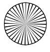

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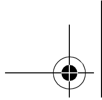
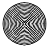
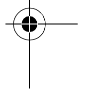
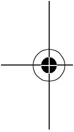
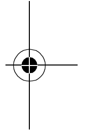
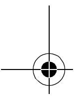
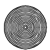
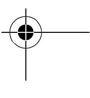
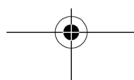
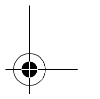
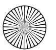
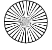
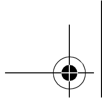
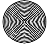




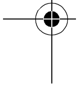
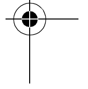
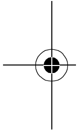
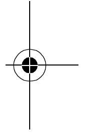
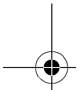
Part II

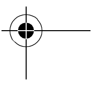
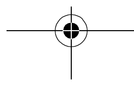
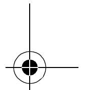
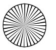
RESEARCH



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7

The Relationship Between Traumatic Stress and Marital Intimacy

VALERIE E. WHIFFEN AND LUIS E. OLIVER

In this chapter, we review the literature on the association between trauma and marital intimacy. Clinical wisdom holds that high quality relationships moderate the impact of trauma. Specifically, individuals with good relationships are thought to be comparatively resilient to trauma while those with poor relationships are at risk of experiencing such adverse consequences as emotional distress. For most adults, the relationship with one's spouse is the most significant of any social relationship. Thus, marital relationships should be a particularly potent resource for individuals coping with trauma. In the first section of this chapter, we assess the empirical evidence to support this hypothesis. In the second section, we introduce a parallel hypothesis: trauma has an impact on individuals' ability to develop and sustain good interpersonal relationships. We conclude with a section on possible mechanisms of action that may account for the apparent effects of trauma on marital relations. Throughout the chapter, we adopt a broad definition of traumatic stress. The *DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition)* definition of a traumatic event is generally regarded to be too narrow. We accept Carlson and Dalenberg's (2000)

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definition of a traumatic event as any event that is uncontrollable, extremely negative, and unpredictable or sudden.

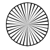
DO MARITAL RELATIONS MODERATE THE IMPACT OF TRAUMA?

Clinicians generally believe that the quality of intimate relationships moderates the impact of trauma (Carlson & Dalenberg, 2000). For instance, Judith Herman (1992), in her widely influential book on the treatment of trauma survivors, *Trauma and Recovery,* asserted that a critical component of therapy with this population is the therapist's "bearing witness," that is, hearing empathically and validating the story of the trauma. Other clinicians who work extensively with trauma survivors also emphasize the importance of intimate, validating relationships in the recovery process. If intimate relationships are so strongly implicated in recovery, then it follows logically that adverse emotional responses to trauma, such as posttraumatic stress disorder (PTSD) and depression, may be avoided altogether by the presence of warm, supportive relationships. Who better to provide this warmth and compassion than one's spouse?

Methodological Considerations

This intuitively sensible proposal is, from an empirical point of view, surprisingly difficult to demonstrate. Ideally, a researcher would need to have a measure of the quality of marital relations before the trauma because, as we will show in the second section, there is ample evidence that the experience of trauma can have a negative impact on marital relations. Therefore, if the researcher evaluates the marriage after the trauma has occurred, it is difficult to disentangle cause and effect. This research requirement is virtually impossible to meet because, in most instances, researchers cannot predict that an individual will experience a traumatic event. One possible exception is with novice emergency workers and policemen who are highly likely to experience critical incidents in the course of their work. Researchers who are interested in the buffering effects of marital relations may find this an ideal population on which to test their hypotheses.

The remaining requirements for demonstrating moderation are methodological and statistical. How a researcher demonstrates moderation differs depending on the nature of the group sampled. If all of the individuals in the sample experienced traumatic stress, then the researcher only needs to show that better quality relationships are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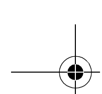
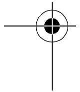
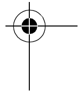
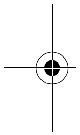
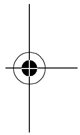
 

associated with better outcomes. However, if the sample included both individuals who experienced traumatic stress and those who did not, a different set of statistical analyses would be required. Baron and Kenny (1986) provided a relatively simple method for demonstrating moderation under these conditions. Conceptually, the researcher examines the association between the independent variable (traumatic stress: present versus absent) and the dependent variable (emotional distress) at different levels of the moderator (marital relations). Typically, high, medium, and low levels of the moderator are examined. Moderation is demonstrated if the association between traumatic stress and emotional distress differs as a function of high, medium, or low levels of marital relations. Thus, a researcher might predict that traumatic stress is associated with emotional distress more strongly if the marital relationship is of poor quality. Although this is the standard procedure for testing moderating effects that is widely used in the social support literature, few of the studies we reviewed formally tested for moderation.

