

Broken hearts and mending bodies: the impact of trauma on intimacy

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ABSTRACT *Links have already been forged between sexualized trauma and difficulties with intimacy in clinical practice. This article seeks to examine those links more closely by exploring both the psychological and biological impact of traumatic life events on intrapsychic and interpersonal intimacy. In addition, the progression of grief within couple relationships, the impact of brain injury and the adverse effects that residual disabilities can cause with intimacy are examined in detail. Two case samples highlight the real difficulties experienced in sharing emotions and the need for prior acknowledgement of the impact of trauma before attempts to reassure are made. Finally, this article aspires to increase the insight of couple therapists who tackle the problems created by the impact of trauma by introducing them to new developments in the assessment and treatment of traumatic stress injuries.*

KEYWORDS: *trauma; intimacy; relationship; therapy; neurobiology.*

Introduction

Many people find that their ability to relate to others has an altered quality following personal exposure to trauma. The scientific literature strongly supports this observation. It is quite clear that the development of blunted emotionality and also cognitive functioning is such a regular feature of post-traumatic stress reactions that these phenomena are regarded as primary criteria for making the diagnosis of Post-Traumatic Stress Disorder (PTSD). It also follows that the ability to relate to a trauma survivor will become different. The 'wires' of normal human interaction, with all the complexities involved in sharing impressions of the world, can become well and truly 'crossed'. The impact is not focused exclusively on intimate relationships, although that is where the changes are usually felt most keenly, and the net spreads widely to influence interactions with partners, friends, family, co-workers, and everybody else with whom the trauma survivor comes into contact (International Society of Traumatic Stress Studies [ISTSS] Fact Sheet 2003). This 'ripple effect' leaves a flotsam of pieces of damaged relationships in its wake leading to dyadic splitting, separation, and unhappy isolation and it is important to see that this applies

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to both sides of the relationships that are compromised by the impact of the trauma. The management of *psychological* trauma has taken its natural lead from its forebear, *physical* trauma, and has tended to focus on the most noticeable and most urgent needs in the aftermath of traumatic situations, the needs of the trauma-exposed individual. Perhaps this has had to be the case in what we must remember is a relatively new field of serious study of the human psyche, but this article seeks to encourage further exploration beyond the boundaries of the individual to look at the impact of trauma on partners and other family members who have experienced the trauma directly or indirectly (D'Ardenne & Morrod, 2003).

Literature review

It is well established that a history of sexual trauma, including childhood sexual abuse, can lead to the development of significant sexual difficulties in adult life (De Silva, 2001). An extensive literature has clearly demonstrated links between sexual abuse in childhood and serious, negative consequences for a person's later sexual functioning and intimacy (Courtois, 1979; Jehu, 1988; Finkelhor, 1990). It is also well recognized that following rape and sexual torture, individuals suffer sexual dysfunction (Feldman-Summers *et al.*, 1979; Becker *et al.*, 1986). Females suffer avoidance of intimacy and problems with trust and openness in subsequent relationships. This results in loss of interest in sex, sexual phobias, vaginismus, difficulties with sexual arousal and anorgasmia. Male victims of rape or other sexual assault are reported to develop subsequent sexual dysfunction, common problems being loss of interest in sexual engagement, sexual phobias, physical pain during intercourse and erectile dysfunction (Mezey & King, 1989; Vearnal & Campbell, 2001).

Following female genital mutilation, immigrant women in cultures with different or 'more liberal' attitudes towards sexuality may face challenges or altered expectations as a result of the new sexual culture, media or new peers. The circumcised woman aware of differences in the appearance of her genitalia may feel deeply embarrassed during clinical examination or coitus. Furthermore, such women aware of a lack of sexual enjoyment, may respond with feelings of anger, guilt, shame or inadequacy (Whitehorn *et al.*, 2002).

It is very important not to think that future sexual dysfunctionality is the exclusive legacy of sexual trauma, because the literature makes it clear that this is definitely not the case. Problems with intimacy are caused or exacerbated by traumatic life events of a non-sexual nature. Zahava Solomon's work with combat-exposed military personnel in Israel (Solomon, 1993) revealed that a significant proportion of combat veterans subsequently developed problems with intimacy and that the reported changes were of the same nature as those described after exposure to sexual trauma. Solomon emphasized the special difficulties that the combat veterans developed with general issues in intimacy such as getting close to spouses or partners. Although the evidence was in favour of normal functioning prior to trauma exposure, many subsequently became secretive and emotionally withdrawn from their intimates following exposure to combat.

Many studies of Vietnam war veterans (Carroll *et al.*, 1985; Garte, 1986; Wilson, 1990) arrived at similar conclusions. Wilson (1990) compared war veterans with a group that had not been exposed to trauma and demonstrated that veterans had more problems with interpersonal relationships. Another study of a similar group (Kulka *et al.*, 1990) yielded similar results, specifically illustrating that war veterans who had developed an impaired ability to be intimate in their relationships post-trauma experienced more divorces and frank marital or relationship problems compared with those who made a good post-trauma adjustment. An extensive literature review (Busuttill & Busuttill, 2001) of the psychological effects on families subjected to enforced and prolonged separations brought about by life-threatening situations clearly demonstrated that both trauma survivors and their partners experienced difficulties with the reunification and reintegration process.

De Silva (1999) studied a cohort of 24 accident victims who had subsequently developed PTSD and found that 15 (10 females and 5 males) had significant sexual problems following the accident. Women presented with reduced sexual desire, inability to relax during sex, and anorgasmia. Men had reduced sexual desire and erectile dysfunctions. Some studies have looked at other kinds of trauma. Berry (1999) studied the psychosexual effects on parents who lose a young child. Lunde & Ortmann (1990) focused on the sexual consequences of torture. Wilson and Kurtz (2000) studied the impact of PTSD on couple relationships. The outcomes demonstrated that although the circumstances of the traumatic events were clearly different, the impact on survivors and their partners and the damage to their intimacy were very similar.

Components of traumatic life events

Trauma can be singular or multiple. Single traumas tend to have catastrophic and immediately obvious effects. Multiple traumatic exposures can accumulate over a longer period of time, often for several years, before the effects of a post-traumatic stress reaction become manifest. Both create problems for individuals (often the primary victims) and their partners (secondary victims) and families (most commonly the tertiary victims).

Traumatic events have been described as violent encounters with nature, technology, or humankind (Norris, 1990). *Natural* traumatic events such as the devastation caused by famine, fire, flood and earthquakes are often regarded as 'Acts of God' or attributed to fate. The traumatic impact usually spreads way beyond individuals to affect the whole community. Studies have shown that natural disasters generate less post-traumatic psychopathology than interpersonal trauma. D'Ardenne (2001) has attempted to categorize different types of interpersonal traumatic events in terms of their relative traumagenicity and her findings appear below in ascending order of seriousness to the victim.

- Accidental injury where another may be held responsible but where there is no intent to harm.

- Deliberate intention to harm or kill a victim where the victim has a chance to fight back (e.g., combat and criminal activity).
- Detention and confinement with the use of torture.

