

SYSTEMIC TRAUMATIC STRESS: THE COUPLE ADAPTATION TO TRAUMATIC STRESS MODEL

Briana S. Nelson Goff

Kansas State University

Douglas B. Smith

Kansas State University

Briana S. Nelson Goff, PhD, and Douglas B. Smith, MS, Marriage and Family Therapy Program, School of Family Studies and Human Services, Kansas State University.

Portions of this paper were presented at the 2001 and 2002 AAMFT Annual Conferences.

Address correspondence may be addressed to Briana S. Nelson Goff, PhD, Marriage and Family Therapy Program, School of Family Studies and Human Services, Kansas State University, 322 Justin Hall, Manhattan, Kansas, 66506-1403; E-mail: bnelson@ksu.edu

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 stress affects the spouses/partners, children, and professional helpers of trauma survivors. However, empirically supported, theory-based literature that identifies the mechanisms by which interpersonal or “secondary trauma” occurs in response to traumatic events is limited. Here, we present the Couple Adaptation to Traumatic Stress Model, a systemic model of the development of interpersonal symptoms in the couple dyad based on empirical literature. Potential mechanisms and clinical vignettes are included to describe the systemic processes that occur with trauma couples. Areas for future research and clinical implications also are identified.

Traumatic events have received much clinical and empirical focus in the last 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). In the past, the fields of traumatic stress and marriage and family therapy (MFT) have only occasionally intersected in the development and conceptualization of psychological trauma. As mental health professionals in the 21st century, it is necessary for MFTs to become knowledgeable in the field of traumatic stress.

THEORETICAL AND EMPIRICAL FOUNDATIONS OF SYSTEMIC TRAUMATIC STRESS IN COUPLES

This article highlights the importance of identifying a more systemic focus on traumatic stress within the MFT profession. 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 systemic 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). Several terms have been used to describe these secondary effects, like “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).

Secondary Traumatic Stress

The integration of MFT and traumatology has occurred predominately over the last decade. Specifically, the work by Figley (1983, 1989, 1995, 1998, 2002; Figley & McCubbin, 1983) has

bridged these, often distinct, fields. 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, Fried, Mikulincer, Benbenishty, Florian, & Bleich, 1992).

The basic premise 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, 1992a; 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, whereby 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; 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), 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 victims/survivors on a personal level. The dilemma with 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).

The current empirical literature on trauma in couples that is available will be described next. For the purpose of this article, which specifically focuses on the couple relationship, “couple dyad” is defined as including two individuals in a committed partnership.

Empirical Studies of Secondary Traumatic Stress in Couples

The research by Solomon and colleagues (Arzi et al., 2000; Mikulincer, Florian, & Solomon, 1995; Solomon, 1988; Solomon, Waysman, Avitzur, & Enoch, 1991; Solomon, Waysman, Belkin, Levy, Mikulincer, & Enoch, 1992; Solomon, Waysman, Levy, et al., 1992) has focused on the effects of combat trauma on the spouses/partners of veterans. Solomon, Waysman, Levy, et al. (1992) studied 205 wives of Israeli combat veterans to determine if combat stress reaction (CSR; a more immediate reaction to combat trauma) and PTSD in veteran husbands were related to psychiatric symptoms in wives. The authors found CSR and PTSD in husbands to be related to greater somatization, depression, anxiety, loneliness, hostility, and impaired marital, family, and social relations in the wives.

Mikulincer, et al. (1995) found marital intimacy to be negatively related to levels of emotional distress among wives of combat veterans diagnosed with CSR and suggested that marital intimacy may moderate the relationship between symptoms of primary trauma and the development of secondary traumatic stress. In addition, they found that wives of veterans with CSR had greater psychiatric symptoms than the wives of veterans without CSR. Solomon, Waysman, Belkin, et al. (1992) reported greater conflict and reduced marital satisfaction and cohesion in couples where the husband had been diagnosed with CSR.

Riggs, Byrne, Weathers, and Litz (1998) examined the quality of the intimate relationships of male Vietnam veterans and their partners in the United States, comparing veterans with PTSD to a

sample of veterans without PTSD. The results indicated that more than 70% of the PTSD veterans and their partners reported clinically significant levels of relationship distress, as compared with only 30% of the non-PTSD couples. The PTSD-positive couples reported significantly more relationship distress, difficulties with intimacy, and relationship problems than the PTSD-negative couples.

