

PRACTICE BRIEFS



Counseling Couples with a Trauma History

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ABSTRACT: Trauma in couples may be misread as an individual problem or a relationship problem, when sometimes it may be both. Treating trauma among couples requires flexibility and a systemic perspective to appropriately navigate individual and couple-specific needs simultaneously. This brief presents guidance on trauma in relationships, assessment considerations, determining what level of intervention is most appropriate, and cultural and ethical considerations for working with couples with trauma.

Introduction

The concept of trauma encompasses both exposure to potentially traumatic events and the psychological, relational, and behavioral responses that may follow. From a counseling perspective, a traumatic event may be understood as an event that has the potential to severely challenge an individual's or community's ability to adapt, requiring substantial changes to ways of living or thinking (Brewin et al., 2025). Importantly, exposure to a traumatic event does not necessarily result in psychopathology. Individuals may experience strong emotional or behavioral reactions that are transient, adaptive, or associated with outcomes other than posttraumatic stress disorder (PTSD), including depression or prolonged grief (Brewin et al., 2025). Thus, trauma exposure and PTSD should not be treated as synonymous.

The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; *DSM-5-TR*; American Psychiatric Association [APA], 2022) provides a more specific definition of trauma exposure within the diagnostic criteria for PTSD. For PTSD, Criterion A requires direct exposure to actual or threatened death, serious injury, or sexual violence in one or more of the following ways: witnessing traumatic events; learning that traumatic events occurred to close others; directly experiencing the traumatic event; or repeated exposure to aversive details of traumatic experiences (APA). Thus, although the *DSM-5-TR* criteria provide an important framework for identifying PTSD, the present brief uses the broader term *trauma history* to refer to prior exposure to potentially traumatic events and associated trauma-related responses, regardless of whether an individual meets full diagnostic criteria for PTSD. Trauma-related symptoms such as hypervigilance, emotional numbing, avoidance, irritability, impairment in relationship functioning, and long-term outcomes associated with trauma may significantly affect intimate relationship satisfaction (APA, 2022; Brewin et al., 2015; Campbell & Renshaw, 2018). Trauma exposure may occur before or during the relationship, individually, and collectively as a dyad (APA, 2022; Charbonneau-Lefebvre et al., 2026).

When individuals impacted by trauma bring prior traumatic experiences into their intimate relationships, this influences how partners perceive the relationship, respond to conflict, communicate, and navigate needs within the relationship (Campbell & Renshaw, 2018; Charbonneau-Lefebvre et al., 2026). Research often refers to couples in which both partners have a history of trauma exposure and present with trauma-related symptoms as dual-trauma couples (DTCs; Braughton et al., 2022;

Charbonneau-Lefebvre et al., 2026). Couples who experience shared or collective traumatic events within the relationship itself, such as the sudden or traumatic death of a child or loved one, pregnancy loss, traumatic childbirth, neonatal medical crisis, or surviving a serious motor vehicle accident together, may experience significant disruptions in relational functioning, potentially contributing to concurrent trauma symptoms or PTSD among both partners (Collazo, 2021).

Recent literature has increasingly conceptualized trauma as both an individual and relational phenomenon, emphasizing how trauma-related symptoms may affect couples counseling (Braughton et al., 2022; Campbell & Renshaw, 2018). For example, Smedley and Goff (2025) illuminated the bidirectional nature of trauma transmission between trauma-surviving partners, non-trauma-surviving partners, and overall couple functioning. They found that secondary traumatic stress (e.g., trauma reactions experienced by a non-trauma-surviving partner) has a moderate to large effect on relationship functioning (Smedley & Goff, 2025). As such, counselors must evaluate individual trauma symptoms, relational functioning, and safety to determine the appropriateness of conjoint treatment and select relevant interventions for couples in which one or both partners have trauma histories. Counselors should also use care when discussing traumatic experiences in conjoint sessions, particularly when one partner has not previously disclosed a traumatic event to the other, to avoid inadvertently exposing a partner to traumatic information without adequate preparation and consideration of safety.

Assessment Strategies

Trauma-informed couples counseling requires counselors to determine whether conjoint work is appropriate and tailor interventions to address individual symptoms or problems within the couple relationship. Interventions should be guided by assessment findings, including risk factors, coping patterns, and relational dynamics. First, counselors should carefully evaluate the appropriateness of couples' therapy by assessing the reciprocal effects of PTSD symptoms, emotional reactivity, and each partner's ability to remain emotionally present and responsive within the relationship. When trauma-related symptoms such as emotional dysregulation, avoidance, or hyperarousal significantly interfere with communication and emotional intimacy, individual trauma-focused treatment may be more appropriate initially before engaging in conjoint therapy (Charbonneau-Lefebvre et al., 2026).

