support, and similar positive qualities are necessary for successful relationships.

What is unique to the current study is the focus on identifying how past trauma exposure directly affects current relationship functioning. This focus was maintained in the research methodology, participant interviews, team analysis and subsequent manuscript preparation. Even with participants who reported not directly or avoiding discussing the trauma history with their partner, the trauma had a place in the relationship and in their interpersonal interactions. Most often, these relational effects involved individual reactions to triggers or behaviors in the trauma survivors. It is possible that when the connection is not made between current individual and relationship patterns and the trauma history, that decreased communication, decreased understanding, decreased supportiveness, and increased relationship distress may be the result. Previous trauma appears to act as a "phantom" in the couple relationship, always present but not always seen or understood by either partner.

An important aspect of this study was the inclusion of both primary trauma survivors and secondary trauma survivors/partners, as well as participants with varied histories of trauma exposure. One of our assumptions in this research was that there may be common or similar issues across various traumatic experiences. Although there may be differences as well, understanding the similarities and common effects that occur in people who have been exposed to a variety of traumatic experiences is important, particularly because of the potential range of trauma survivors that may present to therapy (as can be seen from the range in experiences reported by the clinical participants in the current study). In addition, it is interesting to note that in all but three themes (increased understanding, support from partner, and relationship resource), there were equal or almost equal numbers of male and female participants reporting each theme. In these three themes where gender differences were noted, more men than women reported increased understanding, support, and relationship resources.

Just as there are common trauma symptoms (e.g., flashbacks, intrusive memories, avoidance behaviors), there also may be “common trauma factors” and mechanisms at work in the couple and family systems of trauma survivors, resulting in similar interpersonal patterns for trauma survivors. One possible common trauma factor may be impaired sexual functioning, particularly because the current results suggest that this symptom was reported across a variety of traumatic experiences, not only sexually-based traumas. In the current study, sexual intimacy problems appear to be a possible common trauma factor that need to be further explored. Sexual problems and reduced intimacy were reported even in relationships that were described by participants as positive or nondistressed.

Open communication about trauma plays a clear role in increased relationship functioning. This may be difficult for trauma survivors, because of individual symptoms of avoidance that may negatively affect their relationship (as was observed by the quotes in the decreased communication and reduced cohesion themes). Also, increased conflict may play a key role in the relationships of trauma survivors. As with avoidance patterns, increased hostility and conflict may be due to trauma survivors’ individual symptoms of increased arousal, which contribute to destructive interpersonal patterns. The other key themes identified in this study may be common factors, as well; however, whether these are variables unique to the current sample or actually common across trauma survivors needs to be further explored in trauma research.

Clinical Practice Implications

The key trauma variables described here may be particularly important to recognize clinically, because they can provide a guide for therapists in assessment and interventions with trauma survivors and their partners. For example, systemic therapies often are viewed as "adjunct" to other individual trauma treatments (e.g., cognitive behavioral therapy, exposure

therapy; Riggs, 2000); however, even with nonsexual traumas, issues related to sexual functioning, communication, cohesion, conflict and other issues need to be evaluated and understood within a trauma framework (Johnson, 2002). Ignoring or not addressing these symptoms in treatment may serve to continue and possibly exacerbate the individual and relationship distress trauma survivors may be experiencing.

It is also necessary for clinicians to help trauma survivors and their partners address the covert symptoms and patterns that are the result of previous trauma exposure and current trauma-related symptoms, as well as possible gender differences, particularly those found in the areas of increased understanding, support from partners, and relationship resources. It is important to help trauma survivors communicate with their partners about their past trauma experiences, which will help partners have a greater understanding about the current effects that trauma has on the primary trauma survivor, reduce any potentially triggering or retraumatizing behaviors, and provide a mutually supportive environment within the couple dyad that can be a resource in healing.

Research Implications

Although it is beyond the scope of the current study, it should be noted that both primary and secondary trauma symptoms in both partners and the systemic mechanisms by which trauma affects couple functioning were included in the larger study; however, the current results reported here are limited to identifying the key interpersonal patterns or symptoms that trauma survivors and their partners described. The results of the other research questions will be further explored elsewhere. We note this here simply for the reader to understand the breadth of the research questions that were addressed, as these are other critical areas that need further empirical support.