Lev-Wiesel and Amir (2001) examined secondary trauma in a nonclinical sample of spouses of Holocaust survivors. Approximately one-third of the partners reported secondary traumatic stress symptoms. The authors found that levels of anger and hostility, paranoia, and interpersonal sensitivity in Holocaust survivors were related to increased levels of secondary trauma symptoms in their spouses and decreased marital quality in the relationship. Related to the quality of the marital relationship, when child survivors of the Holocaust suffering from full or partial PTSD shared their memories of trauma with their spouse, the spouse reported lower perceived marital quality; however, when survivors reported no symptoms of PTSD, sharing traumatic memories had no effect on marital quality.

In a study conducted by Nelson and Wampler (2000), 96 clinic couples that reported a history of physical and/or sexual childhood abuse in one or both partners were compared with 65 clinic couples in which neither partner reported childhood physical or sexual abuse. The results indicated that the couples with an abuse history reported lower marital satisfaction and higher individual stress symptoms for both partners than those couples in which neither partner reported an abuse history. In couples in which only one partner reported an abuse history, there was no difference between the levels of individual stress symptoms for the abuse and no-abuse partners, indicating support for secondary traumatic stress theory.

Finally, 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. The results from this study indicated that veterans experienced both higher individual stress symptoms and trauma symptoms than either the sexual abuse survivors or the clinical control primary partners. Childhood sexual abuse survivors reported more individual trauma symptoms than the clinical control primary partners but not significantly more stress symptoms. The partners in the veteran sample reported higher individual stress and secondary trauma symptoms than the partners in the other two groups, but there was no difference between the groups on trauma symptoms and no difference between the childhood sexual abuse survivor secondary partners and the clinical control secondary partners. In addition, there was not a significant difference in relationship impairment between the groups, indicating mixed support for the theory of secondary trauma, particularly the negative effects of trauma on the couple relationship. Although some of the literature reviewed here indicates support for secondary trauma effects in couples, the results are varied. Studies have not identified the specific effects or mechanisms of trauma on interpersonal functioning. It is difficult to separate marital problems from trauma symptoms, and the available research does not provide a clear description of the relationship between marital problems and individual symptoms due to trauma exposure.

Clinical Models of Systemic Traumatic Stress

Emotionally focused therapy and attachment theory. One systemic theoretical and clinical approach to trauma is the work by Johnson (2002). The application of emotionally focused couple therapy (EFT) to the treatment of trauma is based on Bowlby's (1969) attachment theory and focuses on restructuring bonds between partners as a necessary part of trauma recovery. Although this couple therapy approach is not intended to replace individually oriented treatment modalities, especially for severe individual trauma symptoms (e.g., PTSD), Johnson emphasized that many traumatic experiences occur within a relational context and the consequences often are transmitted across or

“contaminate” other interpersonal relationships. As Johnson (2002) stated, “if a person’s connection with significant others is not part of the coping and healing process, then, inevitably, it becomes part of the problem and even a source of retraumatization” (p. 7).

Johnson’s (2002) clinical approach emphasized establishing safety and stabilization, healing and restructuring the attachment bonds between partners, and reducing the marital distress and chronic pursue–withdraw patterns that trigger or maintain the trauma symptoms. Isolation, reduced emotional expression, and impaired interpersonal connections often result from trauma.

Emotionally focused couple therapy with trauma survivors involves recognizing the systemic effects of trauma on both partners and creating the potential for the interpersonal relationship to provide a crucible (i.e., secure base) for healing from trauma. (For additional clinical applications of attachment theory, see Cassidy & Shaver, 1999.) Although EFT has received much empirical research on its effectiveness as a clinical method of treatment, the role of attachment security in the couple relationship of trauma survivors requires empirical support. Attachment will be described later as a possible mechanism of the systemic process that occurs in the trauma couple dyad.

Relational approach to trauma. Sheinberg and Fraenkel (2001) provided a description of a family-based approach to treating incest. Also using attachment theory, their clinical model “is designed to strengthen the safe, protective relationships between the child and her family members and to re-empower these individuals and relationships so that the family can be a safe, nurturing place” (Sheinberg & Fraenkel, 2001, p. 7). Although their approach primarily addresses the treatment of children’s trauma within a family context (relational trauma), it offers another description of an attachment-based, systemic perspective on traumatic stress. The authors also provide a description of the empirical support for relational trauma theory. However, a limitation of this model is that it may not generalize to other types of traumatic experiences (e.g., nonsexual, extrafamilial trauma).

