



Posttraumatic stress disorder symptoms impact the emotional experience of intimacy during couple discussions



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ABSTRACT

We examined the impact of PTSD symptom severity on emotional reactions to one's own and one's partner's intimacy behaviors. Heterosexual, community couples in which at least one partner reported elevated symptoms of PTSD were video-recorded discussing a relationship problem and self-reported their emotions immediately before and after the discussion. Each partner's intimacy behaviors were coded. Actor–Partner Interdependence Models indicate that, among those with greater PTSD symptom severity, partners' caring, understanding, and validation were associated with increased negative emotions, particularly fear. Among those with greater PTSD severity, provision of caring was associated with decreased anger, guilt, and sadness. Therefore, the receipt of intimacy was associated with increased negative emotions among individuals with elevated PTSD symptoms while provision of intimacy was associated with decreased negative emotions. Existing treatments for PTSD should consider the emotional context of provision and receipt of intimacy to more fully address relationship problems among couples dealing with PTSD.

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Compared to other psychological disorders, posttraumatic stress disorder (PTSD) has one of the strongest links to distressed intimate relationships (Whisman, 1999). PTSD is associated with sexual and emotional intimacy problems, difficulty providing support to one's intimate partner, lower relationship satisfaction, violence perpetration, and less dedication to the relationship (Allen, Rhoades, Stanley, & Markman, 2010; Hanley, Leifker, Blandon, & Marshall, 2013; Riggs, Byrne, Weathers, & Litz, 1998; Solomon, Dekel, & Zerach, 2008; Taft, Watkins, Stafford, Street, & Monson, 2011). Partners of individuals with PTSD are also more likely to report relationship distress, engage in negative communication, and experience more difficulty providing intimacy (Allen et al., 2010; Riggs et al., 1998). Because care and support from intimate partners strongly predicts recovery from psychopathology (Pierce, Sarason, & Sarason, 1996), these relationship problems may lead to difficulty maintaining the intimate bonds that are needed most to promote recovery (Kiecolt-Glaser & Newton, 2001; Pierce et al., 1996).

Intimacy (defined as feelings of mutual understanding, closeness, and affection) is a key component of close relationships

(Prager, 1995; Reis & Shaver, 1988). Intimate interactions are comprised of two types of behaviors: self-disclosure (i.e., sharing personal thoughts and feelings) and support provision (i.e., providing understanding, validation, or caring to one's partner; Cordova & Scott, 2001; Prager, 1995; Reis & Shaver, 1988). Each dimension of support provision functions to increase the depth of intimacy expressed. For example, understanding can be a prerequisite to providing validation (Reis & Shaver, 1988), validation may extend understanding to convey acceptance (Gottman, Markman, & Notarius, 1977), and caring, such as affectionate concern or expressions of love, represents an affective component of support provision (Mitchell et al., 2008). Additionally, one's provision versus receipt of intimacy differentially impacts the experience of intimacy (Mitchell et al., 2008).

Intimacy behaviors can occur during both positive and negative discussions (e.g., Maisel, Gable, & Strachman, 2008; Mitchell et al., 2008), and may be particularly important during negative discussions to deescalate conflict and contribute to long-term relationship satisfaction and stability (Gottman, Coan, Carrere, & Swanson, 1998). Regardless of the nature of the discussion, in many theories of intimacy, a positive emotional experience signifies a “successful” intimate exchange (Prager, 1995; Reis & Shaver, 1988). Indeed, perceived intimacy is associated with increased positive affect (Laurenceau, Troy, & Carver, 2005). Behavioral models of intimacy propose that experiencing positive emotions as a result of intimacy raises the reinforcement value of engaging

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in intimate behaviors, thereby increasing the likelihood of similar future behaviors and deepening the intimate connection (e.g., Cordova & Scott, 2001; Reis & Shaver, 1988). Because caring and self-disclosure may more strongly predict perceived intimacy during relationship problem discussions (Mitchell et al., 2008), these distinct aspects of intimacy may be most strongly associated with emotional responses to intimate behaviors.

As PTSD symptom severity negatively impacts the provision of intimacy (Hanley et al., 2013; Solomon et al., 2008), it may also negatively impact the degree to which intimacy increases the experience of positive emotions. In general, PTSD is associated with alexithymia (i.e., difficulty with labeling, awareness, and communication of emotional states; Frewen, Dozois, Neufeld, & Lanius, 2008) and deficits in emotion regulation (Tull, Barrett, McMillan, & Roemer, 2007). Compared to those without PTSD, individuals with PTSD experience fewer positive (and more negative) emotions when presented with standardized positive visual stimuli (Amdur, Larsen, & Liberzon, 2000) or when asked to imagine positive social events (Frewen et al., 2010). Compared to those without PTSD, individuals with PTSD also experience increased negative emotions, but no change in positive emotions, when viewing an amusing video (Orsillo, Batten, Plumb, Luterek, & Roessner, 2004). While these paradigms did not use personally relevant stimuli, it may be that individuals with elevated PTSD symptoms will experience blunted positive emotions in response to their partners' provision of intimacy, potentially explaining why they are less likely to reciprocally engage in intimacy (Hanley et al., 2013). The observed relation between PTSD and negative emotional reactivity to positive stimuli is not surprising given consistent findings of negative emotional reactivity to negative stimuli or uncertain situations (Amdur et al., 2000; Litz, Orsillo, Kaloupek, & Weathers, 2000) and that maladaptive posttraumatic cognitions (cf., Foa, Ehlers, Clark, Tolin, & Orsillo, 1999) bias cognitive and emotional responses to positive events (Frewen et al., 2010).