There are several limitations of the current study, which have implications for future research. As has been mentioned, the variability in trauma history may have been an influential factor in the results. Although it can be viewed as a strength of the current study, future research comparing systemic effects within similar trauma samples (e.g., childhood sexual abuse survivors, war veterans, or partners experiencing simultaneous trauma experiences) is necessary. Second, previous trauma exposure was used to identify potential participants for the study, as opposed to a PTSD diagnosis or elevated symptom levels. Although several experts in the traumatic stress field believe it is important to not limit the operational definition of trauma to only PTSD as the criterion for research participation (Brewin et al., 2005), future research is needed that compares participants with high PTSD or trauma-related symptoms and their partners to couples without a trauma history or those with low trauma symptoms to more clearly understand how relationship functioning differs between these couples. Clearly, the presence or absence of PTSD is a key variable that may affect relationship dynamics between partners.

Although the participants included an equal distribution of males and females, the participants were matched as couples. Individual interviews provided separate data and independent perspectives from both partners; however, because the participants were matched, some of the data may have overlapped, not providing a distinct and unique data set. Future research could include unmatched participants, or an analysis that compares data between the matched partners, to compare the consistency in themes and patterns described within the couple relationship.

Finally, the themes reported here could appear among couples without a trauma history. The themes and supportive quotes provide a description of trauma survivors and their partners explaining how past trauma affects their current dyadic relationship functioning. To our

knowledge, conducting interviews with both partners is a new contribution to the literature; however, a limitation of this methodology is the lack of a separate control group with which comparisons can be made. Future research should identify whether the current themes are unique to trauma couples by including a comparison group of couples without a history of trauma in either partner.

Conclusion

The impact of traumatic stress on survivors and their families should be of particular interest to clinicians and researchers. The similarity between the symptoms reported in the literature and the presenting problems many couples and families bring to therapy is striking. Treating trauma victims in isolation may overlook the consequences for couples and families, as well as the potential for interactional patterns to exacerbate symptoms of primary trauma. Understanding how trauma effects manifest within the couple and family system will improve clinicians' ability to intervene successfully with these client systems. In order to provide effective clinical treatment, it is critical to recognize the consequences of trauma on couple functioning to promote healing for the primary and secondary survivors of traumatic events and to prevent further individual and systemic damage from trauma.