The following features are commonly found in traumatic life events:

- A sudden, dangerous and often life-threatening turn of events either in the context of an *acute* situation (e.g., a road traffic accident) or a protracted and stressful *long-term* event (e.g., chronic illness).
- Exposure to the stressor needs to be accompanied by a significant and distressing emotional reaction such as fear, helplessness, or horror. (*The word 'trauma' actually means 'a penetrating wound'*).
- Potential for actual loss, danger or humiliation.
- The unexpected nature of a trauma leads to feelings of helplessness and loss of control (particularly unfamiliar in professionals trained to cope and probably also in most individuals).
- Major disruption of routine to the individual, partner, or the family.
- Protracted distress over time with uncertainty for the future and unresolved physical and psychological health problems.
- Significant social and occupational dysfunction and impaired intimacy with partners.

Some of the common traumatic life events that damage *intrapyschic* and *interpersonal* intimacy include: *diagnosis of cancer, death of a loved one (especially when unexpected), sexual assault, domestic violence, criminal acts, travel accidents, abortion/miscarriage, disclosure of an affair, loss of occupation, heart attack, brain injury including stroke, traumatic childbirth, neonatal health problems with a child/congenital abnormality, iatrogenic trauma/medical negligence, survivors of torture or incarceration, diagnosis of HIV or other potentially lethal illnesses, exposure to war or terrorist attacks, industrial accidents/other work related traumas, near-death experiences such as electrocution and drowning, and natural disasters.* Subjective appreciation of the traumatic impact is a much more reliable guide to traumagenicity than the objective observations of an onlooker.

As the '*ripple effect*' of trauma is increasingly recognized, the work of rehabilitation following traumatic exposure will need to broaden its scope to focus on couples, families and other groups related to the primary victims. The couple therapist has an important role to play in the recovery process of such traumatized systems.

Impact of trauma on the individual

Trauma exposure (which proves to be 'traumatic') results in the development of a spectrum of psychological and physical reactions. These can be further categorized as *short-term* and *long-term*. *Short-term* reactions are described as: *Acute Stress Reactions* (*International Classification of Diseases – ICD 10*, World Health Organization, 1992) and *Acute Stress Disorder* (*Diagnostic and Statistical Manual of Mental Disorders – DSM-IV*, American Psychiatric Association, 1994).

The majority of trauma victims develop an acute stress reaction (approximately 70%) which lasts for about one month. Only a minority of trauma victims go on to develop the long-term reactions such as Post-Traumatic Stress Disorder (PTSD), major depression etc. This is a great tribute to the factor that is often ignored in traumatology, namely, *resilience*. Most people who suffer an initial reaction to a trauma recover quickly and can make positive gains from the experience. The long-term reactions seldom develop in isolation. Co-morbidity is the norm and the most common combination is PTSD with depression.

Early-onset depression and *peritraumatic* dissociation are known to make it more likely that an acute stress reaction will go on to develop into a long-term reaction. Traumatologists actively involved in the management of trauma victims deliberately look for these vulnerability factors (see below).

PTSD is an anxiety disorder defined by the co-existence of three clusters of symptoms each of which fluctuates in intensity so that the clinical picture changes with time and prevailing circumstances: *re-experiencing*, *avoidance*, and *hyperarousal*. Notably, *avoidance* features are prominent at times of further challenge and *intrusive recollections of the trauma* tend to occur when danger recedes and probably represent the organism's attempt to process the traumatic experience. PTSD is one of the potential long-term reactions to trauma. Others include depression, grief reactions, alcohol and drug dependency, and other anxiety disorders (generalized, panic, or phobic). Comorbidity is common, reaching approximately 80%, and the most common combination is PTSD with depression. Although PTSD shares some symptoms with other anxiety disorders, the dynamic coexistence of the three core clusters is unique. PTSD also has its own exclusive biological signature.

Two features of PTSD, *avoidance* and *hyperarousal* (criteria C and D in DSM-IV), specifically damage intimacy. *Avoidance* includes markedly diminished interest or participation in significant activities, feelings of detachment or estrangement from others, restricted range of affect, and a sense of a foreshortened future. These features of avoidance are the results of loss of *intrapersonal* intimacy and will inhibit recovery through *interpersonal* intimacy. *Hyperarousal* damages intimacy because of increased irritability and outbursts of anger.

A convenient way to examine links between the process of psychological traumatization and subsequent loss of intimacy is to look at conditioning factors that prevailed before, during, and after the impact of trauma. *Pre-traumatic factors* will take account of family and personal history of psychiatric illness, socio-economic status (lower at greater risk), and gender (women are at greater risk). In general terms, inauspicious psychosocial environments do not promote the development of emotional intelligence (Goleman, 1998) or emotional literacy (Turnbull *et al.*, 2001).

Peri-traumatic factors include the type of trauma (rape and assault carry a higher risk), the level of perceived danger, and early-onset depression and/or sustained dissociation (Shalev, 2000). Depression and dissociation have a particularly damaging effect on intimacy. *Post-traumatic factors* will address issues such as the level of social support, economic resources, the extent of loss, and secondary stressors. Loss of intimacy creates isolation and this makes interpersonal support very difficult to achieve.

What does PTSD feel like?

Understandably, trauma victims feel grief-stricken, depressed, anxious, guilty and angry following exposure to trauma. Characteristically, victims feel helpless and unable to take steps to restore control. If they develop PTSD, then trauma survivors are unable to get the trauma out of their minds. Three symptom clusters are characteristically associated with PTSD: re-experiencing symptoms, avoidance and psychic numbing, and hyperarousal. *Re-experiencing* distressing images, unwanted memories, nightmares or flashbacks of the trauma that cause distress and physical symptoms such as palpitations, shortness of breath and other panic symptoms is the 'cornerstone' feature of PTSD. Because the memory imprint has not been processed by the brain in the usual way, the flashbacks are very vivid and realistic and there is a frightening and uncanny sense of going through the trauma all over again. This can seem very strange and people sometimes think that they are going out of their minds and is one of the main reasons why people keep their trauma reactions to themselves. Experiencing flashbacks clearly separates the sufferer from those around and will damage intimacy. *Avoidance & Numbing* with avoidance of reminders of the event, including people, places or things associated with the trauma becomes a major preoccupation, leading to increasing emotional numbness and withdrawal and being generally unresponsive to things that used to be interesting. Increased use of alcohol and tobacco and other substances (including painkillers) are often used to 'douse' the memories and represent 'chemical' avoidance. Less communication with other people makes relationships at home and at work difficult. *Hyperarousal* means that trauma victims suffer physical symptoms such as headaches, muscular aches and pains, diarrhoea, nausea and palpitations, as well as insomnia, irritability, poor concentration, being 'on guard' most all the time (hypervigilance which may approach the intensity of paranoid suspiciousness), and increased startle responses.

New biological insights into the development of acute stress reactions and PTSD

Neuroscience is beginning to answer fundamental questions about the nature of post-traumatic symptoms. It is evident that the brain is a 'plastic' structure, altered by events. The brain is not only the master controller of stress reactions but is also a prime target for their effects. *Manageable* stress engenders biological changes that facilitates greater endurance, clarity, strength, determination, and immunity. Exposure to *extreme* stressors releases exactly the same chemicals but in increased amounts and this damages the brain and inhibits memory functions. *Catastrophic* mental experiences change the functioning and structure of the brain, emphasizing its 'plastic' nature. The memory imprint of a traumatic experience progressively invades the entire cognitive field by 'conditioning' and the ongoing sensitization of the brain develops through repeated exposure to reminders of the trauma on an already established neurobiological substrate. This is called '*reiterative stress*' and may explain why depression is such a strong predictor of chronic PTSD because it is a mechanism

for repeated exposure to the trauma memories by rumination (van der Kolk *et al.*, 1996).

