AAMFT Journal of Marital & Family Therapy

Journal of Marital and Family Therapy
doi: 10.1111/j.1752-0606.2010.00203.x
July 2011, Vol. 37, No. 3, 319–332

TRAUMA AND COUPLES: MECHANISMS IN DYADIC FUNCTIONING

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Research traditionally has focused on the development of symptoms in those who experienced trauma directly but overlooked the impact of trauma on the families of victims. In recent years, researchers and clinicians have begun to examine how individual exposure to traumatic events affects the spouses/partners, children, and professional helpers of trauma survivors. The current study reports data from a larger mixed-methodology study that includes qualitative interview data from 17 individuals, coded to identify the mechanisms that may affect the couple's interpersonal functioning when there is a history of trauma exposure in one or both partners. The following primary themes were identified: role in the relationship, boundary issues, intimacy problems, triggers, and coping mechanisms. Areas for future research and clinical implications also are identified.

The Systemic Impact of Trauma

Traumatic events have received much clinical and empirical focus in the past 25 years. Although traumatic experiences have been survived by people for centuries, scientific knowledge of trauma has increased in recent history. Much of the literature on trauma and posttraumatic stress focuses on the individual effects of trauma on the primary victim—the person who directly experienced the traumatic event (Herman, 1997; van der Kolk, McFarlane, & Weisaeth, 1996). The predominant focus in the trauma literature has been on the treatment of posttraumatic stress disorder (PTSD; American Psychiatric Association [APA], 2000), a disorder that by definition focuses on the intrapersonal effects of traumatic events on the individual trauma survivor.

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

The theory of secondary traumatic stress contends that being in close contact with and emotionally connected to a traumatized person becomes a chronic stressor, and family members often experience symptoms of traumatization (Arzi, Solomon, & Dekel, 2000; Figley, 1983, 1995; McCann & Pearlman, 1990; Solomon, Waysman, Levy, et al., 1992). The basic premise

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behind secondary trauma theory is that individual stress symptoms are communicable, and those who are close to the trauma survivor can be ''infected'' with the trauma symptoms (Catherall, 1992; Figley, 1995). Often the problems experienced by people close to a trauma survivor ''mimic'' (Coughlan & Parkin, 1987) the trauma symptoms in the survivor. This may result from an internalization process, where family members identify so closely with the experiences of the victim that they begin to internalize the trauma symptoms of the victim and experience their own stress reactions (Maloney, 1988). These effects are considered ''secondary'' because they occur in those who have not been directly traumatized by the event. Frequently, these effects may resemble PTSD symptoms (Bramsen, van der Ploeg, & Twisk, 2002; Nelson & Wright, 1996) but may be less intense (Maltas & Shay, 1995).

Several authors have described the secondary effects traumatic events have on children (Barnes, 1998; Nelson Goff & Schwerdtfeger, 2004; Steinberg, 1998), spouses and partners (Arzi et al., 2000; Bramsen et al., 2002; Lev-Wiesel & Amir, 2001; McCann & Pearlman, 1990; Nelson & Wampler, 2000; Nelson, Wangsgaard, Yorgason, Higgins Kessler, & Carter-Vassol, 2002; Nelson & Wright, 1996; Remer, 2004), therapists (Figley, 2002; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995), emergency and medical professionals (McCammon & Allison, 1995), direct and indirect witnesses (Weingarten, 2003, 2004), and others who work and interact with trauma survivors on a personal level. A drawback to the secondary traumatization hypothesis is that there is limited empirical support for the theory. Much of the literature on secondary traumatization gives brief mention of this concept, citing clinical support (Figley, 1983, 1989; McCann & Pearlman, 1990; Miller & Sutherland, 1999; Nelson & Wright, 1996).

Secondary Traumatic Stress in Couples

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

Research conducted by Nelson and Wampler (2000) reported that clinic couples with an abuse history reported lower marital satisfaction and higher individual distress symptoms for both partners than those couples in which neither partner reported an abuse history. However, further research conducted by Nelson (1999) addressed the impact of traumatic experiences on dyadic relationships by comparing individual symptoms and relationship impairment measures between three clinical groups: veteran couples, childhood sexual abuse survivor couples, and a control group of couples. Although the results indicated differences between groups on individual stress and trauma symptoms, no significant difference in relationship impairment between the groups was found, indicating mixed support for secondary trauma theory, particularly the negative effects of trauma on the couple relationship.