The final requirement is methodological. Most of the research we reviewed was cross-sectional; that is, data were collected from participants at one point in time only. Thus, trauma, marital relations, and emotional distress were all measured at the same time. While cross-sectional studies are useful for pointing researchers in the direction of meaningful relationships, they are not conclusive because, conceptually, the IV (independent variable), DV (dependant variable), and moderator are confounded with one another. Ideally, the demonstration of moderation requires the collection of longitudinal data. Levels of traumatic stress and the moderator at Time 1 would be used to predict levels of emotional distress at Time 2. None of the studies we reviewed collected longitudinal data and tested for moderation. Therefore, we must conclude before we have even begun our review that, up to this point in time, no study can conclusively support the hypothesis that marital relations moderate the impact of traumatic stress.



Literature Review

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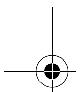
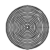
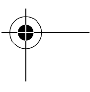
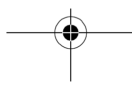
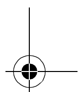
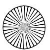
Clinicians often write about the importance of marital relations in coping with trauma. For instance, Dyregrov (2001) published a paper based on his years of experience counseling families coping with trauma and loss. He argued that the family's level of functioning at the time of the loss is an important determinant of individual outcomes. One common source of difficulty is "asynchrony" in the reactions of family members to the trauma that can create misunderstanding and conflict. In particular, he discussed the typical asynchrony that arises between husbands and



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wives who tend to cope with trauma in radically different ways. Women's emotional reactions tend to be intense and long lasting and they tend to want to talk extensively about the trauma. In contrast, men use distraction and avoidance to cope and they tend to prefer solitary coping strategies. Couples who default to asynchronous coping strategies may become maritally distressed, or the emotional distress of one or both partners may be exacerbated. Similarly, Johnson and Williams-Keeler (1998) asserted that the marital relationship has the potential to be a "recovery environment" for individuals coping with the emotional aftermath of trauma. Spouses are in an ideal position to help trauma survivors regulate their negative emotions, and the survivor's experience of the partner as caring, responsive, and accessible provides a corrective emotional experience that contradicts the learning that took place during the trauma. Furthermore, we speculate that the spouse's provision of this corrective experience is especially potent when the trauma has been interpersonal. These observations are consistent with our own clinical experiences, which suggest that the quality of marital relationships influence the trajectory of therapy.

Clinical observations are supported by the results of a handful of qualitative studies. Cagnetta and Cicognani (1999) used the grounded theory method to analyze their interviews with 20 individuals who sustained serious, permanent injuries after motor vehicle accidents (MVAs). They reported that the stage immediately after the injury was characterized, in part, by patients being anxious about the security of their relationships with family members and about the continuity of these individuals' love for them. The patients tended to seclude themselves at home and to derive a great deal of relief and comfort from their relationships with significant others. Similarly, Valentine and Feinauer (1993) interviewed 22 women who had been sexually abused as children. Most of them felt that support from others in both childhood and adulthood had been important in helping them to overcome their abuse. In particular, many respondents felt that the support they experienced in their marriages had been pivotal to their recovery. Even trauma that does not have direct negative consequences for the individual shows similar effects. McCarroll, Ursano, Wright, and Fullerton (1993) interviewed several hundred individuals who handled human remains after major disasters. The authors reported that many workers wanted to tell their spouses about their experiences but felt that they were unwilling to listen. Those who perceived their spouses as sensitive and caring were more likely to talk about their experiences (see section "Why Does Trauma Have a Negative Impact on Marital Relations," p. 000) which helped them to make the transition "back to the real world" after returning from the disaster site. The major limitation of these studies is the lack of comparison groups.

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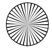
Without them, we do not know that marital relations are more important after trauma than they are normally.

The empirical support for this hypothesis is very limited. A recent meta-analysis concluded that there is support for the general notion that social support buffers the impact of trauma (Brewin, Andrews, & Valentine, 2000). The authors reviewed 11 studies that correlated lack of social support with PTSD symptoms among trauma survivors. Their analysis showed the average association between lack of support and PTSD symptoms to be .40, which was the largest effect size they obtained among the risk factors they evaluated. However, there was significant variation in the effect size from one sample to another. In particular, lack of social support was more strongly correlated with PTSD symptoms in military (.43) than civilian (.30) samples, which suggests that lack of social support is particularly detrimental to individuals who experience combat-related trauma.

We were able to locate only two empirical studies that assessed marital relations specifically and tested appropriately for moderating effects. Both studies were cross-sectional and both involved samples of women who were sexually victimized. The first was a study of 29 married or cohabiting women who were sexually assaulted in the month prior to data collection (Moss, Frank, & Anderson, 1990). Women's perceptions of the preassault quality of their relationships, as well as the amount of support provided by their partners since the assault, were determined from their responses to a structured interview. More than half of the women reported problematic relations since the assault, including temporary separations from their partners, physical and verbal abuse, and sexual problems. About a third of the women who reported that they did not have marital problems prior to the assault reported low levels of partner support postassault. Consistent with the moderating hypothesis, women with poor partner support reported higher levels of depression, anxiety and fear, and lower levels of self-esteem than did women with supportive partners. These effects were even more pronounced among women whom the researchers characterized as "let down"; these were the women without previous relationship problems who experienced poor partner support after the assault. The researchers speculated that an unexpected lack of support from the spouse is particularly demoralizing.