Of particular interest to the theme of stress reactions and consequent alteration in brain function is the *hippocampus*, an organ in the limbic system especially sensitive to fluctuations in levels of the stress hormones, adrenaline (and noradrenaline) and the glucocorticoids (especially cortisol). Stress-induced changes in the hippocampus helps to explain the onset of and recovery from traumatic stress reactions.

The hippocampus is equipped with a 'fuse' composed of neurons that are especially sensitive to stress hormones. The fuse cells are damaged by elevated levels of stress hormones and the function of the hippocampus is impaired. Since the function of the hippocampus is heavily bound up with cognitive and memory function and the creation of new thought, this impairment goes a long way towards explaining why these features are so prominent in both acute and long-term stress reactions and, also, their relevance to damaged intimacy function (Jacobs *et al.*, 2000).

It might seem that the sensitivity of the hippocampus to elevated stress hormone levels represents a flaw in human evolution but that is not the case, because of the brain's inherent capacity to repair the damage. The brain produces new pluripotent stem cells that repair the fuse. The damage to the hippocampal fuse is brief and temporary (about 4–6 weeks) if the adrenaline and cortisol levels subside rapidly after exposure to trauma. This can only happen if safe conditions have been restored, when physical injuries are healing, when losses can be restored, and when the future looks assured. This is a description of an *acute stress reaction* which leads to early recovery. It can be seen as a positive adaptation: learning to survive in extreme circumstances (Turnbull, 2003).

Long-term PTSD and other chronic stress reactions (such as depression) develop because the brain fails to repair the hippocampal fuse. Significant secondary stresses maintain high levels of adrenaline which continue to spoil the function of the hippocampus which has a crucial role in memory processing and the development of new and innovative thinking. As a result the memory imprint of the trauma remains unabsorbed and continues to act as if the trauma has just occurred. In effect, the trauma victim remains 'stuck' in the trauma, re-experiencing it over and over again, and responding to each fresh episode with a new wave of adrenaline at survival levels. Hence the development of the three key features of PTSD as a 'cascade' from flashbacks → hyperarousal → avoidance of reminding cues.

Criteria for intimacy

Healthy intimacy in couples or partners in a committed relationship, whether they are heterosexual, married, cohabiting or homosexual, is characterized by the following criteria (Schwartz, 2001):

- They *communicate* openly, non-defensively and spontaneously.
- They *respond* with empathy (able to relate to the other).
- They *negotiate* conflicts by accommodating and compromising with each other.
- They *affirm* each other's vulnerabilities.

- They *enjoy* physical contact ranging from affection to sex.
- They *create* a unique identity from their mutual developmental history derived from shared experiences.
- They *respect* and *support* each other's evolution as individuals by accepting their differences in interests, friendships, careers, hobbies, etc.
- They *provide* support for each other during crisis.
- They *contribute* to mutually shared goals and responsibilities.
- They *play together* openly and spontaneously.
- They *remain* monogamous and faithful to each other.

Mills' classification of intimacy

This includes both intrapsychic and interpersonal intimacy.

Intrapsychic intimacy

- having a good knowledge of self.
- being aware of strengths and limitations.
- self-acceptance/being kind to oneself.
- ability to maintain good self-respect by protecting oneself from others who are hurtful, disrespectful or exploitative.
- ability to experience a wide range of feelings deeply and spontaneously and foster willingness to share these thoughts and feelings with another.
- feel worthy of happiness and pleasure and make choices that lead to these experiences.

Interpersonal intimacy

Psychological: Self-esteem

Self-awareness

Respect, trust, honest, loyalty, commitment & openness

Intellectual compatibility

Emotional: To be able to share emotional needs

Verbal communication of affection

Sharing of mutual empathy

Physical: Non sexual—hugs, cuddles, physical affection

Sexual—Sexual communication

Compatibility of interest

Arousal

Orgasm

Variety (with the same partner!)

Operational: Sharing of responsibilities

Decision-making

Role expectations

Control

Social: Shared activities

Hobbies

Holidays

Mutual friends

Wider community

Spiritual: All of the above to achieve a body, mind and soul connection. In order to achieve this all lines of communication need to be open with a mutual desire. This is often referred to as the '*right chemistry*'.

How trauma affects intimacy

Functions of the mind that spoil what we call 'intimacy' will deepen and darken the 'black hole of trauma' (van der Kolk & McFarlane, 1996). It is also known that secondary stressors play an increasingly influential role in the development of a trauma reaction progressively over time and damaged capacity for intimacy represents an important potential secondary stressor.

Catastrophic mental experiences have been shown to change the functioning of the human brain. The experience of trauma produces a memory imprint that alters both the cognitive and emotional memory fields with its conditioning influence. Although the symptoms of PTSD remain the same over time (intrusive recollections/persistent avoidance of stimuli/hyperarousal) the actual memories tend to become distorted. Post-traumatic factors are more important than pre-traumatic factors in explaining the enduring characteristics of PTSD (Shalev, 2000). These include damage to intrapsychic and interpersonal intimacy (Mills, 2000). In general terms, demographic and traumatic factors become progressively less important as the time between the trauma and the assessment increases, whereas social factors become progressively more important over time. The influence of childhood vulnerability factors does not appear to change over time (Shalev, 2000).

Intimacy is, therefore, a characteristic of human functioning that can influence the initial impact and the eventual meaning of the traumatic event and it can also influence the course of memory processing after the impact of the trauma.

Impact of trauma on subtypes of intimacy

(Mills & Turnbull, 2001)

Psychological intimacy

The responsibility for damaged self-esteem is very easily transferred to a partner. Partners may boost self-esteem with compliments or the right gestures, or, alternatively, may lower self-esteem even further with critical comments, deprecatory statements or the absence of positive gestures. Self-awareness is jeopardized by dysfunctional intrapsychic intimacy that inevitably has a secondary impact on

relationships with others. Trust, openness and honesty will be adversely affected. Lack of personal respect will be transformed into dependency.

Emotional intimacy

Increased anger and irritability leads to verbal and physical hostility and violence. Increased fear leads to generalized anxiety and panic attacks. Fear of rejection and abandonment, confusion, shame, doubt, guilt, feelings of sadness and depression with suicidal thoughts are common occurrences within a relationship after trauma.

Physical intimacy

Physical injuries as a result of trauma, such as backache, can impair physical intimacy significantly. Non-sexual physical contact may either increase or decrease. For example, partners may cling together or stay detached. Non-sexual detachment is closely linked to sexual detachment.

Sexual intimacy

Interest in sex may increase or decrease. Although sexual libido usually decreases after a sexualized trauma it sometimes increases because survivors may actively seek a good experience to counter the bad one. In the case of women this phenomenon is closely linked to psychological and emotional closeness. Sexual arousal may be impaired significantly. Men may remark, '*I'm stiff everywhere except where I should be*'. Women may experience painful intercourse due to lack of lubrication.