Assessment should also include evaluation of intimate partner violence (IPV), which may involve physical, verbal, emotional, psychological, sexual, and/or coercive behaviors used by one partner to harm, intimidate, or exert control over another partner within an intimate relationship (Craven et al., 2023). Importantly, not all relationship conflict constitutes bidirectional violence, and counselors should differentiate between situational couple violence (SCV; Hines & Douglas, 2018) and power and control-related IPV (Craven et al., 2023). Keilholtz and Spencer (2022) emphasized that couples therapy is generally contraindicated in cases of intimate terrorism, a form of IPV in which one partner uses violence, intimidation, coercion, and control to establish power over the other partner, while also recognizing that certain forms of SCV may warrant carefully assessed conjoint treatment approaches when appropriate safety conditions are present. Brief screening measures may assist counselors in identifying potential IPV and determining when further assessment of safety and relationship dynamics is warranted. For couples counseling, the Intimate Justice Scale (IJS; Jory, 2004) may be useful for screening psychological abuse, physical violence, and relational dynamics associated with partner abuse. The Hurt, Insult, Threaten, and Scream (HITS) scale, which is a four-question scale (Sherin et al., 1998), is another brief screening measure that counselors may consider when assessing IPV and determining when further assessment of safety and relationship dynamics is warranted.

Individual assessments for trauma symptoms can include the PTSD Checklist 5 (PCL-5; Weathers et al., 2013), the Trauma Symptom Inventory-2 (Briere, 2011), or the Impact of Event Scale-Revised (IES-R; Weiss & Marmar, 1997). The IES-R is a brief, event-specific measure of posttraumatic distress that has demonstrated utility across diverse cultural contexts. Counselors should also assess sociocultural and systemic sources of trauma, including experiences of racism, discrimination, community violence,

and other forms of collective or systemic adversity, recognizing that these experiences may not be fully captured by standardized trauma measures. Secondary traumatic stress screeners for non-trauma-surviving partners might include the Modified Secondary Trauma Questionnaire (Motta et al., 2001) and Secondary Traumatic Stress Scale (Bride et al., 2004). Assessments for risk or protective factors may include the Childhood Trauma Questionnaire (Bernstein & Fink, 1997) and the Adverse Childhood Experiences Study Questionnaire (Felitti et al., 1998). Additionally, common measures of relationship functioning, such as the Revised Dyadic Adjustment Scale (Busby et al., 1995), can be used to assess relationship quality and differentiate between distressed and non-distressed couples.

Treatment Approaches

Trauma-informed couples counseling may support emotional safety, co-regulation, collaborative coping, and relational resilience among couples impacted by trauma (National Child Traumatic Stress Network, n.d.). Despite experiencing significant emotional and relational challenges, DTCs have demonstrated strengths, including shared goals, psychological flexibility, mutual understanding, supportive communication, and collaborative meaning-making processes that foster resilience within the relationship (Charbonneau-Lefebvre et al., 2026). For example, Henry et al. (2024) found that although greater PTSD symptom severity among emergency medical service workers was associated with increased PTSD symptomology among their partners, relationship satisfaction was not significantly impacted, suggesting that some couples may maintain relational satisfaction and continue to be supportive of each other despite trauma-related distress.

Approaches that focus on couples affected by trauma include emotionally focused couples therapy (EFCT; Johnson, 2002) and integrative behavioral couples therapy (IBCT; Christensen et al., 2020). Although these approaches were not specifically developed for DTCs, their emphasis on attachment, emotional responsiveness, acceptance, communication, and relationship functioning may offer clinically relevant components that can be adapted when working with couples affected by trauma. However, this brief focuses on the Couple Adaptation to Traumatic Stress model (CATS; Goff & Smith, 2005; Smedley & Goff, 2025) as a conceptual framework for understanding how trauma may affect both partners and the couple system, and cognitive-behavioral conjoint therapy (CBCT; Monson & Fredman, 2012) as a structured trauma-focused intervention that addresses PTSD symptoms within the context of the relationship.

The CATS model (Goff & Smith, 2005; Smedley & Goff, 2025) is predicated on the idea that trauma can have systemic effects within the couple dyad, whereby a partner may internalize the experiences and symptoms of the primary trauma survivor and develop secondary traumatic stress symptoms. The CATS model is useful for understanding where and how symptoms may be perpetuated within couples and identifies three key areas of intervention: (a) individual-level functioning, (b) individual predisposing factors and resources, and (c) couple functioning. In this model, individual-level functioning is comprised of symptoms that would meet criteria for a trauma and stressor-related diagnosis. The model also considers each partner's unique predisposing factors (i.e., risk and protective factors) and resources (e.g., coping skills or external supports) that influence how trauma affects individual functioning and/or the dyad. Lastly, couple functioning includes dynamics between partners, such as attachment, support and nurturance, intimacy, communication, and conflict resolution (Smedley & Goff, 2025).