Qualitative research and clinical literature. In addition to the quantitative research described previously, only a few qualitative studies are available in the literature on the systemic effects of trauma in couples. The published literature that is available focuses predominately on the partners of Vietnam veterans (Maloney, 1988; Verbosky & Ryan, 1988) or childhood sexual abuse survivors (Reid, Wampler, & Taylor, 1996; Wiersma, 2003). This research describes the individual or secondary effects on the partners of trauma survivors, rather than a description of the interpersonal patterns or mechanisms that may occur between partners. Nelson et al. (2002) and Nelson Goff and Smith (2005) provided a clinically based

framework (2002) and theoretical model (2005) to describe the interpersonal patterns that may be characteristic of trauma couples; however, these models, although based on empirical literature, have not been empirically supported.

There are several limitations currently in the literature on the systemic effects of trauma in couples. First, although some of the literature reviewed here indicates support for secondary trauma in partners of trauma survivors, the results are mixed. Second, current literature has not identified the specific systemic effects of trauma on interpersonal or relationship functioning in couples; thus, more empirical description of the mechanisms of trauma in couples is needed. Finally, most of the research in the trauma field includes participants with homogeneous trauma histories (e.g., all participants experienced childhood sexual abuse or war trauma), yet clinical descriptions (i.e., PTSD symptoms described in the *DSM-IV-TR*; APA, 2000) identify similarities across survivors of different types of traumas in terms of individual symptomatology. Thus, much of the current research does not include a broad description of the systemic effects of trauma comparing participants with diverse trauma experiences. The current study attempts to address these limitations in the field by providing an empirical description of the systemic and relationship mechanisms of trauma exposure and traumatic stress symptoms in couples.

METHODOLOGY

Qualitative Theory and Research Design

We used a mixed-methodology research design, which included quantitative questionnaires identifying posttraumatic stress symptomatology in both partners and quality of the current marital/couple relationship. The data collection, qualitative interviews, and data analysis were conducted using a team-based approach. The research team consisted of the faculty primary investigator (PI), the primary qualitative methodologist (QM), doctoral and master's-level graduate students, and undergraduate students who were members of the *Trauma Research, Education, and Consultation at Kansas State University* (*TRECK*) *Team*. The study reported here is part of a larger study of trauma in couples conducted by the TRECK Team, which included three separate primary research questions. In the current study, only data from Research Question #3 are reported: *In what ways do trauma survivors and their partners describe the impact of previous trauma exposure on themselves, their partner, and the dyadic relationship? What mechanisms or moderating factors related to trauma exposure affect the couple system and functioning of the dyad?* The other research questions focused on primary and secondary trauma symptoms in both partners (Research Question #1; Schwerdtfeger et al., 2008) and the couple's interpersonal functioning (interpersonal/systemic secondary traumatic stress symptoms; Research Question #2; Nelson Goff et al., 2006).

We chose to use a broad definition of "traumatic events" for the study in order to collect data on a variety of traumatic experiences and to not limit the type of data that were included. Although participants were recruited as couples, because of the sensitive nature of the topic and the possibility that partners might choose not to disclose information with their spouse/partner present, the PI or graduate student members of the research team interviewed each partner separately. Each interview was audiotaped and transcribed verbatim by the undergraduate research assistants. The open-ended, semi-structured qualitative interviews consisted of 30 questions and focused on the long-term interpersonal impact of trauma on the couple relationship (e.g., *How is your relationship most affected by your past trauma experiences or your partner's past trauma experiences?*), intrapersonal effects of trauma exposure on both partners (e.g., *Has your partner ever experienced any traumatic events? How is your partner most affected by his or her past trauma experiences? How are you most affected by your partner's trauma?*), and current dyadic functioning (e.g., *How would you rate your ability to talk to your partner about the events that happened in your past?*). (The corresponding author may be contacted to request more specific information about the procedure and the specific qualitative questions used in the study.) The research procedure was approved by the University Institutional Review Board.

The purpose of the current study was to understand the lived experience of couples in which one or both partners have directly experienced a traumatic event. Therefore, a phenomenological perspective was employed. Following the completion of the interviews, a continuous

cycle of inductive and deductive qualitative data analysis, referred to as retroduction (Burr, 1973), was utilized. By allowing researchers to use preexisting theory to guide the view of real-world experiences, the use of a retroduction approach has been identified as a vital process to theory building and theory testing (Burr, 1973). While qualitative research is often inductive in nature, with analysis being data driven, it also is common for analysis to include elements of deduction, in which analysis is theory driven and data are analyzed according to an established framework (Patton, 2002). Considering the available literature on secondary traumatic stress theory, a retroductive analysis was deemed most appropriate for the current study. This method allowed for the use of secondary trauma theory as a basic framework from which to begin data analysis while offering flexibility for new themes to emerge.