Delayed orgasm or even anorgasmia is a common presentation in both men and women. This is complicated by modern antidepressants. In general, it is necessary to be able to lose control to achieve satisfactory orgasm. Traumatized couples become involved in an increased variety of unusual sexual behaviours compared to non-traumatized couples. Paradoxical relating patterns such as trying to obtain closeness from a distance, e.g., pornography, commercial sex phone lines, etc., are often encountered.

Operational intimacy

Role expectations are often altered. For example, one partner may assume the role of 'carer' in the immediate aftermath of trauma that may become permanent.

Attempts to retain self-control and independence intrudes into relationships creating resentment and decision-making may habitually become the province of one individual rather than the other, with consequent impairment in the quality of the relationship.

Social intimacy

Withdrawal from external activities will predictably constrain lifestyle and lead to the loss of social of support systems such as losing friends and hobbies and a general detachment from others. Disconnection between partners will result in isolation and a sense of vulnerability within the relationship. Individuals will adopt separate coping strategies that may involve different sleeping and self-caring patterns. This alienation (addictive behaviour patterns) will often result in intimacy problems.

The impact of loss and grief on the couple

When a significant bereavement occurs, the intensity of the reaction within a relationship fluctuates over time. The impact may last for several weeks or for several months until the couple work through their grief and gradually settle down to their earlier patterns of relating. For some couples the trauma seriously disrupts the relationship (International Society for Traumatic Stress Studies ISTSS Fact Sheet, 2003) on a permanent basis and they may be unable to re-establish the equilibrium.

The '*grief cycle*' represents emotional changes that typically unfold sequentially. Initial shock and emotional numbing give way to denial followed by anger, shame and guilt. Later developments include anxiety for the future and the ultimate acceptance of the loss accompanied by depression. In the case of couples, primary victims of trauma and their partners typically oscillate rapidly between noxious emotional states, frequently even on several occasions each day.

Initial shock and the numbing phase

This is a phase of dissociation characteristic of the immediate aftermath of exposure to trauma. It is a phase of stultification, of ambivalence, and of inactivity characterized by disconnection of the self from the trauma because preconceptions of safety and security are shattered. The dissociation represents a psychological defence mechanism as the impact of the trauma penetrates. Feelings of control and mastery are replaced by extreme vulnerability and helplessness. Doing nothing is naturally protective until coping strategies are reassembled. Physical and emotional numbness prevent reckless strategies. Impaired attention, 'focus', and concentration impair memory and other cognitive functioning. The external world that has suddenly and unpredictably become extremely dangerous and even life-threatening, is effectively 'shut out' by this defence mechanism. The emotional numbness experienced by the primary victim engenders a degree of introspectiveness that effectively obstructs any possibility of expressing emotions within the context of a relationship.

In this acute phase of traumatization partners typically feel that they have to take over responsibility for making decisions and practical arrangements. Effective communication with trauma victims is extremely compromised at such times and this may bring about irritability, anxiety and impatience in partners. Some partners may become extremely over-protective of trauma victims at this stage.

If the impact of the trauma is not resolved and the reaction becomes chronic, it is not unusual for the victims to attempt to self-anaesthetize with alcohol and drugs (both prescribed and non prescribed). This further exacerbates difficulties within a relationship.

Phase of denial

Psychological denial is a way of not acknowledging something that has happened. A degree of denial may be seen as an adaptive response to disaster and may prove conducive to healing and recovery (Hybels-Steer, 1995). Denial helps to dampen or obliterate feelings of horror, helplessness, and fear of abandonment or extinction. On the other hand, it is not helpful if it catapults the trauma victim back into situations of danger or prevents appropriate steps to gain assistance. This phase often creates confusion for couples because of the potential misinterpretations that survivors do not care what happens next. Partners may also enter a state of denial. Unrealistic expectations to 'get on with life' or 'pull yourself together' can lead to irritability and anger.

Phase of anger

Survivors and their partners may feel angry because of feelings of helplessness and loss of control in their lives and they may become aggressive or try to control others. Anger and aggression may also arise because of a heightened sensitivity to feeling threatened after experiencing trauma. If anger is directed inwards at the self it readily leads to self criticism, erosion of self esteem, guilt and self-recrimination, and, ultimately, depression. If anger is projected outwards, it may be either destructive or constructive. Destructive projections of anger lead to verbal or physical violence. Constructive anger may energize creativity and lead to inventiveness and innovative thinking. Intimacy may be positively maintained.

In order to suppress their anger and impulsive actions, survivors may avoid closeness by expressing criticisms towards or dissatisfaction with partner and friends. D'Ardenne and Balakrishna (2001) raised issues for therapists involved in domestic violence in relationships. They emphasized that domestic violence has been a neglected topic, that violence is no respecter of class, creed or social status, that it is often the result of poor early attachments, and that perpetrators of domestic violence often have difficulties with intimacy.

Women partners were found to under-report violence and blame themselves more than male victims (Kershaw *et al.*, 2000). McFarlane and Van der Kolk (1996) gave a detailed description of the problems experienced by victims to reveal abuse. Hence they concluded that seeking help requires courage and persistence.

Bouchard and Lee (1999) pointed out that the most successful therapies are those that seek first to eliminate violence or the threat of it from the relationship and that, second, focus on dysfunctional or coercive interactions between the partners. It is important that the therapy has to start with reducing risks. Crowe and Ridley (1990) emphasized the need for the couple to take joint responsibility so that the problems

can be seen as mutually shared territory. Nowhere is this more appropriate than when violence has occurred within the relationship. An open attitude on the part of both therapists and clients facilitates open accurate and truthful reporting of such difficult problems for traumatized couples and the aim becomes one of helping both the violent individual and the couple to project their anger constructively

Guilt and shame

The development of self-criticism and self-doubt in the aftermath of trauma is commonplace. It can lead to 'should have, could have, would have' preoccupations. The resultant shame and guilt often deepens into more profound feelings of worthlessness and hopelessness followed by depression. Self-criticism in the aftermath of trauma also has a positive aspect. It may prove to be the starting point to understand what happened. For example, victims may be disadvantaged if they are led to perceive that they had no responsibility for what occurred because it means that, in the future, they will face an existence in a chaotic, random, and potentially very cruel world where anything can happen at any time. If a trauma victim can believe that there was a degree of personal responsibility for the development of the traumatic situation then at least there exists the potential to change actions and behaviour to make further involvement in trauma less likely (e.g. installing a burglar alarm after the robbery and the observation that perpetrators of road traffic accident less often develop chronic traumatic stress reactions compared with blameless victims).

It is not uncommon for partners to suffer from *survivor guilt* and it can have a particularly corrosive effect on those who develop deep-rooted feelings that they should have been involved in the traumatic situation rather than a partner, or, that they should have been injured or even died in their place. Survivor guilt is one of the associated features of PTSD in the DSM-IV criteria and it is very important to identify its presence in the course of therapy.

Loss of body parts and scarring not only leads to grief reactions but often leads to feelings of shame and interferes powerfully with intimacy. Missing parts of the body and scarring provide obvious and permanent reminders of the trauma and its damaging impact for both trauma victims and their partners.

Acknowledgement of such losses of actual parts of the body or its normal contours takes priority over attempts to reassure. Partners, friends and families naturally tend to try to reassure without acknowledging the loss first. Attempts are also often made to sweep away any evidence of developing self-blame and self-criticism in trauma victims, especially if there has been serious or disfiguring injury. The frequent result of such manoeuvres is anger in the sufferers and feelings of rejection and bewilderment in the partners because they were only 'trying to help'.