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Table 1

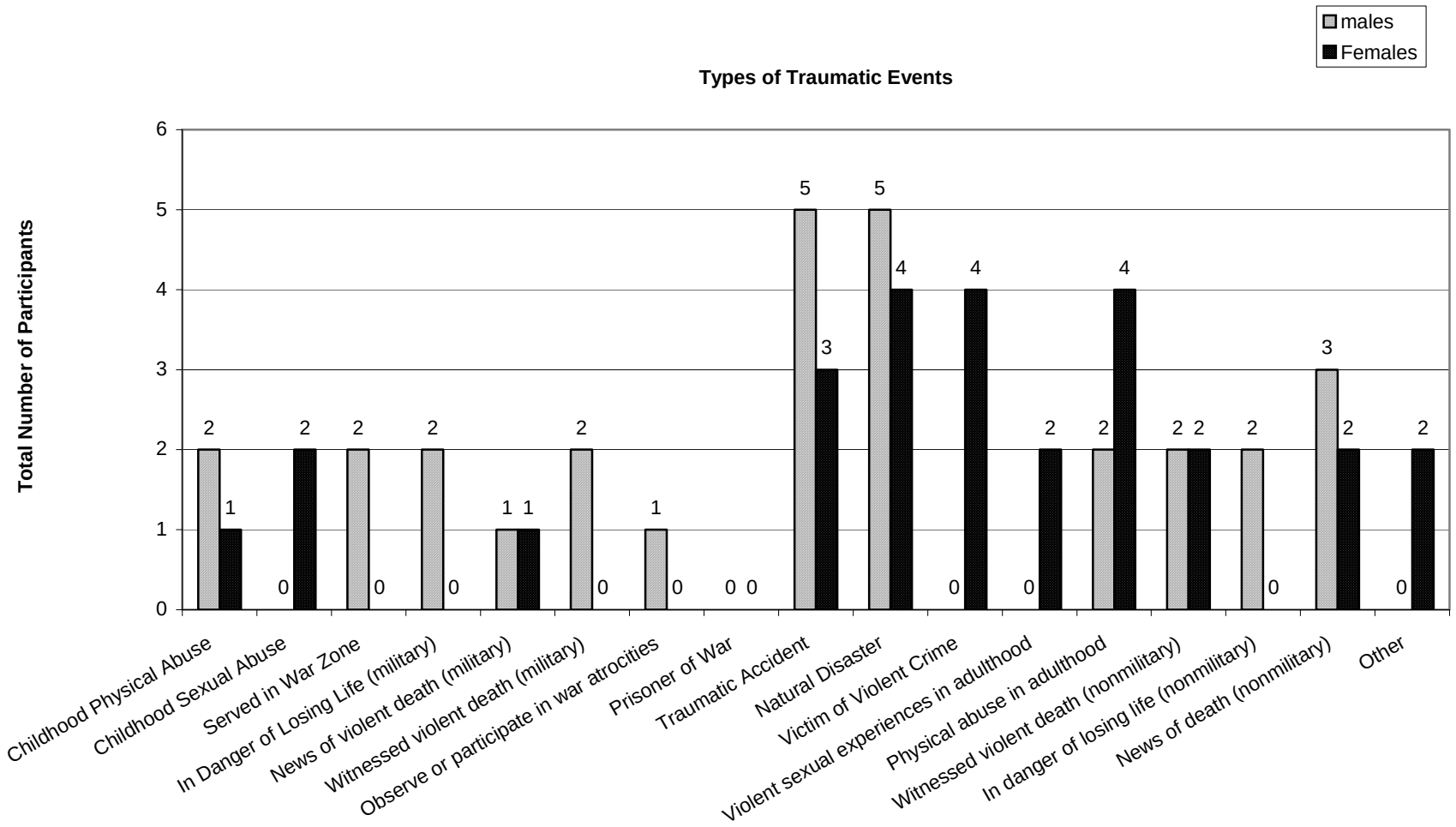
Summary of Study Variables

Variable	Literature/Clinical Support	Current Study
Increased conflict*	X	
Decreased conflict**		
Increased marital satisfaction**		
Decreased marital satisfaction*	X	
Increased cohesion/connection**		X
Decreased cohesion/connection*	X	X
Increased relationship distress*	X	
Decreased relationship distress**		
Increased sexual intimacy problems*	X	X
Decreased sexual intimacy problems**		
Increased separation/divorce*	X	
Decreased separation/divorce**		
Relationship resources*	X	X
Increased communication***		X
Decreased communication***		X
Increased understanding***		X
Decreased understanding***		X
Support from partner***		X

* = preliminary literature-supported themes; ** = preliminary themes included that were not identified in the literature; *** = additional themes identified during analysis

Figure Caption

Figure 1. Types of traumatic events experienced by participants.


males
Females
Types of Traumatic Events
Total Number of Participants
0
1
2
3
4
5
6
2 1
0 2
2 0
2 0
1 1
2 0
1 0
0 0
5 3
5 4
0 4
0 2
2 4
2 2
2 0
3 2
0 2
Childhood Physical Abuse
Childhood Sexual Abuse
Served in War Zone
In Danger of Losing Life (military)
News of violent death (military)
Witnessed violent death (military)
Observe or participate in war atrocities
Prisoner of War
Traumatic Accident
Natural Disaster
Victim of Violent Crime
Violent sexual experiences in adulthood
Physical abuse in adulthood
Witnessed violent death (nonmilitary)
In danger of losing life (nonmilitary)
News of death (nonmilitary)
Other