The second study examined marital relations in a community sample of 60 women, 22 of whom had a history of childhood sexual abuse (CSA). Whiffen, Judd, and Aube (1999) found that the relationship between CSA and depressive symptoms was moderated by marital intimacy and comfort with closeness. CSA survivors were better protected from depression when they perceived their relationships to be high in intimacy and when they preferred to be emotionally close to their



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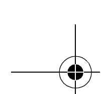
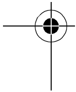
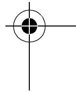
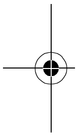
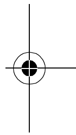


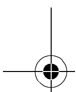
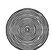
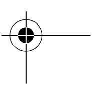
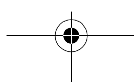
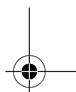
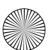
partners. While these effects also were present among women without a CSA history, they were stronger among the survivors. It is important to emphasize that, in contrast to the Moss et al. study (1990), these women were not coping with the immediate emotional aftermath of trauma. Thus, intimate and supportive marriages appear to buffer both the immediate and the long-term effects of sexual victimization.

To summarize, the clinical wisdom that marital relationships are an important determinant of recovery from trauma is supported by three qualitative studies and by two empirical studies that used appropriate methods to analyze data for moderation. However, our conclusion must be seriously qualified because both empirical studies sampled very small numbers of women who had been sexually victimized. Therefore, we do not know whether or not these results would generalize to survivors of other forms of traumatic stress. It may be the case that good quality relations with husbands are particularly critical when the trauma being coped with is sexual victimization. While there is evidence from a qualitative study that marital relations help buffer the impact of MVAs involving serious injuries, as well, this hypothesis, ideally, needs to be tested empirically with a variety of trauma populations. We also do not know if these results would generalize to male trauma survivors. Given that women and men have been found to cope differently with traumatic events, gender differences may exist in the moderating impact of intimate relationships. Thus, more research is needed to determine whether the above findings also are applicable to traumatized men. Finally, both studies were cross-sectional. Ideally, longitudinal research is needed to demonstrate that marital relations facilitate adaptation to the trauma or recovery from acute symptoms of emotional distress over time.

DOES TRAUMA HAVE A NEGATIVE IMPACT ON MARITAL RELATIONS?

In the following subsections, we review the evidence that trauma has an impact on marital relations. We review the research separately for traumas that occurred in childhood and adulthood, and for different types of trauma. This approach permits us to evaluate the possibilities that different types of trauma have different impacts on the relationship, and that trauma that occurred before the development of the relationship has a different impact than trauma that occurs during the relationship.

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Childhood Trauma

Childhood sexual abuse. A history of sexual abuse during childhood has a clear, deleterious impact on adult interpersonal functioning. In a review of the interpersonal consequences of CSA for women, Rumstein-McKean and Hunsley (2001) concluded that CSA survivors experience greater interpersonal difficulties than do nonabused women. They feel more detached and isolated, and report difficulties becoming emotionally engaged with others. Specifically, CSA adversely affects the quality of marital relationships. Most research finds that CSA survivors, compared to nonabused controls, are more likely to avoid developing close adult relationships and to have never married. Although the data are inconsistent across studies, CSA survivors also tend to report lower levels of marital satisfaction and higher levels of marital disruption and divorce than do nonabused women.

Further exploration of this general finding suggests that women with a CSA history have specific difficulties forming secure adult attachment relationships with romantic partners. The studies reviewed by Rumstein-McKean & Hunsley (2001) generally found that CSA survivors report less security in their adult attachment relationships than do women who were not sexually abused. A study by Roche, Runtz, and Hunter (1999) found that, as a whole, women who had been sexually abused in childhood were less secure and more fearful–avoidant than were women who had not experienced CSA. Individuals who are fearful–avoidant in adult attachment relationships want to be close to romantic partners but they are afraid of being rejected by them, a dilemma that they resolve by maintaining emotional distance in their close relationships (Bartholomew & Horowitz, 1992). Within the abused group, women who had experienced intrafamilial sexual abuse were even less secure, more fearful, and less dismissing than those who had experienced extrafamilial abuse. Thus, incest appears to be particularly strongly associated with insecure adult attachment. The finding that incest survivors are both more fearful and less dismissing suggests that they are ambivalent about romantic relationships. Individuals who are dismissing discount the importance of close relationships. Thus, the combination of higher levels of fearfulness with lower levels of dismissing attachment suggests that romantic relationships are simultaneously important and the source of painful fears.