The literature identified here provides a systemic focus and an initial description of the effects

traumatic events have within a traumatized person's system. There is clinical and anecdotal evidence of the systemic impact of trauma on couple and family systems of trauma survivors (Balcom, 1996; Catherall, 1992a; Figley 1989, 1998; Johnson, 2002; Nelson et al., 2002; Nelson & Wright, 1996; Sheinberg & Fraenkel, 2001). However, a clear and consistent description of the systemic or interpersonal effects of traumatic stress is needed, particularly a theoretical description of the unique systemic mechanisms specific to trauma.

Based on the reviewed literature, we will describe a systemic model of traumatic stress. Because of our clinical and empirical experience, and because the available empirical literature has focused primarily on the couple dyad, the couple subsystem is emphasized in the proposed model. In addition, although the specific individual and interpersonal symptoms may be unique to different types of traumatic experiences (e.g., sexual dysfunction may result from a history of childhood sexual abuse), we purport that the systemic processes and mechanisms that occur may be similar across various traumas; thus, the proposed model may be applied equally to various traumatic events. We recognize the limitation that focusing exclusively on the couple subsystem presents but believe it is important to provide an initial description of a model of systemic trauma to eventually be expanded to other subsystems (e.g., parent–child, sibling) and systems (e.g., family of origin, communities) and across diverse types of traumatic events.

TRAUMATIC STRESS IN COUPLES: THE COUPLE ADAPTATION TO TRAUMATIC STRESS MODEL

The Couple Adaptation to Traumatic Stress (CATS) Model (see Figure 1) includes the primary and secondary trauma effects in the individuals, as well as the interpersonal effects within the couple system. Based on the literature, there are several empirical studies that support the CATS model. Each component of the model will be described next, including clinical vignettes that illustrate the model components.

Individual Level of Functioning: Symptoms of the Primary Trauma Survivor

The individual trauma survivor may experience problems while the event is occurring (peritraumatic effects) and may continue to be impaired after the event (posttraumatic effects).

McCann, Sakheim, and Abrahamson (1988) categorized these individual effects as emotional, behavioral, cognitive, and biological symptoms. The symptom categories of PTSD (APA, 2000) are classified as reexperiencing (e.g., flashbacks, intrusive memories), arousal (e.g., anger outbursts, hypervigilance), and avoidance (e.g., avoiding reminders of the event, restricted range of affect). In general, these individual symptom categories comprise the level of functioning of the individual and can range from acute to chronic. When individual symptoms are cumulative and severe, they may result in PTSD or other disorders.

The potential range of trauma symptoms or level of functioning in the individual, which may include emotional, behavioral, cognitive, or biological symptoms, is depicted in Figure 1 in the left box. In clients with a history of trauma, these individual problems may present as symptoms of depression or anxiety (emotional), suicidal gestures or substance abuse (behavioral), intrusive or impaired episodic memories (cognitive), and physical disorders or psychosomatic complaints (biological). It is necessary for therapists to evaluate the severity of individual symptoms thoroughly in the primary trauma survivor to determine the best course of treatment (i.e., individual, couple, or mixed modality).

Individual Level of Functioning: Secondary Trauma Symptoms of Partners

The theory of secondary trauma has indicated that the primary trauma survivor's individual symptomatology negatively affects the secondary partner; however, it also can be argued that the secondary partner's symptoms may directly affect the primary partner's symptoms, as well. For example, elevated symptoms of anxiety experienced by secondary partners may create a situation in

which the anxiety symptoms are expressed through anxious or angry behaviors, which increase the arousal symptoms of the primary survivor. The following case example illustrates this situation:

A man sought therapy to deal with vicarious trauma issues resulting from his work as a police officer. He had responded to a shooting incident in which several children were killed or severely injured. Although he requested services from the department immediately after the event, none were offered. Now, several months after the incident, he was continuing to experience trauma-related symptoms, which were significantly affecting his personal and professional life. His spouse attended a few couple therapy sessions for education and support. She was very vocal about her anger at the department for “letting him get this bad.” When her anger began to escalate, she would launch into frequent attacks of the “system.” He would become passive and sullen, with increasing symptoms of depression.