ANALYTIC STRATEGY

The faculty PI and the QM (a doctoral student) initially identified appropriate methodology for the analysis of the qualitative data. The PI and the QM reviewed the qualitative interview questions, which had been developed by a previous research team under the direction of the PI. Next, the PI reviewed the available literature on the effects of trauma and posttraumatic stress on individuals (primary traumatic stress), their partners (secondary traumatic stress), and the relationship (interpersonal/systemic traumatic stress). This literature included both empirical research and clinical descriptions of trauma in couples. To address the need for convergence, the process of determining what variables, or "themes," fit together (Patton, 2002), the PI identified the primary themes from the literature, resulting in 33 total themes, and grouped them into three lists, according to each of the three primary research questions of the larger study.

After the initial grouping of themes was completed, the PI and QM organized the themes and evaluated their placement according to internal homogeneity and external heterogeneity. These two criteria ensure that the themes in each of the three lists adhere in a meaningful way and also that the differences between lists are clear, respectively (Patton, 2002). For purposes of external heterogeneity, the PI assigned the initial themes to only one research question as a way to reduce potential overlap between research questions. For internal homogeneity, the PI and QM both independently assigned the themes to the questions and then analyzed the lists based on both criteria. The PI and QM utilized a method of triangulation and found only seven disagreements in reference to which research question each theme belonged. The researchers then discussed the differences in coding and agreed on the categorization of all themes according to the three research questions. The QM developed a coding scheme of the identified themes for each of the three research questions, which consisted of a list of all of the themes belonging within each research question, and a shorthand "code," or abbreviation, to be used by the research team in analyzing the transcripts.

In the current study, all members of the TRECK Team were involved in the data analysis. Once the initial themes were identified, the team members were then placed into one of three separate research groups (RG), based on the three research questions. For the larger study, the PI, QM, graduate students, and undergraduate students were distributed across groups, with an even distribution of experience level, ethnicity, and gender. Each group consisted of two to three graduate students and one to two undergraduate students. Each interview transcript was individually coded and analyzed by the RGs.

Each TRECK Team member independently performed a content analysis on each of the 17 interviews, based on the coding scheme for their assigned RG question. Coding consisted of matching the content of the interviews with the identified themes for each research question. In order to reduce potential bias, group members alternated reading the male and female transcripts (i.e., one person read a male transcript first, then a female transcript, with a second group member reading a female transcript first and then a male transcript) and were not informed of the demographic or quantitative data of the participants. The groups then triangulated their individual content analyses by negotiating the coding of each transcript. Once group consensus was reached regarding the coding of each transcript, each group submitted a "master" coded transcript to the QM. The groups also revised their initial coding scheme based on any new themes that emerged from the data.

Each of the identified themes and the corresponding data, identified by group consensus on the master transcript, were then entered by the QM into NUD*IST Version N6 (Richards & Richards, 2002), a software program designed for qualitative research, for purposes of data organization only. Each RG checked the input into N6 for accuracy. In the final stage of the research analysis, the RGs then read the N6 reports, consisting of the selected data from the transcripts that were organized according to the identified themes, for each individual research question in order to assess the substantive significance of the themes. Substantive significance is the method by which qualitative findings are evaluated for scientific merit, similar to that of statistical significance for quantitative data (Patton, 2002). To conclude the analysis, the group identified the strongest of the themes, based upon breadth and depth, and identified quotes that particularly captured the essence of each theme to serve as theme exemplars (Patton, 2002). Thus, substantive significance was determined through the use of several methods of triangulation (e.g., multiple coders and team consensus) and through consensual validation by all team members.

In the current study, the researchers identified 22 variables for Research Question #3 (e.g., roles, coping mechanisms, triggers), determined through descriptions given by both the trauma survivors and their partners of the impact of the trauma experience on themselves, their partners, and the dyadic relationship. The final themes described here consisted of the five most frequently identified and most salient themes, based on individual member coding and RG consensus.

Participant Characteristics

Participant couples were recruited through a university-based counseling center in the Midwest. The couples, who were receiving therapy services at the center, received one free therapy session for their participation in the research. All participants were at least 18 years of age and reported they had been in a committed relationship (dating, married, cohabiting) for at least 1 year. After completing the informed consent forms, the participants completed quantitative questionnaires and semi-structured qualitative interviews.