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One of the most frequently researched and consistent findings in this literature is that sexual abuse in childhood is associated with sexual problems later in life (cf., review by Beitchman et al., 1992). Although the strength of this association varies widely across studies, CSA survivors in both community and clinical samples experience higher levels of sexual dissatisfaction and dysfunction than do nonabused women (Rumstein-McKean & Hunsley, 2001). Survivors report higher

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levels of bodily shame, sexual shame, fears, anxieties and guilt about sexuality, confusion about sexual orientation, difficulties with sexual arousal and desire, and coital pain (Andrews, 1995; Barnes, 1995; Briere & Runtz, 1988; Gold, Milan, Mayall, & Johnson, 1994). Some studies found survivors to show higher levels of sexual distrust and conflicts with men (Barnes, 1995), as well as multiple sexual partners and brief sexual relationships (Wyatt, Guthrie, & Notgrass, 1992). A recurrent finding is that CSA survivors are at risk for being sexually revictimized as adults (Beitchman et al., 1992; Briere & Runtz, 1988; Gold et al., 1994; Wyatt et al., 1992). The highest rates of sexual disturbance are found in cases involving penetration or father–daughter incest, which suggests that abuse severity contributes to greater problems in sexual relationships later in life (Beitchman et al., 1992).

CSA not only affects the survivor's ability to form and maintain positive, intimate relationships, but may also have an adverse impact on partners. Support for this hypothesis stems primarily from clinical observations. For instance, Oz (2001) argued that husbands of women being treated for CSA may experience feelings of rejection, loneliness, guilt, and inadequacy, and may perceive their wives as making unrelenting demands on them for support. She also speculated that CSA survivors often choose men who have trauma histories themselves and who may have their own difficulties with intimacy and sexuality. There is limited empirical evidence from clinical samples that romantic partners feel frustrated, isolated, and dissatisfied, and that they experience a variety of communication problems in their relationships (Rumstein-McKean & Hunsley, 2001).

It is important to emphasize that these studies did not include clinical comparison groups. Therefore, we do not know how much these results are due to an individual being treated specifically for CSA-related problems, rather than for other emotional problems that may be unrelated to CSA. Nelson and Wampler (2000) sampled couples that were requesting treatment at a marital and family therapy clinic, and classified couples into abuse groups based on the clients' self-reports about childhood physical and sexual abuse. They found that the partners of individuals with an abuse history who had no history themselves reported more emotional distress than did no-abuse couples, although they did not report less marital satisfaction or rate their relationships as less cohesive. The generalizability of these results is limited by the fact that all of the couples were experiencing marital problems; a clinical sample of clients being treated individually for CSA versus nonabuse emotional problems would better reflect the array of marital outcomes that are associated with CSA. However, the results do suggest that partners of abused individuals experience more emotional distress, which partly confirms clinical observations.

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Finally, there is some evidence that the association between CSA and emotional distress is mediated by the negative impact of CSA on intimate relationships. That is, the deleterious impact of CSA on emotional functioning is due to the disruptive effects of CSA on the quality of survivors' intimate adult relationships. Roche et al. (1999) found that insecure attachment accounted statistically for the association between CSA and emotional distress in a sample of female undergraduates. Similarly, in a community sample of women and men, Whiffen, Thompson, and Aube (2000) found that interpersonal problems partially mediated the association between CSA and depressive symptoms for both sexes. Thus, there is evidence that CSA not only contributes to relationship difficulties, but that these difficulties, in turn, contribute to the emotional distress consistently associated with CSA.

To summarize, the impact of CSA on marital relations is negative. Women who are CSA survivors are more likely than nonabused women to avoid establishing intimate relationships, possibly because they tend to feel insecurely attached to romantic partners and to fear that their partners will reject them if they get too close. Even when they are able to establish intimate relationships, they experience attachment insecurity (Whiffen et al., 1999) and a variety of sexual problems ranging from guilt and shame about their sexuality to low sexual desire and pain with intercourse. These results are particularly pronounced among incest survivors who appear to differ along at least two dimensions from survivors of extrafamilial abuse. First and most obviously, incest involves interpersonal victimization by a family member. It makes sense that this fact alone may be sufficient to account for incest survivors' pervasive insecurity in subsequent intimate relationships. Second, incest tends to extend over a longer period of time and the abuse is more likely to involve intercourse (Beitchman et al., 1992). Abuse severity also may be implicated in the finding that incest survivors generally experience more difficulties in their marital relations than do survivors of extrafamilial abuse.

In closing, it is important to emphasize that the vast majority of this research was done with female CSA survivors. Therefore, we know nothing about the marital relations of male CSA survivors. One study that compared male and female survivors found that the men's interpersonal relationships were not characterized by the mistrust and disengagement that is pervasive among female survivors (Whiffen et al., 2000). In contrast, male survivors reported difficulties with feeling overly responsible and unassertive in their relationships. This study underscores the need for research with male CSA survivors, and cautions the clinician against generalizing from the research on women to their male clients.

Physical abuse and witnessing interparental violence. Very little research has examined the impact of childhood physical abuse on intimate

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relationships in adulthood. There is evidence that children who have been physically abused or neglected are more likely to be insecurely attached during childhood than those who have not (Carlson, Cicchetti, Barnett, & Braunwald, 1989). Severely maltreated children develop a disorganized attachment style that has components of both approach and avoidance (cf., review by Cassidy & Mohr, 2001). While there is speculation that physically abused children may be more vulnerable to attachment difficulties in their romantic relationships later in life (Downey, Khouri, & Feldman, 1996), this hypothesis has not been tested directly.