Although limited in number, because there is empirical support for secondary trauma symptoms in partners, these effects are indicated in the right box in Figure 1. In addition, the arrows between “individual level of functioning of the primary trauma survivor” and “individual level of functioning of the secondary trauma survivor” are depicted as a mutually influential, circular process, based on the literature that is available on the mutual impact of individual symptoms on partners (c.f., Mead, 2002). Although not empirically validated, the potential for a mutual process involving individual symptoms of both partners supports a systemic theory of traumatic stress.

Predisposing Factors and Resources

Historically, family stress theory (McKenry & Price, 1994) provided the foundation for understanding family response to stress and crisis. Hill’s (1949) roller-coaster profile of adjustment and the ABC-X Model of family crisis (Hill, 1958) described the process of responding to stressful events. The roller-coaster model included the period of disorganization, the angle of recovery, and the level or reorganization after the crisis, indicating that postcrisis adjustment may be below, equal to, or above the previous level of functioning. Hill’s (1958) original description of the ABC-X Model was expanded by McCubbin and Patterson (1982), resulting in the Double ABC-X Model. This model has been applied to a variety of stress/crisis events; however, it has been used primarily to describe the systemic effects of events that are experienced by whole families, rather than

understanding the family system effects when one member is exposed to trauma (prior to or after the couple or family becomes a unit), as is the case with most trauma survivors. In addition, the book edited by McCubbin, Cauble, and Patterson (1982) on family stress and coping does not specifically describe severe traumatic experiences as potential stressors. The chapters in this book, which was published soon after the initial description of PTSD in the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition (*DSM-III*; APA, 1980), provided an important early description of family functioning when facing difficult circumstances, but these early theories of family stress and coping are limited in their current applicability to systemic traumatic stress. In the last 20 years, progress has been made to expand the knowledge of traumatic stress in individuals; however, our understanding of family stress needs to include specific awareness of the direct effects from traumatic events. Two concepts are borrowed from the original work on stress in families to understand systemic traumatic stress: predisposing factors and resources (McCubbin & Patterson, 1982).

Predisposing factors. McCubbin and Patterson (1982) suggested that "prior strains" are related to the demands faced by families encountering stress. New demands may increase the strain caused by prior stressors. In the model, "predisposing factors" refer to individual characteristics or unresolved stress experienced by either partner prior to the primary trauma. These characteristics may include: Childhood or previous stress/trauma, mental illness, individual coping responses, trauma-specific characteristics, age, sex, or other factors (Shalev, 1996). Preexisting vulnerabilities and individual characteristics may intensify role disruption and interpersonal conflict in the couple dyad, while reducing relationship functioning. These factors also may increase the partners' susceptibility to primary and secondary trauma symptoms.

Resources. Personal resources of individual family members may include financial resources, education, physical health, self-esteem, positive coping strategies, and other psychological

resources. Couple or family system resources may include cohesion, adaptability, shared power, and social support. The Double ABC-X Model identified social support as a mitigating factor in family response to stress (McCubbin & Patterson, 1982). Social support resources provide emotional support to family members, reinforce the value of individuals and the family as a unit, and provide practical assistance with the demands of dealing with a major stressor (McCubbin & Patterson, 1982). Often, the loss of social support is a common occurrence following trauma, which affects the individual trauma survivor and the couple/family system.

In the CATS Model, “predisposing factors and resources” are variables that impact both the individual level of functioning and the interpersonal functioning and dynamics of the couple. Predisposing factors and availability of resources can serve as risk or protective factors that influence adjustment to the traumatic event for both partners or within the couple system.

Relational Functioning and Dynamics within the Couple System

Based on the literature reviewed previously, current research suggests that relationship problems faced by couples that have experienced trauma may include role disruption, parenting problems, poorer family adjustment, difficulties with intimacy, lower relationship cohesion and satisfaction, greater conflict, anger, and violence. The following case example presents a description of the connection between trauma and couple functioning:

A couple presented for marital therapy due to high conflict and communication problems. In the initial paperwork, the husband indicated that his wife “never wanted sex.” The wife reported a history of childhood sexual abuse and a rape during early adulthood, which was contributing to the couple’s current marital problems, particularly since many of their arguments involved pursuer-distancer dynamics involving sex. As therapy continued, the couple disclosed previous episodes of domestic violence when their conflict was particularly intense. Although the husband denied any childhood abuse, he reported witnessing severe violent episodes between his parents. It became apparent that both partners’ early experiences were directly related to their current issues of sexual problems and violence. Although a victim of exposure to violence, the husband became aware of how his behavior and reactions with his wife were affected by the violence he observed as a child.