Fear apprehension and anxiety

Survival of traumatic events will naturally lead to heightened vigilance and may result in increased anticipation of danger, betrayal and potential harm within new and old

relationships, even when there is no actual reason for such suspicions. An increased sense of vulnerability can lead to problems in trusting others and this may extend to close friends and partners. Isolation becomes a safer state to be in compared with closeness to others. It may be very frightening to get close to others, because relationships are always at least slightly unpredictable adventures and the post-trauma world appears to be a very unsafe place to be for trauma victims. Heightened physiological arousal leads to both mental and physical changes. Mental anxiety often mounting to panic proportions and derealization and depersonalization are accompanied by adrenergic over-activity with palpitations of the heart, tremor, sweating, hyperventilation, nausea, diarrhoea and vomiting. Hypervigilance protects trauma victims with 'hair-trigger' responses. One unfortunate consequence is that partners may very easily and inadvertently trigger these extreme reactions by making unexpected movements, noises or gestures. Frequently, this creates 'knee-jerk' anger and irritability and subsequent guilt.

The physical symptoms associated with fear can lead to hypochondriasis and phobias. Fear of rejection and abandonment can lead to the survivor trying to control the partner with jealousy. Self doubt and feelings of inadequacy can push the individual into depression.

As in the management of anger, the couple therapist should aim to motivate the sufferer and partner to channel these emotions constructively into work, exercise and sports, creative hobbies, taking up a project, relaxation and anxiety management while working on improving the quality of the relationship.

Sadness and depression

Depression is a common reaction to loss. It can include feeling down, sad, hopeless or despairing. The survivor may cry more often, feel they are being punished unfairly and feel like a failure. Associated hopelessness, pessimism and the inability to see anything positive in the future, can lead to suicidal thoughts. The inability to see anything positive for the future often makes the partner feel rejected or hopeless. Any attempts at self-harm will leave partners in a state of anger, fear and frequently they feel betrayed. The survivor in a depressed phase feels the loss of motivation, energy and drive including loss of interest in sex. The anhedonia extends to loss of interest in hobbies and other people. This, in addition to disrupted sleep patterns and cognitive distortions and the ability to make decisions, can lead to a formidable raft of problems within the relationship. While partners are typically feeling increasingly rejected by their traumatized partners, the survivors, on the other hand, tend to become more introspective, preoccupied with their compromised and uncertain state of health and negative perceptions about their physical appearance. Depressed trauma victims may also transmit their melancholia onto their partners who will then absorb this noxious emotion so that they may also become significantly depressed (Mills, 2001).

The role of the couple therapist in the management of post-traumatic depressive reactions is to attempt to instil hope and restore realistic optimism for the future but, as always, in the context of the creation of a safe, secure and contained psychological environment which is an essential prerequisite for all successful post-trauma work.

Formal treatment of major depression usually requires a combination of pharmacological and psychotherapeutic interventions.

Although primary victims and their partners feel the whole range of emotional reactions to trauma as individuals the following research shows that they are seldom able to share these emotions together. Ninety percent of a cohort of 300 couples (where one or both partners were suffering from PTSD) were unable to share their emotions within the grief cycle (Mills, 2001). This post-traumatic phenomenon had a predictably deleterious effect on the couple relationships that were studied effectively blocking communication and preventing open and honest negotiation. Mutual understanding and empathy became difficult to achieve and intimacy was damaged. The following were given as common reasons for not being able to share:

- (1) Fear of overburdening the partner.
- (2) Fear of unsympathetic responses from the partner.
- (3) Fear that the partner would be unable to manage intense reactions.
- (4) Fear of loss of respect from the partner.
- (5) Fear of losing the partner '*if the whole truth is known*'
- (6) Fear of partner sharing it with others not approved by the sufferer.
- (7) Anxiety that the partner will not let them forget the trauma when the survivor is actively trying to avoid being reminded.
- (8) Concern about contamination of the family system with trauma memories, even in the case of a common/mutual traumatization.
- (9) Fear that the partner would use perceived weakness to gain more power within the relationship.
- (10) Anxiety about critical comments from partners regarding what are perceived to be 'dysfunctional' coping strategies and about the potential for hostile and destructive reactions.

There was no statistical difference between men and women when it came to actual sharing with the partner (Mills, 2001). However women expressed the desire to share more than men. The most common reasons given by women who expressed misgivings about sharing is that they might receive the wrong response from their partners, or that they might not be 'listened to'. Men most commonly expressed their desire to protect their partners and that they were also fearful of being regarded as weak or vulnerable individuals. Even when the trauma was common to both partners, i.e. death of a child or being involved in the same road traffic accident, the statistics remain the same for not sharing.

The impact of brain injury on intimacy

In the UK National Traumatic Brain Injury Study (Stillwell & Stillwell, 1997) 30% of marriages in a sample of 234 ended in divorce within 7 years of severe traumatic brain injury to one of the partners compared with a 7 year failure rate of 14–18% in the general population. Wood and Yurdakul (1997) found male and female partners were equally likely to leave and that there was no relationship between age and separation.

However, the implications of the problems faced by partners of someone who has suffered a severe acquired brain injury need to be seen in a broad context (Oddy, 2001). Sexual dysfunction, in the presence or absence of disabling conditions, has many causes. Organic/structural, psychological, or relationship issues may need to be considered, regardless of the underlying disability diagnosis.

Cognitive challenges (Merritt, 1998)

- Damage to the brain, whether traumatic, vascular, or hypoxic, may result in numerous cognitive changes that may be associated with behavioural changes (e.g., anger, compulsion, inconsistency). Reduced memory and organizational skills may result in easy distractibility and inattention to previously observed details. For example, a couple may have a usual routine, knowing what the other likes, possibly in sequence, or cued with certain gestures or comments. Such a routine may be forgotten or changed by the person with brain injury.
- Lack of interest because of pain, fatigue, or loss of libido may frustrate both partners. Memory impairments and distractibility can be quite challenging for a couple. The partner with traumatic brain injury (TBI) may not be able to recall having sex and may make repeated demands. On the other hand, easy distractibility may interfere with full participation in sexual activities.
- A person with brain injury may not be able to pick up on subtle cues, and the partners may need to start over as if from the beginning of the relationship. Sometimes, memory can be impaired to the extent that there is no recollection of sexual encounters at all, and, therefore, frequent demands for sex are made. Patients with hypoxia frequently manifest this type of behaviour. Memory impairment makes the partner feel unappreciated and used, particularly when accused of refusing to participate. Use of a memory book may be helpful. The partner who is not disabled notes dates and times of sexual encounters and can refer back to this record if needed for reference.
- Sometimes a person who was sexually aggressive before sustaining illness or injury may become more passive or forget about sex altogether unless reminded. On the other hand, a sexually passive person may become quite disinhibited. Challenges may develop with emotional lability (e.g., crying or laughing not necessarily associated with activities at hand). This behaviour could be quite disconcerting in the midst of passionate lovemaking. Insuring adherence to safe sex protocols is a further challenge, as is consistent use of contraceptive methods that require physical coordination and memory.
- According to Schover and Jensell (1988) depression, altered body image, personality/behavioural changes, social distance, anxiety, fear of rejection, fear of inadequate performance, fear of pain/spasticity interference, and bad memories of prior experience can all hamper sexual interest and performance.