There is evidence that childhood physical abuse increases the risk of being in a physically abusive marital relationship—both as a perpetrator and as a victim (cf., meta-analysis by Busch, Lundeberg, & Carlton, 2000). Witnessing interparental violence also is a risk factor for being in a physically abusive adult relationship (Busch et al., 2000). While it may be plausible to infer that physically abusive relationships are less intimate, we did not find any research that tested this hypothesis. The handful of studies that directly examined the effects of childhood physical abuse on adult intimacy produced conflicting results. Ducharme, Koverola, and Battle (1997) reported that male and female university students who were physically abused as children reported lower levels of intimacy in their relationships than did nonabused controls. However, this finding was not replicated in a study of female undergraduates (Davis, Petretic-Jackson, & Ting, 2001). Similarly, Belt and Abidin (1996) did not find an association between physical abuse and perceived marital support in a community sample of couples, once other childhood variables such as parental care were taken into account.

Multiple forms of childhood abuse. The research on childhood abuse is complicated by the fact that many children are multiply victimized. For instance, in one study of female undergraduate students, 18% of the sample reported a history of sexual abuse, 11% reported physical abuse, and 7% reported both forms of abuse (Davis et al., 2001). The existing evidence suggests that adults with histories of multiple forms of abuse are particularly at risk for interpersonal problems. For instance, Allen et al. (2001) compared a community sample of women with a clinical sample of female inpatients receiving treatment for trauma. The women in the latter group typically had a severe trauma history which included multiple forms of childhood trauma (e.g., sexual, physical and emotional abuse, and neglect). While the community sample was predominantly secure in their attachment classification on a number of measures, the trauma sample was chiefly fearful–avoidant and preoccupied. These styles will give rise to competing demands in relationships, with the fearful style creating a desire to avoid close relationships while the preoccupied style creates a desire to pursue and

cling in close relationships. Similarly, Davis et al. (2001) found that multiply abused female undergraduate students reported a greater fear of intimacy than did individuals reporting either a single form of childhood abuse or no abuse.

Trauma in Adulthood

Sexual assault. In a review of the empirical literature on the psychological impact of sexual assault on women, Hanson (1990) reported that up to a quarter of women show ongoing interpersonal difficulties in the mild to moderate range for as long as several years after the assault. However, there appears to be surprisingly little controlled research specifically on the effects of sexual assault on marital intimacy. Some studies examined the impact of sexual assault on one form of intimacy—sexuality. Most women experience sexual disturbances in the weeks and months following a sexual assault. These problems can include reduced sexual desire and arousal, flashbacks during sex, physical discomfort, and phobic responses to specific sex acts associated with the assault (cf., reviews by Barnes, 1995; Hanson, 1990). Not surprisingly, sexual problems are more common among sexual assault victims than among victims of nonsexual crimes such as armed robbery (Hanson, 1990).

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Sexual difficulties may be particularly problematic when the assaulted woman is involved in an ongoing intimate relationship. Holmstrom and Burgess (1979) interviewed 16 married or cohabiting women and 11 of their boyfriends or husbands within three months of the assault. Notably, the majority of couples did not discuss the assault openly; this finding is significant in light of empirical results indicating that the romantic partner's support is a crucial moderator of women's emotional distress after sexual assault (Moss et al., 1990). All of the couples interviewed experienced some problems when they tried to resume sexual relations. Some men believed that their partners had been sexually unfaithful or they felt physically repulsed by knowing that the women "had sex" with another man. Most of the men wanted to have sex soon after the rape as a test of the impact that the assault would have on their sexual relationships. However, it was common for the couples to delay intercourse for as long as several weeks after the assault.

Talking about the assault and expressing feelings is seen by victims to be very helpful immediately after the assault, and the majority of women list their boyfriends or husbands among the people that they have talked to (Frazier & Burnett, 1994). However, romantic partners are perceived to be the least supportive members of victims' social networks. The fact that their wife or girlfriend was assaulted sexually may be difficult

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emotionally for boyfriends and husbands in ways that interfere with their relationships. Earlier in this chapter, we described the results of a study by Moss et al. (1990) who assessed a small sample of married or cohabiting women shortly after they were sexually assaulted. More than half of the women reported problematic marital relations since the assault, including temporary separations and physical and verbal abuse by their partners. About a third of the women who reported that they did not have marital problems prior to the assault reported low levels of partner support postassault which suggests that it may be difficult for some men to cope with the immediate aftermath of their wives' and girlfriends' sexual assaults even in the context of a good relationship.