Particularly when partners are debilitated by traumatic stress (primary or secondary), the needs of the individuals become of primary importance, and interpersonal functioning in the couple relationship is at greater risk of disruption, as the following case example describes:

A wife reported experiencing severe physical and emotional abuse as a child. She often behaved in emotionally immature ways, reaching varying levels of emotional reactivity (extreme sadness/tearfulness to almost giddiness) several times during therapy sessions. She often became very agitated at little things that went wrong. Her husband would respond with minimal emotion in an attempt to calm the situation. He also reported feeling that he had to constantly be in contact with his wife to counterbalance her emotional extremes. He felt pursued by her to be her caretaker, and he frequently created situations to distance himself. The husband reported feeling very overwhelmed by all the responsibilities and often became deceptive about where he was in order to get some time away from the family situation. This husband eventually abandoned the family, cutting off all ties with his wife and children.

In the CATS Model, the “couple functioning” component is based on the specific areas identified in the clinical and empirical literature, including issues related to attachment, relationship satisfaction, support/nurturance, power, role disruption, stability, adaptability, intimacy, communication, and conflict, which are indicated as mutually influential components of the dyad system. Although there is some empirical evidence that describes these primary issues in trauma couples, further empirical research is needed (indicated in the model by the dashed circle). The arrows between couple functioning and individual level of functioning (primary and secondary partners) suggest a mutual process. However, because the direct relationship between these components has not been empirically validated, the lines are dashed, suggesting that these effects are tentative and require further empirical validation. Finally, the lighter top arrows and darker bottom arrows indicate the potential range of effects on the individual and dyad systems, depending on the level of symptom severity in each component.

To summarize, the CATS Model provides a systemic description of how individual and couple systems are affected when trauma has occurred. The model assumes that a primary survivor’s level of functioning or trauma symptoms will set in motion a systemic response with the potential to

result in the development of secondary traumatic stress symptoms in the partner. Because the model is circular, symptoms of secondary trauma in the partner may intensify symptoms of primary trauma in the spouse. However, the CATS Model proposes that adaptation to traumatic stress in the couple dyad is dependent on the systemic interaction of the three primary concepts: Individual level of functioning, predisposing factors and resources, and couple functioning.

It should be noted that the model does not assume that the only outcome from trauma will be individual trauma symptoms or PTSD, secondary trauma, or relationship dysfunction. This is depicted in the CATS Model as “acute” and “chronic” individual symptoms in the primary and secondary partners, with acute symptoms suggesting short-term or minimal individual and interpersonal effects from trauma exposure. Chronic individual symptoms would include more severe or long-term disruption, such as PTSD. Many individuals who experience traumatic events do not develop PTSD (van der Kolk & McFarlane, 1996). Likewise, rather than being a source of problems, the couple relationship may serve as a crucible or resource for healing for the primary trauma survivor through the development of attachment bonds, breaking dysfunctional patterns, and creating healthy functioning in interpersonal relationships.

We acknowledge in the CATS Model that a possible outcome from trauma is positive adaptation, support, and growth; however, when there are problems related to previous traumatic experiences, the model suggests that individual, secondary, and systemic traumatic stress symptoms can result. When trauma disrupts interpersonal functioning in couples and families, the question of *how* these systemic effects occur remains uncertain. The following section provides a description of the potential mechanisms of trauma transmission in couples.

MECHANISMS OF SYSTEMIC TRAUMATIC STRESS IN COUPLES

There are several mechanisms that may provide an understanding of systemic traumatic stress and trauma transmission in couples, as depicted in the CATS Model. These include chronic stress,

attachment, identification and empathy, projective identification, and conflict and physiological responses. The possible mechanisms described here are not empirically supported but are included to identify theoretical descriptions of *how* these systemic effects may occur in couples.