Neurogenic problems (e.g., autonomic, central, peripheral)

- Autonomic dysfunction, as a result of brain dysfunction or spinal cord injury (SCI), may distort stages of the sexual response cycle. The fight or flight response is generated by the sympathetic nervous system. This impulse can be increased psychogenically by anxiety or from organic lesion in the brain or spinal cord.
- With increased sympathetic tone, excessive constriction of blood flow is common, reducing engorgement of sexual organs and orgasm. Multiple levels of dysfunction can exist. Head trauma, for example, may be accompanied by other injuries (e.g., spinal injuries, soft tissue injuries, fractures).

Pain/spasticity as inhibitor

- Pain or limitation of motion from other injuries may depress interest in sex or sexual performance even further.

Traumatic structural changes

- Diffuse or focal brain injury may result in mild-to-severe physical and cognitive impairments that may impact sexual function. Diffuse injury may impact deep hemisphere structures that regulate sexual function, including possible direct injury to the pituitary gland or hypothalamus, which could disrupt normal hormonal functions. Imbalance in available neurotransmitters may disrupt normal function. Thus, the practitioner must be aware that traumatic effects on different areas of the brain lead to alteration of certain functions.
- Several dysfunctions are associated with certain symptoms, such as the following:
 - Amygdala with sexual disinhibition/hypersexuality
 - Brain stem with decreased libido, inappropriate processing of information
 - Hypothalamus with general initiation, dyscontrol of sexual behaviour, hormonal regulation
 - Frontal lobes with sexual apathy, loss of initiative
 - Pituitary gland with infertility, decreased secondary sex characteristics, decreased libido
 - Septum with decreased libido, impotence, decreased ability to experience pleasure/orgasm
 - Temporal lobe with diminished responsiveness
 - Thalamus with hypersexuality
- Most often brain injuries are not discrete lesions but represent a combination of involvement of different areas of the brain with overlapping challenges. The main challenges are disinhibited or socially inappropriate behaviour demonstrating lack of restraint, lack of initiation, or inability to find a start button to

get things going. Sexual dysfunctions (e.g., hypersexuality, hyposexuality) may result.

Sexual counselling can help the individual learn to communicate needs and feelings concerning sexual issues. Implementation of strategic solutions may require assistance from the partner. The person who is disabled may find it difficult to admit to sexual dysfunction and to ask for assistance.

Dr Annon (1976) describes a system known as PLISSIT, which includes the following:

- Permission
- Limited information
- Specific suggestions
- Intensive therapy

Care providers can provide significant impact on a patient's recovery process. Inclusion of sexual history as part of the evaluation and treatment process validates or gives the patient permission to include healthy sexual functioning as part of overall functional goals.

When possible, it is important to ask both partners to share information regarding sexual functional status before and after the disability. They need to think in terms of both physical and mental changes and work together, possibly with a counsellor, to devise solutions or optimal coping strategies for those problems. The level of information provided should be tailored to the couple's level of comprehension.

Couples are encouraged to use a desensitization approach, returning gradually through each stage of the sexual response cycle. Advise that they first get used to sleeping together again. After a while, they should practice minimal intimacy such as kissing, fondling, and hugging. Discuss how that went, and, when they are ready, have them proceed through each subsequent step. This eliminates the goalpost mentality of having to reach orgasm each time, while permitting enhancement of the quality of interaction that is comfortable for both participants.

Disability and relationship difficulties

The impact of a disabling condition on a couple is profound and complex. Role changes can interfere with adult-to-adult relationships. Making the transition from being an anxious observer/caregiver in the initial recovery phase back to being a lover may be difficult. This situation may be exacerbated if the necessary role changes include greater responsibilities (e.g., paying bills, working, making decisions that previously were the responsibility of the person with the impairment). Confusion and resentment may develop.

Disagreement over timing of pregnancy subsequent to injury may be a problem, and it may be compounded further by physical or mental challenges involved in using contraceptive devices.

Communication problems associated with speech and language deficits (e.g., nonfluent speech, word-finding deficits, memory loss) may aggravate attempts to

work out mutually agreeable solutions. A neutral intermediary (e.g., a counsellor) may be helpful.

Survivors may feel self-conscious about changed physical or mental states. In certain conditions (e.g., TBI), individuals may not demonstrate any physical deficits, further compounding the partner's frustration with multiple cognitive changes.

Few opportunities for social interaction may exist, causing patients to feel shy and fear rejection. These individuals may not have had much sexual experience prior to onset of the disabling condition or already may have had problems with sexual dysfunction, now further compounded by effects of the condition. Patients or partners may be fearful of increasing pain or physical damage.

Doubts about sexual identity can cause great consternation. These issues must be handled with sensitivity and compassion to help avoid reduced self-esteem and depression. Recommend discussion of such questions with a knowledgeable counsellor or sex therapist, so that successful strategies can be worked out.

Individuals and couples coping with sexual limitations of disability must work to accept those limits and develop options available to them.

A constellation of limiting factors may be involved, such as the following:

- Depression
- Altered body image
- Personality/behavioural changes
- Social distance
- Anxiety
- Fear of rejection
- Fear of inadequate performance
- Fear of pain/spasticity interference
- Negative memories of prior experience

In addition, couples may be challenged by issues like the following:

- Change in role
- Caregiver vs. lover conflict
- Communication problems
- Contraception

Sexual Wisdom from Masters and Johnson (1986) put it well:

‘A stiff penis does not make a solid relationship, nor does a wet vagina.
Absence of sensation does not mean absence of feelings.
Inability to move does not mean inability to please.
Inability to perform does not mean inability to enjoy.
Loss of genitals does not mean loss of sexuality’.

Case examples

Case 1

John, a 58-year-old man who has been married to Jean (54 years) for the last 30 years had a serious road traffic accident while he was driving to the hospital to pick Jean up after one of her routine reviews for arthritis. His right leg was amputated below the right knee joint. In the immediate aftermath they were both in a state of shock. A few days later when Jean went to the hospital to see John, she found a screen around his bed and when she peeked inside she saw a young female nurse giving him a wash. When he saw Jean he shouted at her to go and wait in the waiting room. At that point she felt rejected and could not understand why she was not allowed to stay there. This incident transformed itself in Jean's mind to firm belief that he was angry with her and that she was to blame for the loss of his leg. She was also convinced that he was going to leave her for a younger girl who could look after him more efficiently. When John came home he found Jean in a depressed mood state with loss of interest in emotional or physical closeness. This was a real shift in their relationship over the last 30 years and both partners were struggling with their new roles and lack of intimacy at the time of referral.

Within a safe and contained environment, they were able to explore their doubts and fears. The psycho-education session initially normalized a lot of their feelings for them including survivor guilt. John was able to explain the reason for him asking Jean to go out and wait at the hospital. He was at that time feeling 'protective' towards her and did not want her to get the shock of seeing him without his right leg. At that point he had not come to terms with it either. He was able to reassure her that she was the one he wanted to spend the rest of his life with while she was able to reassure him that he was no less attractive to her. They were able to work through their loss together and rebuild the relationship. This case also highlights for the healthcare practitioners the importance of involving the partner from a very early stage in the treatment programme.