There also is evidence that relationship difficulties can persist long after the assault. Miller, Williams, and Bernstein (1982) assessed a sample of 43 couples in which the female partner had a history of sexual assault. To attract couples to the research, they offered free marital therapy and, as a result, we consider this an uncontrolled clinical study even though less than half of the couples accepted treatment. The results are interesting because they indicate that these couples exhibited many difficulties in empathy, commitment, emotional support, and communication, in addition to the sexual problems observed by other researchers. The researchers observed that both the assaulted women and their partners appeared to lack empathy for one another due to their emotional reactions to the assault. While women experienced intense fear and concerns about safety, their partners often experienced rage and they desired retribution; both emotional reactions appeared to attenuate the partners' sensitivity to one another. These researchers speculated that communication problems played a major role in the sexual problems of these couples, in that neither partner was able to communicate clearly about how to resume their sexual relationship. Clinically, the researchers noted that the couples were very difficult to treat—in part because of both partners' unwillingness to discuss the assault and in part because of the many symptoms of emotional distress experienced by the women.

To summarize, sexual assault has a clear impact on women's sexual functioning and can disrupt established intimate relationships. Men's anger toward the perpetrator may overwhelm their empathy and compassion for their partners, while women's pervasive and persistent fears and difficulties with sex also are likely to have a negative impact. Both clinical observation and empirical research suggest that the couple's ability to discuss the assault and to provide support to one another may be an important determinant of the extent to which the assault has a long-lasting impact on the relationship.

Exposure to combat. An early empirical study compared the marital relations of Vietnam veterans who experienced combat during their

tours of duty to those who did not (Penk et al., 1981). All of the veterans were voluntarily receiving inpatient treatment for substance abuse. The combat veterans were best discriminated from the noncombat veterans by their reports of greater difficulty getting along with their spouses or mates, marital problems, and difficulties trusting others. Married combat veterans also reported higher levels of conflict in their families of procreation.

Researchers soon began to focus their efforts on veterans who developed symptoms of PTSD because they reasoned that PTSD is the mechanism that creates the marital problems. For instance, Carroll, Rueger, Foy, and Donahoe (1985) identified 21 vets with PTSD and 18 without PTSD among former combat veterans who were voluntarily receiving psychiatric services. When the researchers compared the two groups of veterans, they found no differences in the amount of affectionate behavior the men reported in their marriages. However, the vets with PTSD were less self-disclosing and emotionally expressive with their partners, they were more hostile and physically aggressive, and they were less satisfied with their marriages, describing more conflicted and less engaged marriages, in particular. Levels of hostility statistically discriminated the PTSD and non-PTSD veterans. High levels of hostility are likely to have a dramatic impact on marital relations, promoting both conflict and emotional disengagement. A study by Roberts and his colleagues (Roberts et al., 1982) compared PTSD veterans with both non-PTSD veterans and a noncombat clinical control group. The authors reported that the PTSD veterans reported more difficulties with intimacy and sociability than either of the control groups, which indicates that it is PTSD rather than combat which is associated with intimacy problems. Similarly, Caselli and Motta (1996) showed that combat exposure was a redundant predictor of marital dissatisfaction when PTSD symptoms were taken into account.

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Such findings are not confined to veterans of the Vietnam War. One study assessed Israeli soldiers who experienced acute stress reactions during combat in the 1982 war with Lebanon (Solomon et al., 1992). A large proportion of these men went on to develop chronic PTSD. First, the researchers confirmed the results found with Vietnam veterans: Six years after the war, the wives of veterans who experienced stress reactions were less happily married than the wives of men who did not experience stress reactions. Next, the researchers tried to determine whether or not differences existed in these men's marital relations prior to the war. The researchers asked the wives a series of questions about their marriages at four points in time: at marriage, 1 year before the war, 1 year after the war, and in the previous year which was approximately 6 years after the end of the war. The women's responses were coded by two independent judges who rated the marriage at each time point along

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such dimensions as intimacy, conflict, and emotional expressiveness. The researchers compared the scores of 49 women whose husbands experienced stress reactions to 31 women whose husbands did not. The wives whose husbands experienced stress reactions reported marked reductions in marital satisfaction and cohesion immediately after the war. However, they reported many more significant differences before the war. They viewed their marriages as less intimate, less emotionally expressive, less cohesive, less satisfactory, more conflicted, and less integrated even before the war. These results must be interpreted with caution because the retrospective method may introduce a source of bias into the results: Having marital difficulties currently may color these women's perceptions of their entire married life. However, this research raises the possibility that preexisting interpersonal and emotional difficulties may contribute to both marital difficulties and the development of PTSD.

Gimbel and Booth (1994) tested this hypothesis in a large, representative sample of Vietnam veterans. They were interested in understanding why combat exposure in the 20th century is associated with increased rates of divorce. They compared the empirical support for two alternatives: First, the same factors that lead to adverse reactions to combat also interfere with marital stability, and second, marital stability is negatively affected by combat exposure. They assessed early emotional problems by asking veterans about anxiety, depression, and phobias prior to service, and early antisocial behavior by asking about misbehaving, fighting, truancy, and being suspended or expelled from school. They found that veterans who reported childhood emotional problems also were more likely to report combat-related PTSD symptoms. However, these symptoms did not subsequently predict marital breakdown. Similarly, veterans who reported childhood school problems were more likely to engage in antisocial behavior after the war, such as physical violence and crime, which did predict marital breakdown. The researchers speculated that, in a combat situation, young men are rewarded for antisocial behavior, which encourages them to extend these behaviors into civilian life. While PTSD symptoms may have an adverse impact on the quality of marital relations, antisocial behavior may be intolerable and result in marital breakdown.