Chronic Stress

Based on the ABC-X Model, being in a committed, long-term relationship with a person who is experiencing chronic trauma-related symptoms (e.g., PTSD) can become a chronic stressor. The severity of the individual symptoms of the trauma survivor may produce individual symptoms in the secondary partner because living with a person with chronic trauma-related PTSD produces chronic stress in the partner, like depression, anxiety, isolation, and other individual symptoms. Second, a related mechanism is mate selection, which may contribute to the partner experiencing increased traumatic stress problems because both partners may share a common history of trauma (dual trauma couples; Balcom, 1996; Compton & Follette, 1998, 2002; Nelson et al., 2002) or an increased vulnerability due to other experiences (e.g., mental illness, low self-esteem). Bramsen et al. (2002) described this as the “assortative mating hypothesis” (p. 243) in trauma couples. Thus, both partners may have high individual and relational impairment, one because of trauma history and the other because of general insecurities or other issues, which produce chronic individual and interpersonal distress. These partners may self-select because of similar impairments, which may increase the potential for chronic and severe relational problems.

Attachment

Another mechanism may result from the emotional connection or attachment a person has with a trauma survivor. Johnson and Williams-Keeler (1998) described the emotional responses and patterns of distance, defense, and distrust that occur in couples in which a partner has a history of trauma that negatively affects their relationship functioning. Loss, isolation, and lack of safety frequently result from traumatic events and are key components of impaired attachment in

interpersonal relationships.

When trauma disrupts a person's ability to connect or attach with others (particularly a spouse/partner), the numbing, isolation, anger, and other individual symptoms of the primary survivor may result in secondary trauma in partners because of the primary survivor's inability to connect and respond to the partner's attachment needs in a safe environment. The negative impact of numbing, avoidance, and other symptoms of the individual(s) produces a relational cycle of mutual distance and disconnection between partners, reducing the secure attachment necessary for healthy functioning (Johnson, 2002). However, the attachment that partners develop for one another also could provide a positive resource in healing from trauma, through the development of a safe, stable and "secure" bond between partners that promotes mutual attachment and connection.

Identification and Empathy

Related to attachment, a person may experience secondary trauma issues resulting from empathy and identification with the trauma victim. Rosenheck and Nathan (1985) identified this mechanism in their description of the children of trauma survivors who also may experience symptoms (e.g., depression, guilt, rage) because of an indirect effect, like identifying with the traumatized parent, or more directly through the parent's behavior toward the child (e.g., anger toward the child). This may result from an internalization process, where family members identify so closely or empathize with the experiences of the trauma survivor that they begin to internalize the trauma symptoms of the survivor and experience their own individual stress reactions (Maloney, 1988).

Similar to Bowen's (Kerr & Bowen, 1988) concept of "differentiation of self," people vary in their ability to separate feeling from thinking. Partners who are able to maintain their individuality and objectively achieve emotional separation from others can provide genuine empathy and caring for a trauma survivor. As with attachment, this empathy can serve as a resource and produce positive coping for both partners, by providing comfort to the primary traumatized partner and helping the

other partner feel effective in supporting the trauma partner, which may decrease the likelihood of secondary traumatization and relationship disruption.

Shared emotions, experiences, and memories provide the foundation for an empathic bond in couples. However, when this empathy creates an interactional process where the partner's empathic connection or exposure to the survivor's experience becomes extreme or overwhelming for the partner, the result may produce decreased relationship satisfaction and secondary trauma. Figley (1995, 1998) described this process as related to the nontraumatized partner's empathy and identification with the trauma victim and energy depletion within the couple/family system. Cerney (1995) indicated that identification is a specific mechanism of secondary traumatic stress in those who closely interact with trauma survivors; however, she also described "projective identification" (p. 136) as a separate mechanism that may contribute to secondary trauma.

Projective Identification

Object Relations Theory examines the link between the primitive defenses of splitting and projective identification and family functioning. This process has been described as "projective identification" in couples (Catherall, 1992*b*) and families (Weingarten, 2004), where partners or parents project unacceptable or overwhelming feelings onto others (e.g., their partner) by attributing what was initially an internal threat (e.g., emotion) to an external threat by projecting it to the other person. Trauma survivors frequently struggle with issues of self-esteem, guilt, self-blame, and other negative self-attributions resulting from the trauma. The survivor may maintain his/her self-image by projecting the "bad" self or object onto the spouse or other family member. A pattern of interpersonal process develops that serves to influence the spouse to think and act in ways that are consistent with the projection, which is reinforced by the survivor's identification with the behaviors of the spouse. A stable negative feedback loop driven by the process of projective identification may lead the spouse to experience intrapsychic and interpersonal symptoms

associated with the trauma (Slipp, 1993). When the partner is unable to identify with and “hold” or contain the feelings projected onto him/her, a pattern of distance and disconnection between the partners may occur, resulting in continuous conflictual interactions.