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

The total sample included nine males and nine females. The age range for the participants was 21–52 ($M = 34.89$, $SD = 10.20$), with 7.37 years as the average length of their relationship ($SD = 9.13$; range = 1 month to 23 years; 1 month was the length of marriage for couples who had been together as a couple longer, but recently had been married). Seven of the nine couples were currently married, one couple was dating, and one couple was separated. Except for one male participant (Asian or Pacific Islander) and one female participant (American Indian or Alaskan Native), all other participants were European American. Eleven of the 18 participants (61%) were employed full-time, with 10 of the 18 (56%) reporting an annual income under $40,000.

The quantitative instruments for this study included the Traumatic Events Questionnaire (TEQ; Vrana & Lauterbach, 1994), Purdue Post-Traumatic Stress Disorder Scale-Revised (PPTSD-R; Lauterbach & Vrana, 1996), Trauma Symptom Checklist-40 (TSC; Briere, 1996), and Dyadic Adjustment Scale (DAS; Spanier, 1976).

Male participants reported an average number of traumatic events (based on TEQ total scores) at 3.33 ($SD = 2.24$), while female participants reported an average of 3.00 traumatic events in their lifetime ($SD = 1.41$). However, females reported higher trauma symptom scores (PPTSD-R: $M = 47.22$, $SD = 18.91$; TSC: $M = 33.56$, $SD = 18.26$) than males (PPTSD-R: $M = 30.98$, $SD = 15.31$; TSC: $M = 26.00$, $SD = 19.93$). Finally, DAS scores were comparable between male ($M = 107.13$, $SD = 19.10$) and female ($M = 103.66$, $SD = 20.84$) participants.

As mentioned previously, participants were not limited by type of previous traumatic events; however, each participant was asked to identify their primary or most traumatic experience for the quantitative and qualitative questions. The range of traumatic events reported by participants is presented in Figure 1.

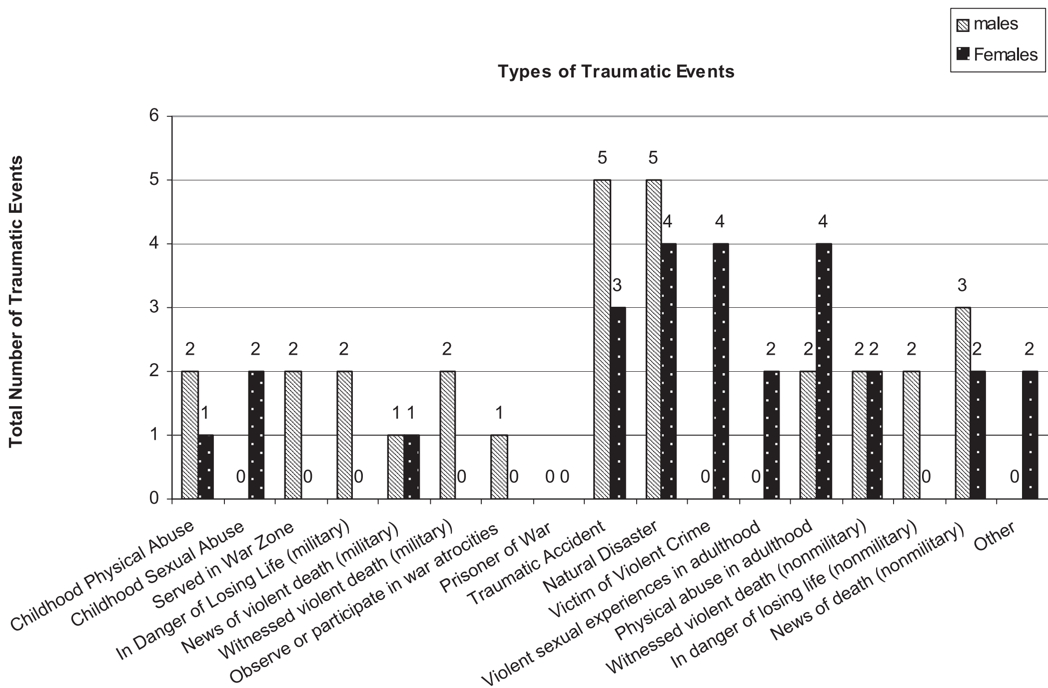

Figure 1. Types of traumatic events reported by participants.