PTSD symptom severity is likely to be associated with negative emotional reactivity to the experience of intimacy, particularly during difficult relationship discussions. Yet, it is important to consider how intimacy impacts particular negative emotions (e.g., fear, sadness, guilt, anger). Functionalist perspectives on emotion highlight the role that emotions play in motivating one's own behavior (Frijda, 1988; Keltner & Gross, 1999). Certain emotions, such as fear, sadness, and guilt, often motivate withdrawal behaviors, while other emotions, such as anger, typically motivate approach behaviors (Frijda, 1988; Harmon-Jones & Allen, 1998). As PTSD severity is associated with providing less partner support (Hanley et al., 2013; Solomon et al., 2008), this may be partly a function of experiencing emotions that motivate withdrawal from difficult interactions. Further, because PTSD is associated with fear of intimacy (Cohen, Dekel, Solomon, & Lavie, 2003; Riggs et al., 1998), receipt of intimacy while discussing relationship issues may be associated with increased fear. In contrast, approach emotions, such as anger, are implicated in relationship problems (Taft, Street, Marshall, Dowdall, & Riggs, 2007); therefore, the experience of anger following intimacy may negatively impact the frequency of future intimate interactions. While different emotions may serve unique functions, we first need to know how individuals with PTSD respond emotionally to intimate interactions.

It is important to make a distinction between one's receipt of intimacy behaviors and one's provision of intimacy behaviors, as these may have unique associations with one's emotional response to intimacy. Little research exists examining how the emotions of individuals with PTSD change following engagement in particular behaviors. However, we know that engagement in feared behaviors decreases the experience of fear, potentially due to recognition of one's ability to engage in the feared behavior without negative consequences (Foa & Kozak, 1986). Therefore, because individuals

with elevated PTSD symptom severity tend to experience fear of receiving intimacy (Cohen et al., 2003; Riggs et al., 1998), we expect that their provision of intimacy, to the extent that they are able to do so, may be associated with a reduction in fear. That is, by initiating an intimate exchange, individuals will actively expose themselves to a feared situation, which may in turn reduce their fear. Such emotion change may generalize to other negative emotions (i.e., sadness, guilt, anger) as well.

Intimate relationships are clearly disrupted among individuals with PTSD. We previously found that elevated PTSD symptom severity was associated with reduced support provision to one's partner, particularly among men (Hanley et al., 2013). The current study extends these findings to consider whether emotional responses to intimacy are also disrupted among individuals with elevated PTSD symptom severity. In the first study to do so, we examine the extent to which individuals with elevated PTSD symptom severity experience a change in positive and negative emotions (i.e., happiness, anger, guilt, sadness, and fear) when they provide and receive intimacy during relationship discussions with their partners. We hypothesize that PTSD symptom severity and partners' provision of intimacy will interact such that, when receiving frequent and high quality intimacy, greater PTSD severity will be associated with relatively little increase in positive emotion (i.e., happiness) and increased negative emotions associated with withdrawal motivations (i.e., guilt, sadness, and particularly fear). In contrast, when providing frequent and high quality intimacy, greater PTSD severity will be associated with reduced negative emotions, particularly fear. We also examine the impact of specific components of the intimacy process and expect that provision and receipt of self-disclosure and caring behaviors will be most consistently associated with the hypothesized emotion changes.

1. Methods

1.1. Participants and procedures

Participants were recruited from local rural or semi-rural communities using materials targeting heterosexual married or cohabitating couples in which at least one partner had experienced a stressful life event. Interested couples contacted the lab and each partner was screened via telephone for probable PTSD using the PTSD Checklist-Civilian Version (PCL-C; Weathers, Litz, Herman, Huska, & Keane, 1993). Of the 198 couples that contacted the lab, 134 were excluded from participation because: (1) neither partner met criteria for probable PTSD (i.e., score > 44 on the PCL-C; $n = 122$ couples), (2) lack of interest ($n = 8$ couples), (3) partners' combined income exceeded \$100,000 per year and/or either partner had more than six years post-high school education ($n = 3$ couples), or (4) they ended their relationship ($n = 1$ couple). Income and education restrictions were used to screen out university faculty and post-docs, and produce a sample roughly representative of those served by rural outpatient mental health clinics.

Participants were 64 heterosexual couples (128 individuals) who had a mean age of 37.16 ($SD = 12.64$) years, an average individual monthly income of \$1733.00 ($SD = \1529.00), and an average of 14.31 ($SD = 2.31$) years of education. The majority (68.6%) were employed. Participants self-identified as Caucasian (85.9%), African-American (6.3%), biracial/multiracial (3.9%), or Hispanic/Latino (3.9%). Couples had been together for an average of 11 years and 11 months ($SD = 11$ years, 10 months; range = 4 months–45 years), and most were married (72%; for the sake of brevity, partners will be referred to here as husbands and wives). Among 48 couples, one partner met full or subthreshold DSM-IV PTSD diagnostic criteria, while neither partner met such criteria in 8 couples and both partners met such criteria in another 8 couples.

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