Few of the veterans of Vietnam were married prior to the war. Therefore, we can reasonably conclude that combat exposure has a variety of adverse consequences for subsequent marital relations. Combat veterans in general report more difficulties trusting others and greater conflict in their marriages. These effects are both more pervasive and more pronounced when the veteran develops PTSD. Veterans with PTSD report a range of marital difficulties, particularly with intimacy and the control of anger. In addition, combat exposure may promote the

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development of antisocial behaviors, such as the use of physical violence to resolve interpersonal problems, which ultimately lead to marital breakdown.

Death of a child. The death of a child is generally considered to be among the most stressful events an adult can experience, and parental grief following such a death has been found to be one of the most severe and enduring forms of bereavement. We include it in this chapter because the death of a child is uncontrollable, extremely negative, and unpredictable in the sense that parents expect to outlive their children. In a review of the literature on the impact of the death of a child on the marital relationship, Oliver (1999) found that up to a third of couples go through a significant disruption in marital functioning after a child's death. These couples experience increased marital dissatisfaction, friction and conflict, disengagement and withdrawal, and breakdowns in communication. Compared to nonbereaved couples, parents who have lost a child are also more likely to seriously consider separation or divorce. One of the most consistent findings is that the death of a child can have a pronounced negative impact on couples' sexual intimacy. Numerous studies have concluded that sexual intimacy and satisfaction decrease significantly following the child's death, even when other forms of intimacy do not.

However, many couples do not experience enduring disruptions to their relationships, and some relationships are actually strengthened as the couple grieves the loss together. Qualitative studies suggest that the quality of the marital relationship prior to the death may be an important factor in determining outcome because the death can amplify preexisting marital difficulties (Oliver, 1999). Thus, this literature provides evidence for both the mediating and moderating effects of marital relations. This trauma also is interesting because it is a shared trauma. Most traumatic stress occurs only to one partner in the relationship, which leaves the other person in the position of providing emotional support. The death of a child is traumatic for both partners and, as such, may present special challenges to the couple.

SUMMARY

There is a good deal of evidence that traumatic stress has an adverse impact on individuals' ability to develop and maintain positive marital relationships. Much of the research has focused on individuals with a history of childhood traumatic stress, and the evidence is clear: With few exceptions, the research shows that childhood sexual abuse and experiencing multiple forms of abuse have a negative impact on the levels of intimacy and attachment security in subsequent adult

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relationships. Because the research has not been done yet, the jury is still out on the impact on the capacity for adult intimacy of childhood physical abuse and witnessing violence between one's parents.

In terms of trauma that occurs in adulthood, similar difficulties with intimacy appear to result from combat exposure, particularly when the veteran goes on to develop PTSD. Veterans with PTSD report more difficulties with intimacy and the control of anger in their marriages than do veterans without PTSD. Anger likely has an impact on intimacy because anger creates emotional distance. The death of a child also is a traumatic stress that can create emotional distance between couples. Sexual assault, specifically, appears to have an impact on the capacity for sexual intimacy—a finding that makes good sense intuitively. Individuals who are not involved in romantic relationships at the time of the sexual assault may cope with their sexual disinterest or aversion by avoiding the development of new sexual relationships. However, problems with sexual intimacy are likely to be especially detrimental to the relationships of married and cohabiting couples. Sexual intimacy is an important part of marital relations and its absence may create more general intimacy deficits in these couples.

However, there is a need for studies that examine gender differences in samples where the same trauma was experienced. Studies of female trauma survivors typically involve the trauma of sexual assault, while males have been studied almost exclusively as survivors of combat exposure. Although we know that both traumas have an impact on marital intimacy, we do not know that the impact is identical for men and women.

WHY DOES TRAUMA HAVE A NEGATIVE IMPACT ON MARITAL RELATIONS?

The specific causal link between trauma and marital difficulties remains undetermined. In this last section, we discuss two plausible mechanisms.

PTSD as a confounding variable. The first possibility is that group differences between individuals with and without trauma histories may be due largely to those individuals who develop PTSD as a consequence of their exposure to traumatic stress. This would mean that not all trauma survivors develop marital problems but that these problems predominate among individuals with PTSD. Both central aspects of the PTSD syndrome—avoidance and hyperarousal—may have a negative impact on marital intimacy (Mills & Turnbull, 2001). The avoidance features of PTSD that could influence intimacy include diminished interest in activities, feelings of detachment from others, and restricted affect, while hyperarousal could have an impact through preoccupation

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with the trauma, irritability and anger. Both avoidance and immersion in the trauma may leave spouses and romantic partners feeling alone and abandoned in their relationships (Johnson & Williams-Keeler, 1998), while an inability to regulate negative emotions may create or exacerbate marital conflict (Cassidy & Mohr, 2001; Johnson & Williams-Keeler, 1998).