Case 2

Lisa (35 years) who has been married to Dave (45 years) for the last 10 years had a mastectomy for cancer of the breast, followed by reconstructive surgery. She presented with loss of interest in sex and could not let Dave anywhere near her. She was extremely mindful of her scars which were a constant reminder to her of her cancer. Although Dave was reassuring (he even made a comment she looked better now and the reconstructed breast felt better than the original!) he had not acknowledged the impact of the loss for Lisa as well as for himself and the threat of cancer re-occurring. It is important that acknowledgement must come before reassurance. The psychoeducation session highlighting the fact that Dave was still on denial while Lisa was on fear and sadness on the grief cycle helped to normalize. Lisa and Dave recaptured their intimacy by improving their understanding of each other's coping skills with mutual respect and honesty. They used body paints as creative play to overcome anxiety regarding the scars.

What a partner/carer can do and should not do in the aftermath of the trauma

What will not help—the survivor

- By making it obvious you are not available to listen.
- By blaming what the person
 - should have done
 - should not have done
- By minimizing what the person is feeling
- By suggesting the trauma should not be talked about
- By minimizing the loss
- By suggesting it was fate
- By being critical of the person's reactions
- By telling the person you know 'exactly' how they feel
- Do not advise or take over control (except in case of poor judgement).
- 'Most of life's worst hurts can't be seen'

What will not help—you (partner or carer)

- Don't mistakenly believe you can do more than you can
- Stay away from non-supporters
- Don't minimize your emotions
- Avoid survivor guilt
- Don't slip into isolation
 - secondary debriefing

What will help—both be a 'lover'

- L**isten
- O**bserve
- V**erify
- E**mpathize
- R**eassure and offer practical help
 - to—Fight back
 - Rebuild
 - Console
 - Repair
 - Prevent

Secondary traumatic stress and protection for the carers

A single 'umbrella' term to convey the meaning of exposure to traumatic stress reactions as a result of being a carer or helper does not exist (Stamm, 1995).

Commonly used terms are ‘compassion fatigue’ (Figley, 1989), ‘counter-transference’ (Danieli, 1994), ‘burn-out’ (Riordan & Saltzer, 1992), ‘secondary traumatic stress’ (Stamm, 1995) and ‘vicarious traumatization’ (Pearlman & McCann, 1995). Some of these terms are used quite loosely. For example, ‘burn-out’ is used to describe emotional exhaustion in other situations with increased workload, poor relationships with work colleagues, lack of job satisfaction, or a poor home–work interface.

‘Counter-transference’ is also described beyond the context of exposure to traumatic reactions (Stamm, 1995). Counter-transference could be viewed as one of the factors that determines the effectiveness of psychotherapeutic work. ‘Secondary traumatic stress’ (STS) may be seen as a factor in how patients affect the lives of therapists, their relationships and their involvement in social networks. STS appears to be the most broadly-based term available at present.

STS can disrupt the therapist’s mental images and schemas for trust, safety, power, independence, esteem, intimacy, and frame of reference (McCann & Pearlman, 1995).

The therapist should have:

- a good balance between professional and personal life.
- consistent limits and take time to reflect and feel.
- regular social support and exercise.
- a sense of humour.
- regular breaks and holidays.
- activities that renew a sense of hope and optimism.
- realistic expectations of their work.
- regular supervision and secondary debriefing.

Some insights into the role of the trauma couple therapist

The aims of the trauma couple therapist should be to create a safe and contained environment in which the couple can share their thoughts and feelings honestly and openly with respect and compassion and to attain a good level of mutual empathy (Mills, 2001). Dysfunctional communication patterns and cognitive distortions need to be identified and eliminated. Sharing of emotional reactions that belong to the loss cycle should be timed with care (Crowe & Ridley, 1990) to enable the couple to recapture some normality at all other times. An infusion of playfulness, spontaneity, relaxation and mutual enjoyment would lighten the load for many traumatized couples.

It is very important to follow up assessment sessions with psychoeducation during which the therapist would be able to ‘normalize’ symptoms. It is also important that mutual acknowledgement of grief and loss should precede any form of reassurance.

The therapist should aim to shift the couple with positive reframes from victims to survivors to thrivers and encourage the couple to plan for the future.

Trauma couple therapists should also update themselves on cultural aspects as there is an influx of refugees many of whom have suffered traumatic experiences. With the number of personal injury litigations increasing, it is strongly recommended

that intimacy assessment should be a part of medico-legal reports (Mills & Turnbull, 2001).

When treating trauma victims, therapists often report feelings of frustration and hopelessness similar to those reported by the partner or spouse. If these feelings are left out of the therapist's awareness, he or she may form a collusive relationship with the partner (Wilson & Lindy, 1994). One of the essential tasks of the supervisor is to minimize this risk.

For many trauma survivors, intimate, family and friend relationships are extremely beneficial, providing companionship and a sense of belonging as an antidote to isolation, self-esteem as an antidote to depression and guilt, opportunities to make a positive contribution to reduce feelings of failure or alienation and practical and emotional support when coping with life stressors (Mills, 2001).

Conclusions

The quality of personal relationships in general, and sexual ones in particular, exerts great impact on a patient's self-esteem and support network. The multiple physical, psychological, and emotional changes that may occur after catastrophic injury or as a result of congenital disability or chronic illness must be addressed not only in the context of the patient, but also of the patient's support system. The issue of sexuality needs to be addressed during both the acute and long-term rehabilitation processes.

References

- AMERICAN PSYCHIATRIC ASSOCIATION. (1994). *Diagnostic and statistical manual of mental disorders: DSM-IV* (4th edn). Washington, DC: APA.
- ANNON, J.S. (1976). The PLISSIT model: A proposed conceptual scheme for the behavioural treatment of sexual problems. *Journal of Sex Education Therapy*, 2, 1–15.
- BECKER, J.V., SKINNER, L.J., ABEL, G.G. & CICHON, J. (1986). Level of post-assault sexual functioning in rape and incest victims. *Archives of Sexual Behaviour*, 15, 37–49.
- BERRY, M. (1999). Grief and Psychosexual disturbance following the death of a young baby: Some issues for practitioners. *Sexual and Marital Therapy*, 14, 27–42.
- BOUCHARD, G.P. & LEE, C.M. (1999). Violence against the spouse: Are couple treatments appropriate? *Canadian Psychology*, 40, 328–342.
- BUSUTTL, W. & BUSUTTL, A. (2001). Psychological effects on families subjected to enforced and prolonged separations generated under life threatening situations. *Sexual and Relationship Therapy*, 16(3), 207–228.
- CARROLL, C.M., RUEGER, C.B., FOY, D.W. & DONAHOE, C.P. (1985). Vietnam combat veterans with posttraumatic stress disorder: Analysis of marital and cohabiting adjustment. *Journal of Abnormal Psychology*, 94, 329–337.
- COURTIS, C.A. (1979). Victims of rape and incest. *The Counselling Psychologist*, 8, 38–39.
- CROWE, M. & RIDLEY, J. (1990). *Therapy with couples: A behavioural systems approach to marital and sexual problems*. Oxford: Blackwell Scientific Publications.
- DANIELI, Y. (1994). Countertransference, trauma, and training. In J.P. WILSON & J.D. LINDY, (Eds), *Countertransference in the treatment of PTSD* (pp. 368–388). New York: Guilford Press.
- D'ARDENNE, P. (2001). *Psychosexual disorders in an East London Trauma clinic paper presented to the Annual Conference of BASRT*. London: Conference Proceedings BASRT.
- D'ARDENNE, P. & BALAKRISHNA, J. (2001). Domestic violence and intimacy; what the relationship therapist needs to know. *Sexual and Relationship Therapy*, 16(3), 229–246.
- D'ARDENNE, P. & MORROD, D. (2003). *The counselling of couples in healthcare settings—A handbook for clinicians*. London: Whurr Publishers Ltd.