RESULTS

Qualitative Interview Results

The qualitative data analysis resulted in five primary categories, including *role in the relationship, boundary issues, intimacy problems, triggers,* and *coping mechanisms.* These categories and corresponding themes will be described below, including supporting quotes and participant number (e.g., 1M = Couple #1, male partner; 4F = Couple #4, female partner).

Role in the Relationship

Boss (1983, 1999) asserted that in order for couples to function effectively within the family system, they must communicate clearly with one another and understand the nature of their roles. "One of the barriers to effective marital communication is confusion or uncertainty about any of these roles or relationships" (Boss, 1983, p. 28). For the current study, we defined "role" as the place or position the person holds in the relationship. Two themes were identified within this primary category: *support role* and *instrumental role*.

Support role. The most frequent categorical theme, *support role*, was expressed by 11 of the 17 participants. Participants reported receiving support from their partner and/or being supportive of their partner in regard to issues directly related to the past trauma experience. *Support role* was expressed in several ways, such as being patient with their partner. Participant 1M stated: "*You just have to have a lot of patience and you have to understand what they went through*." *Support role* was illustrated when Participant 1F gave a statement of needing help: "*I mean it's one thing to go to therapy, and [it's] another thing to have someone who really helps you*." Listening and communication were common methods of support received by trauma survivors from their partners. An example of listening was described by Participant 1F: "*He's really supportive and listening, or he listens and I don't tell people stuff like that*." Participant 9M stated: "*She'll talk me through problems*." When Participant 8F was asked how her partner supported her, she reported:

> If I get freaked out he knows and he's just there for me. He's very understanding and he realizes that that's just who I am, and that's just the way it is. And so he's there emotionally and physically for me when I need him.

Instrumental role. The *instrumental role*, described as taking specific actions in the relationship to address issues related to the traumatic experience, was also a key theme. Several participants (n = 10) indicated some type of action taken by their partner in relation to dealing with the trauma. Some couples experienced a change in the instrumental role, such as one partner taking on more responsibilities after the trauma experience or after becoming more aware of the trauma experiences of their partner. Participant 5M described his relationship as a "*partnership*" and his role as a "*caretaker*" and "*provider*." Another example of the *instrumental role* was described by Participant 10M when asked how his wife helped him recover from his past experience: *"She helps, like with finances and everything. It's more of a 50/50 instead of a—in the past, you know, I would do it all and [previous partner] wouldn't do any of it."*

Participants also viewed themselves or others as having an instrumental role in the relationship by protecting the relationship and/or family. This manifested in several ways, such as "*self-preservation*" (3F) and "*being watchful*" (6F).

Roles were utilized to define the family system; however, each subtheme of roles in the relationship was created in response to previous traumatic events. The various roles in the relationship are often maintained by the establishment of boundaries within the couple system. Boundaries, in the context of a family system, are developed to effectively survive and interact with the various roles within that system.

Boundary Issues

The theme of *boundary issues* emerged from 14 participants' responses. Boundaries define the family system and subsystems within the family. More specifically, they provide a framework for the development of rules, patterns of interaction, and roles within the system (Minuchin & Fishman, 1981). Four themes related to boundary issues emerged from the qualitative data: *pursuer-distancer patterns, power and control, testing the relationship,* and *avoidance*.

Pursuer-distancer patterns. Some participants (n = 7) described *pursuer-distancer patterns* in their relationship. Participants explained utilizing these patterns as a form of boundaries to engage (pursue) relationally or disengage (distance) themselves from their partner (Nelson et al., 2002). The more one partner pursued verbally or nonverbally, the more the other partner distanced himself or herself. This illustrated the survivor's method of implementing relational boundaries as a means of coping with past traumatic experiences. As Participant 1F stated: "*He doesn't like to talk about it. So I kind of have to keep prodding to get stuff out of him.*"

Descriptions from the participants in the current study revealed two patterns related to past trauma experiences: (a) being drawn closer to their partner, or (b) growing more distant from their partner. These two patterns appeared to result from the emotional burden placed upon the couple relationship due to past trauma experiences of one or both partners. Participant 5M shared how a traumatic experience brought the couple closer in their relationship: "*My wife and I have come closer together . . . and communicate more openly about things. And I think that's been positive.*" For many primary trauma survivors, distancing themselves serves as a way to protect themselves from emotional pain, as evidenced by Participant 9M, who described how his interactions with his current partner are most affected by his past trauma experiences:

> Probably with my defensiveness. I think [that] is one of the big ones. And then, the other big one is the fact that I close myself off, which is the terminology that you used. I was using "distancing myself," but closing myself emotionally from our situations or from topics that get heated.