This hypothesis is well-supported by the studies of combat veterans which show that veterans with PTSD show more pervasive and more profound disturbances in their marital relations than do veterans without PTSD. When combat exposure and PTSD symptoms are considered jointly in multiple regression equations, combat exposure is a redundant variable (Caselli & Motta, 1995). Recent research on other traumas also is consistent with this hypothesis. For instance, Regehr and Marziali (1999) assessed a sample of women sexually assaulted an average of 4 to 1/2 years prior to the study. The researchers used measures of interpersonal difficulties to predict levels of PTSD and depressive symptoms. When all of the interpersonal measures were entered into a multiple regression equation, higher levels of PTSD symptoms were associated with mistrusting others, having difficulty expressing feelings, and feeling interpersonally exploited. In contrast, depressive symptoms were associated with egocentrism and feeling overly responsible in relationships. The interpersonal problems associated with PTSD symptoms are commonly reported to be among the sequelae of traumatic stress, while those associated with depressive symptoms are not.

These studies support our hypothesis that the negative impact of trauma on marital intimacy may be attributable to the subset of trauma survivors who develop PTSD. This hypothesis is well developed in Vietnam veteran literature where most research now focuses on veterans with PTSD rather than those with combat exposure. The possibility of a confound with PTSD needs to be considered in other trauma populations as well. For instance, it is possible that not all survivors of CSA inevitably encounter marital problems (see Whiffen et al., 1999, for an example) and that the general finding can be accounted for by those women who develop chronic PTSD. This hypothesis also raises an interesting conceptual problem. Does trauma independently have an impact on both marital intimacy and the risk for PTSD? Or does trauma increase the risk of PTSD which subsequently creates marital problems? The answer to this question has implications both for future research and for treatment.

The impact of childhood trauma on attachment security. Carlson and Dalenberg (2000) argued that peoples' response to traumatic stress is greatly influenced by their developmental level at the time of the trauma. Generally, children are thought to have more severe responses to traumatic stress than adults, and childhood trauma is thought to have a more pervasive impact on functioning. We believe that attachment theory provides a framework for understanding the differential impacts

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of childhood and adult trauma. Our review indicates that childhood trauma, especially sexual abuse, is associated with stable and organized disruptions to interpersonal functioning that are evident in adult attachment insecurity. Unfortunately, researchers interested in adult trauma have not assessed attachment security in their participants, so we do not know whether or not adult trauma also has a negative impact on the ability to form secure attachments. However, attachment is a pivotal developmental task during childhood. Developmental psychologists believe that a child's ability to form secure attachments sets the stage for later emotional and interpersonal functioning (Cassidy & Mohr, 2001). If a child's ability to form secure attachments is compromised by trauma, this difficulty is likely to persist into adulthood. While traumatic stress during adulthood could result in an inability to form secure attachments, theoretically it is much less likely to do so. Thus, childhood trauma may be more likely to impinge upon an individual's ability to form secure adult attachments than adult trauma, and attachment insecurity may be one way of understanding why childhood trauma survivors have difficulty in marital relationships.

From an attachment perspective, trauma both intensifies attachment needs for comfort and reassurance while shattering trust in the benevolence of others (Cassidy & Mohr, 2001; Johnson & Williams-Keeler, 1998). Paradoxically, traumatized individuals may seek out attachment figures while simultaneously fleeing them emotionally. We propose that attachment insecurity among survivors of childhood trauma is likely to take the form of ambivalence or disorganization where competing approach and avoidance behaviors are observed. For example, a disorganized individual may pursue her partner for closeness but reject him when he responds to her. These competing behaviors are extremely difficult for potential partners to understand and tolerate, and may be a significant factor in the perpetuation of attachment insecurities and dissatisfying relationships.

CONCLUSION

There is evidence to support the presence of both moderating and mediating links between traumatic stress and marital intimacy. Women who were sexually victimized are less distressed if they experience their romantic and marital relationships as close, intimate, and emotionally supportive, and these protective effects are apparent both in the immediate aftermath of the trauma and many years later. However, there also is good evidence that trauma, in the forms of childhood sexual abuse, sexual assault, the death of a child, and combat exposure, has a negative impact on sexual and emotional intimacy in marital

relationships. Part of this impact may be attributable to PTSD symptoms of both avoidance and hyperarousal. In addition, traumatic stress during childhood may have a lasting impact on the ability to form secure adult attachment relationships. Clinicians argue that in order to recover from trauma, individuals need to reestablish trust. This can be accomplished through corrective adult relationships, but impaired intimacy in these same relationships will interfere with the healing process and maintain and perpetuate trauma symptoms. Thus, the solution—marital intimacy—may become part of the problem.

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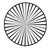

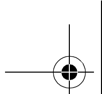

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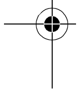
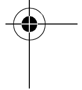

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