In DTCs, the CATS model highlights the importance of considering both partners' trauma experiences rather than conceptualizing trauma solely as an individual problem. Counseling interventions that do not consider both partners' trauma experiences may unintentionally exacerbate individual and systemic concerns (Liebman et al., 2020). A treatment approach such as CBCT provides one structured intervention that can be used to address individual trauma symptoms while simultaneously targeting systemic relational problems. CBCT utilizes a manualized three-phase approach that addresses

1. misinformation about trauma and its impact on relational functioning,
2. communication skills training and reduction of avoidance behaviors, and
3. cognitive restructuring to change unhelpful thinking patterns perpetuating trauma responses and relationship dysfunction (Monson & Fredman, 2012).

Thus, CATS and CBCT serve complementary purposes within this brief: CATS provides a systemic framework for conceptualizing trauma within the couple, whereas CBCT is a cost-effective treatment option that can be completed in as few as 15 sessions to address trauma-related symptoms and relationship functioning. A systematic review by Liebman and colleagues (2020) found that CBCT was highly effective for couples in reducing PTSD, depression, and anxiety and improved relationship satisfaction regardless of whether couples were distressed or in conflict before beginning treatment.

Cultural and Ethical Considerations

To provide high-quality care when working with couples experiencing trauma, counselors should consider systemic factors that may impact trauma presentation (Standards A.1.a. and A.2.c.; American Counseling Association [ACA], 2014.). Trauma responses may be influenced by racial dynamics, sociopolitical stressors, gender socialization, or even occupation-specific expectations. Complex racial trauma (CRT; Cénat, 2023) is the individual, social, and institutional experience of systematic racism for Black, Indigenous, and people of color (BIPOC). CRT inherently shapes how BIPOC individuals navigate relationships and help-seeking and increases the risk for other mental and physical health concerns. Consequently, counselors must ensure services provide opportunities for foundational elements such as acknowledging the reality of racism, safety, disputing self-blame/internalized racism, and expressing grief or anger that can fuel resistance and empowerment (Cénat, 2023). These opportunities are essential to avoid harm when processing deeply painful traumatic experiences (Standard A.4.a.; ACA, 2014).

Counselors should also incorporate culturally responsive approaches such as the Healing Ethno-Racial Trauma framework (Cénat, 2023). Similarly, counselors should be mindful of the broader sociopolitical and historical dynamics that limit safety and access to affirming care, such as anti-gay and anti-trans laws that create systematic interpersonal trauma for LGBTQIA+ clients (Lampe & Sumerau, 2025). Counselors can assist LGBTQIA+ clients in reclaiming their self-definitions and developing supportive, affirming social networks. These strategies support resilience without reliance on counseling services and improve mental health when services may be inaccessible or unavailable (Lampe & Sumerau, 2025). This is consistent with the professional values of beneficence and autonomy and reduces overreliance on counselors for personal well-being (ACA, 2014).

Occupation-specific dynamics may also be important to consider. For example, stigma, fear of job-related consequences, and use of dark humor may be common among first responders, military populations, and healthcare workers. Counselors should prioritize confidentiality and minimal disclosure (Standards B.1.c. and B.2.e.; ACA, 2014) and expect a wide range of reactions that may be a function of culture-bound expression rather than pathology (Standard E.5.a.; ACA, 2014; Smedley & Goff, 2025). Counselors should also consider how age, gender identity, and the intersection of these identities may influence beliefs about gender roles, intimacy, help-seeking, and trauma responses. Older adults and individuals from cultural contexts with different understandings of gender and relational roles may hold perspectives that influence how trauma is expressed, understood, and addressed in counseling. Additionally, counselors should be open-minded about what healthy intimacy, communication, and support look like in a wide variety of relationships, such as among LGBTQIA+ partners, nonmonogamous or polyamorous partners, intercultural couples, or individuals with disabilities.

Conclusion

Couples counseling is highly indicated for the treatment of trauma-related concerns due to the bidirectional transmission and exacerbation of symptoms. If an individual goes untreated, this could prolong and complicate treatment for trauma survivors and their loved ones. However, in cases of significant

distress, IPV, or where partners are unable to engage emotionally in treatment, individual-level treatment may be indicated first. Assessment of trauma symptoms, individual functioning, and risk and protective factors of all partners and relational functioning will be key to guide treatment interventions. Treatment should prioritize the domain that maintains trauma symptoms the most and implement interventions appropriate to that domain. Lastly, counselors should be mindful that trauma expression is diverse, and not all couples will cope similarly. Incorporating individually and systematically meaningful interventions will be culturally responsive and ensure clients receive high-quality care.

Resources

- [Adult Trauma Assessments](#), The International Society for Traumatic Stress Studies
- [Cognitive-Behavioral Conjoint Therapy for PTSD](#), U.S. Department of Veterans Affairs
- [Emotionally Focused Therapy for Couples](#), International Centre for Excellence in Emotionally Focused Therapy
- [Families and Trauma](#), The National Child Traumatic Stress Network
- [PTSD and the Family](#), U.S. Department of Veterans Affairs
- [Treatment Improvement Protocol 57: Trauma-Informed Care in Behavioral Health Services](#), Substance Abuse and Mental Health Services Administration

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