Participant 10M explained a similar pattern of interaction in his partner relationship due to his partner's previous trauma experience:

> She doesn't show her emotions very often. 'Cause she was always told to keep 'em in and just deal with the problem, so it's taken her a long time just to start showing some [emotions]. When I first met her she, she really didn't show emotions that much.

Power and control. Issues of *power and control* emerged in the form of relationship boundaries for trauma survivors and their partners (n = 5). Literature suggests that trauma survivors

often feel a loss of power and control in some aspects of their lives, which may be depicted in relational boundaries as an attempt to regain power and control (Pearlman & Saakvitne, 1995). Participants described the issues of power and control as a means of relationship security. As Participant 1F stated:

> I think that sometimes, like he lets me boss him around. I don't do it on purpose. I really don't, I just, I think since everything happened I just, I have to be in—I'm a control freak. You know? Like I have to be in control all the time.

Participant 9M expressed how a past traumatic event affects his partner in their current relationship:

> I think, um, she wants to control . . . everything now 'cause she had so little power and what he was doing to her. He left and she couldn't control that. He would hold her down and choke her, she couldn't control that. He would tell her how fat and ugly she was and she couldn't control that. And so, she's, she's so over, overpowering sometimes when it comes to just wanting control over little things. And I really don't have any opinion about it, but that's completely wrong because she wants our opinions to be the same, and she wants to have control over that opinion. That's probably the way it's affected her the most.

Testing the relationship. Primary and secondary trauma survivors referred to *testing* their partner to obtain reassurance that their partner would not end the relationship. Although only two participants described this subcategory, the term *test* was actually used by the participants when describing the boundaries of their relationship. Participant 2F expressed how she believed her partner tests her in the relationship, due to his insecurities in past relationships and childhood trauma: "*I think he tests our relationship to make sure that I'm not gonna abandon him. I really think that's the bottom line*." Participant 9M described how his partner's past trauma affects him:

> I have to be really careful . . . with things that I do or say. I feel like I'm walking on eggshells a lot of the time. I felt like a lot of things are tests, like if we go shopping and she says, "Do you like those curtains?" That's not a casual question. I need to really think about my answer and gauge what she's feeling before I answer that, 'cause that could very well spark a huge argument depending on my answer. So, it keeps me on my toes a lot, it makes me a little anxious about certain situations.

Avoidance. The theme of *avoidance* emerged from the data of nine participants, defined as ignoring or blocking an issue in the relationship, which serves as a boundary for the relational system. Participants discussed avoiding particular issues by pretending that the issues did not exist or impact their lives or relationship:

> I thought, "Would I stand up to him more if I hadn't been hit [in a previous relationship]?" 'Cause I'm sure a lot of it—I just am very complacent with him because I don't want to get into a conflict. (2F)

Participant 3M described avoiding issues by focusing their attention elsewhere:

> I'm sure it had some impact for the fact because it was easier to push our problems. . . . She would always say, "Well, I've got too much other stress, I don't need you, I can't deal with that right now."

Participant 6F also described emotionally and physically disengaging to avoid dealing with or addressing issues related to a past traumatic experience:

> I don't think we want to talk about it. Because you don't want to revisit the hell we lived through, so you don't talk about it. If you can just get through this day without any kind of major thing, that's a huge accomplishment and why bring up the past.

The *boundary issues* described by participants included pursuer-distancer patterns, power and control issues, testing the relationship, and avoidance. These issues, which appear to contribute to negative relationship patterns, also may lead to *intimacy problems* for couples.

Intimacy Problems

In addition to some participants describing emotional and physical disengagement, *intimacy problems/issues*, including both sexual and emotional intimacy issues related to past trauma experiences, were reported by nine participants. Participants described experiencing a low desire for sex as a result of feeling uncomfortable, being preoccupied with the trauma experience itself, and issues of self-esteem. Participant 4F reported that her response to physical intimacy with her partner was affected by her past traumatic experience:

> It only affected our relationship, like soon after I told him, with intimacy. Every once in awhile, like during intimacy, either I won't want to do something, and well, sometimes I'll not want to, I'll want to draw the line somewhere, just because it's bothering me at that time.

Participant 2M also reported sexual intimacy issues in their relationship:

> I think it, soon after that when I thought she was feeling better, she wasn't feeling well enough to be intimate and I think that is still ongoing. Yeah it is not a zero, but it's not like it used to be. So I think that's probably one of the lingering effects.