- DE SILVA, P. (1999). Sexual consequences of non-sexual trauma. *Sexual and Marital Therapy*, 14, 143–150.
- DE SILVA, P. (2001). Impact of trauma on sexual functioning and sexual relationships. *Sexual and Relationship Therapy*, 16(3), 269–278.
- FELDMAN-SUMMERS, C., GORDON, P. & MAEGHER, J. (1979). The impact of rape on sexual satisfaction. *Journal of Abnormal Psychology*, 88, 101–105.
- FIGLEY, C.R. (1989). *Helping traumatised families*. San Francisco: Jossey-Bass.
- FINKELHOR, D. (1990). Early and long-term effects of child sexual abuse: an update. *Professional Psychology: Research and Practice*, 22, 325–330.
- GARTE, S.H. (1986). Still in Vietnam: Arrested career maturity in Vietnam veterans with Posttraumatic Stress Disorder. *Psychotherapy in Private Practice*, 3, 49–53.
- GOLEMAN, D. (1998). *Emotional intelligence*. London: Bloomsbury.
- HYBELS-STEER, M. (1995). *Aftermath – Survive and overcome trauma*. New York: Simon & Schuster.
- INTERNATIONAL SOCIETY FOR TRAUMATIC STRESS STUDIES (ISTSS): Trauma and Relationship Fact Sheet 2003. [Ltp://www.istss.org/Trauma and Relationship.htm](http://www.istss.org/Trauma%20and%20Relationship.htm)
- JACOBS, B.L., VAN PRAAG, H. & GAGE, F.H. (2000). Depression and the birth and death of the brain. *American Science*, 88, 340–345.
- JEHU, D. (1988). *Sexual abuse and beyond*. Chichester: Wiley.
- KERSHAW, C., BIDD, T., KINSHOTT, G., MATTINSON, G., MAYHEW, P. & MYHILL, A. (2000). *The 2000 British Crime Survey*. London: Home Office Statistical Bulletin.
- KULKA, R.A., SCHLENGER, W.E., FAIRBANK, J.A., HOUGH, R.L., JORDAN, B.K., MARMAR, C.R. & WEISS, D.S. (1990). *Trauma and the Vietnam War generation*. New York: Brunner/Mazel.
- LUNDE, I. & ORTMANN, J. (1990). Prevalence and sequelae of sexual torture. *Lancet*, 336, 289–291.
- MASTERS, W., JOHNSON, V. & KOLODNY, R. (1986). *Sex and human loving*. Boston, MA: Little Brum & Company.
- MCCANN, I.L. & PEARLMAN, L.A. (1995). Vicarious traumatization: a framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3, 131–149.
- McFARLANE, A.C. & VAN DER KOLK, B.A. (1996). *Trauma and its challenge to society*. Traumatic Stress London: Guilford Press.
- MEZEY, G. & KING, M. (1989). The effects of sexual assault on men: A survey of 22 victims. *Psychological Medicine*, 19, 205–299.
- MILLS, B.C.S. (2001). Editorial. *Special Issue Trauma Sexuality and Relationships Sexual and Relationship Therapy*, 16(3), 197–205.
- MILLS, B.C.S. & TURNBULL, G.J. (2001). Following trauma, why assessment of intimacy should be an integral part of medico-legal reports. *Sexual and Relationship Therapy*, 16(3), 299–308.
- NORRIS, F.H. (1990). Screening for traumatic stress: A scale for use in the general population. *Journal of Applied Social Psychology*, 20, 1704–1718.
- ODDY, M. (2001). Sexual relationship following brain injury. *Sexual and Relationship Therapy*, 16(3), 247–259.
- PEARLMAN, L.A. & MACIAN, P.S. (1995). Vicarious traumatization: an empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and Practice*, 26, 558–565.
- RIORDAN, R.J. & SALTZER, S.K. (1992). Burnout prevention among healthcare providers working with the terminally ill: a literature review. *Omega*, 25, 17–24.
- SCHOVER, L. & JENSELL, S. (1988). *Sexuality and chronic illness*. New York: Guilford Press.
- SCHWARTZ, M. (2001). Intimacy Seminar presented in Chicago IL: Masters & Johnson Programme.
- SHALEV, A. (2000). Keynote Address. Defence Medical Services Conference ‘Trapped by Trauma’. (Abstract). York, UK, October 2000.
- SOLOMON, Z. (1993). *Combat stress reactions: the enduring toll of war*. New York: Plenum.
- STAMM, B.H. (Ed.) (1995). *Secondary traumatic stress: self care issues for clinicians, researchers and educators*. Lutherville, MD: Sidran Press.
- STILLWELL, J.H.C. & STILLWELL, P. (1977). *National traumatic brain injury study*. Warwick: University of Warwick P 53.
- TURNBULL, G.J., MILLS, B.C.S. & REES, P. (2001). Centurion: shielding journalists and aid workers. In *Sharing the front line and the back hills: protecting newsgatherers and peacekeepers*. New York: UN Publication.
- TURNBULL, G.J. (2003). The biology of PTSD. *Psychiatry*, 2(6).
- VAN DER KOLK, B.A. & McFARLANE, A.C. (1996). *The black hole of trauma. Traumatic stress – the effects of overwhelming experience on mind, body and society*. New York: Guilford Press.

- VAN DER KOLK, B.A., MCFARLANE, A.C. & WEISAETH, L. (eds) (1996). *Traumatic stress: the effects of overwhelming experience on mind, body, and society*. New York: Guilford Press.
- VEARNALS, S. & CAMPBELL, T. (2001). Male victims of male sexual assault: A review of psychological consequences and treatment. *Sexual and Relationship Therapy*, 16(3), 279–286.
- WHITEHORN, J., AYONRINDE, O. & MAINGAY, S. (2002). Female genital mutilation: cultural and psychological implications. *Sexual and Relationship Therapy*, 17(2), 161–170.
- WILSON, J.P. (1990). Conflict, stress and growth: The effects of war on psychosocial development among Vietnam veterans. In C.R. FIGLEY & S. LEVENTMAN, (Eds), *Strangers at home: Vietnam veterans since the war*. New York: Brunner/Mazel.
- WILSON, J.P. & KURTZ, R.R. (2000). Assessing PTSD in couples and partners: The dyadic dance of trauma. *Clinical Quarterly of the National Centre for PTSD*, 9(3), 35–38.
- WILSON, J.P. & LINDY, J.D. (Eds) (1994). *Countertransference in the treatment of PTSD*. New York: Guilford Press.
- WOOD, R.L. & YARDAKUL, L.K. (1977). Change in relationship status following traumatic brain injury. *Brain Injury*, II, 491–502.
- WORLD HEALTH ORGANIZATION. (1992). *The ICD-10 Classification of mental and behavioural disorders. Clinical systems and diagnostic guidelines*. Geneva: WHO.

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