Participants also described how the *emotional* aspects of the partner relationship appeared to be affected by past trauma experiences. Participant 1F described how her personal trauma history seemed to impact her emotional intimacy as her current relationship with her partner developed:

> Everything was perfectly fine until about, I don't know, like six months. And then everything just went weird. I think that it's an emotional attachment. As long as I could just see him, not just as a, kind of friend or a cool guy to hang out with or whatever, but it's like the more I got attached to him, the harder everything got.

Triggers

Participants described events that remind the trauma survivors of a past trauma and trigger trauma-related behaviors or symptoms. Thirteen participants, both trauma survivors and their partners, reported these *triggers*, or reminders of their previous trauma experiences, affected their relationships. When asked how he was most affected by his partner's past trauma, Participant 10M stated:

> Probably just watching what I say or do. In the past, if there was a certain item or certain things that would intrude or something in like a memory, she'd let me know, what were some triggering effects, so I could make sure that I didn't say something or do something that would trigger some old memory.

Participant 1F explained how triggers related to a past abusive relationship come up in her current relationship:

> I needed new pots and pans and one day I was making breakfast and the eggs were sticking, no matter how much oil I put on there, 'cause the Teflon was kind of scraped out on places. I was complaining about them and so, being the thoughtful guy that he is, he bought me new pots and pans. And I got mad! Because one year my ex-boyfriend for Christmas, he got me towels, that's it! Towels! Two towels! So I just automatically assumed that he bought me towels and [current partner] bought me pots and pans, so he's a bad guy and I got really upset about that.

Other participants described how triggers or flashbacks of past traumatic events create conflict in their current relationships: *"The flashbacks, that really affects us a lot. Every time I have a flashback, I break up with him, I try to break up with him" (1F); "No it's just like I see things going on that remind me of stuff that happened and I get furious, that he's gonna act like [previous partner's name] and he'll remind me that he is not [previous partner's name]" (10F).* Although these issues may create relationship problems for trauma survivors and their partners, participants also described methods of *coping* with their previous trauma exposure.

Coping Mechanisms

As the themes of *boundaries*, *intimacy,* and *triggers* referred to patterns in the participants' relationships, participants also described various *coping mechanisms* that they used to deal with the effects of the trauma on their partner relationship. Seven participants reported utilizing coping mechanisms to deal with their own or their partner's past trauma experiences. Two styles of coping mechanisms emerged from the interviews: spiritual and verbal. A spiritual style of coping was exhibited by Participant 5M as he described his spiritual beliefs as his most significant way of coping:

> Family, friends, the support and prayers of them. And obviously relationship with God has been the most important thing as far as coping with that traumatic situation. Relationship with each other is important, but it's not near as important as relationship with God.

Verbal coping mechanisms were described by participants as the use of communication strategies to respond to trauma-related triggers. In response to how his partner has helped him in overcoming the trauma, Participant 5M stated: *"Being there as a support and being there to talk about it . . . just being able to talk about it. Being able to communicate with each other about it and our feelings about it so that's been very beneficial."* Other participants reported similar statements about the importance of communication in coping with the trauma:

> I think communication. That's been probably the best thing that can happen is to communicate. I mean good communication not just talking, but really talking, sharing thoughts, and share point of views and sometimes if you're not able to do that then, I mean you can't fix things. We help each other. So, well basically you try to cope with things, with the problems, communicate and talk and help yourself. (4M)

> I just feel it's good to have somebody that you can talk to and that you can trust and that will learn that, and communication is pretty good for a relationship and that you both care. (8M)

DISCUSSION

The current study focused on identifying how the mechanisms in couple relationships are affected when there is a history of trauma exposure in one or both partners. Qualitative data from 17 participants were analyzed using a team-based approach. Five primary thematic categories emerged describing the impact of trauma on the partner relationship: role in the relationship, boundary issues, intimacy problems, triggers, and coping mechanisms. These results provide a unique description of the specific patterns and mechanisms that trauma survivors and their partners use when describing their current partner relationship.

An interesting finding in this study was the range of mechanisms that affected relational functioning in the couple system identified by trauma survivors and their partners. There were several common mechanisms that were identified in this study from the myriad of traumatic experiences reported by these participants. *Role in the relationship* was a common mechanism often described in relation to the *boundaries* within the couple relationship. For example, a partner's role may develop based on his or her own or the partner's traumatic experience,

which provides the framework for the development of rules and relational interactions. Previous research suggests that in couples where a partner has experienced trauma, gender roles may become reversed from the traditional norm (Maltas & Shay, 1995). When a partner experiences a traumatic event, nontraumatized partners may try to compensate by exaggerating their roles, becoming more involved in care and support roles. *Boundary issues* also were found to be a common mechanism among the participants in their relational context (i.e., *pursuer-distancer patterns* utilized in their relationships as a boundary to engage/pursue or disengage/distance themselves relationally; Nelson et al., 2002).

Most of the common mechanisms are connected, in that when a participant described one category, several of the other mechanisms also were described. The connectedness between these thematic categories supports the idea that the participants' relational functioning was affected by the key mechanisms identified in this current research. The connectedness between categories and themes serves to validate each individual category that was identified because one theme seemed to be supported by another. Additionally, these themes may be connected because they were identified in a relational context (i.e., couple relationships) versus an individual context (i.e., no relationship). Some of the themes identified in the current study have been described in other research on trauma in couples (Johnson, 2002; Nelson, 1999; Nelson & Wampler, 2000; Nelson et al., 2002; Reid et al., 1996; Riggs et al., 1998; Solomon, Waysman, Belkin, et al., 1992; Whiffen & Oliver, 2004; Wiersma, 2003). The current study further supports the model of traumatic stress in couples presented by Nelson Goff and Smith (2005).

In much of the previous empirical research on the interpersonal effects of trauma in couples, negative or impaired relationship patterns have been described; however, the current results did not support the assumption that the relationships of trauma survivors are naturally impaired or problematic. The current sample included participants who reported a wide range of relationship functioning, with scores on the Dyadic Adjustment Scale (DAS; Spanier, 1976) ranging from 63 to 136. However, over half of the total sample ($n = 13$) had high DAS scores (> 100), indicating satisfaction/nondistress within the current relationship, with only five participants reporting relationships in the distressed range (≤ 100; Eddy, Heyman, & Weiss, 1991). Even though participants were part of a clinical sample, the present sample was generally satisfied with their current couple relationship. It is possible that the coping mechanisms described by participants, as well as previous or ongoing therapeutic experiences, served to lower relational distress, therefore explaining the generally high relationship satisfaction reported in the current study. Although not the original purpose of the study, these findings suggest that a satisfying partner relationship can be maintained following a traumatic experience, and assuming relational impairment in all survivors may be an error made by researchers and clinicians.

Limitations and Future Research

There are several limitations of the current study. As has been mentioned, the variability in trauma history may have been an influential factor in the results. Although the range of traumatic stressors is a strength of the study, future research comparing systemic effects within similar trauma samples is necessary. The homogeneous demographic characteristics of the sample, such as age, race, and heterosexual couple relationships, are important to recognize as a limitation in regard to external validity. Although there was an age range and both males and females were represented, 10 of the participants were dating, engaged, or recently married (< 3 months), which could have influenced the study results in a more positive or optimistic direction. Also, only two participants were not of European American descent. The lack of diversity limits the generalizability of the current study. Thus, future research needs to include a larger, more diverse sample of trauma survivor couples with a longer relationship history and variability in intrapersonal and interpersonal symptoms in order to promote broader conclusions and external validity.

Clinical Implications

The common mechanisms described here may be particularly important to recognize clinically because they can provide a guide for therapists in assessment and interventions with trauma survivors. Ignoring and not addressing these symptoms in treatment may serve to con-

tinue and possibly exacerbate the individual and relationship distress trauma survivors may be experiencing (Johnson, 2002, 2004).

Clinicians treating trauma survivors individually must be careful not to overlook couple and family symptoms. In addition, the interactional patterns of couples and families may be symptomatic of the primary trauma. Professionals working with clients with interpersonal problems should be aware of the potential for traumatic stress to be the underlying problem in a couple or family system and be prepared to assess for trauma history. Understanding how trauma affects the couple or family system, particularly related to defining roles, boundaries, intimacy, and triggers, will improve clinicians' abilities to successfully treat these systems while also enhancing the trauma research field.

The findings from the current study suggest that there are a range of mechanisms that affect relational functioning in couple systems where at least one partner is a trauma survivor. The results promote the area of trauma research in couples through the presentation of a variety of interpersonal mechanisms that are related to trauma exposure affecting the couple system, including role in the relationship, boundaries, intimacy, triggers, and coping mechanisms. These results also suggest the need to recognize the range of issues, which include strengths and resources, that trauma survivors may present in therapy. Understanding how trauma effects manifest within the couple and family system will improve clinicians' ability to intervene successfully with these client systems, particularly in identifying how partners may provide a resource for survivors in healing from past trauma experiences.

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