Conflict and Physiological Responses

Although not specific to traumatic experiences, Gottman’s (Gottman & Levenson, 1992, 1999; Gottman & Notarius, 2000) research on physiological arousal and marital conflict may describe a potential mechanism for the systemic effects of trauma. Particularly because of the increased physiological arousal experienced by many trauma survivors, there may be a significant relationship between physiological reactivity in partners related to hostile and negative interactions and marital dissatisfaction (Gottman & Notarius, 2000). The literature suggests that increased interpersonal conflict may be a primary component of trauma systems. However, if interpersonal conflict rises to the level of emotional, physical, or sexual abuse, it can no longer be considered a factor in the development of secondary trauma. Instead, violent conflict and abuse would represent a mechanism for direct traumatization of the spouse/partner.

In sum, there are a number of possible mechanisms for the transmission of trauma between partners within the couple relationship; however, current research does not support one theory of transmission over another. The majority of traumatic experiences occur in a relational context (Briere, 2002; Sheinberg & Fraenkel, 2001; e.g., abuse by parent to child, violence between intimate partners), thus producing a disruption in relationships. Trauma alters how people view the world and the meanings they place on what happens in their lives, which affects how they approach and interact with the world around them. How they interact in relationships and with partners is a direct result of their attempt to make sense of a world that has involved traumatizing experiences. Because life often revolves around the trauma (whether it is acknowledged or not) for the individual trauma survivors with PTSD or other trauma symptoms, their relationships also revolve around the

trauma and the effects of the trauma, either overtly or covertly. When these dynamics are covert, it creates the cycle of individual symptoms and relational patterns in which trauma couples often become entrenched. These patterns may include problems in the specific areas of couple functioning identified in the CATS Model; however, these areas require further clinical and empirical evidence to develop a clear picture of the specific relational effects of trauma. The model and mechanisms provide direction for future research and raise additional questions that require systematic empirical study to understand more fully the interpersonal dynamics that occur in the relationships of couples with a history of trauma.

FURTHER CLINICAL AND EMPIRICAL IMPLICATIONS

There are several specific trauma-related areas for additional clinical and empirical focus, which include the following: (a) Dual and single trauma couples (Balcom, 1996; Compton & Follette, 1998, 2002; Nelson et al., 2002); (b) simultaneous and disparate traumatic events; (c) intergenerational and longitudinal effects of traumatic events from a developmental perspective (d) the impact of single versus multiple traumatic events; (e) intrafamilial versus extrafamilial trauma (beyond sexual abuse); (f) gender differences in secondary traumatic stress; and (g) the beneficial role of empathy and attachment in couple relationships that promotes healing from trauma. There are unlimited research questions to be answered in the area of couples and traumatic stress.

However, a clear and discernible theory must be used to approach the empirical questions and understand the results. The CATS Model provides an initial framework from which to pursue future research.

The impact of traumatic stress on survivors and their families should be of particular interest to marriage and family therapists. The similarity between the symptoms reported in the literature and the presenting problems many couples and families bring to therapy is striking. The case examples provided here suggest the importance of understanding the effects of trauma using a systemic

theoretical lens. The potential for the development of disruptive interpersonal processes suggests that individual trauma may have extensive consequences for the entire family system. Treating trauma victims in isolation may overlook the consequences for couples and families, as well as the potential for interactional patterns to exacerbate symptoms of primary trauma. Therapists treating clients for interpersonal problems should be aware of the potential for traumatic stress to underlie problems in the couple dyad and be prepared to assess for a trauma history. Understanding how trauma effects manifest within the couple and family system will improve clinicians' ability to intervene successfully with these client systems.

CONCLUSION

This article provided a review of the current empirical and clinical models of systemic traumatic stress and proposed the CATS Model to describe the intrapersonal and interpersonal/relational effects experienced by trauma survivors and their partners. As further research provides evidence for the mutual impact between individual trauma and couple and family systems, the next step is to increase our empirical understanding of the specific mechanisms by which these systemic effects occur. To provide effective clinical treatment, it is critical to recognize the consequences of trauma on couple functioning to provide healing for the primary and secondary survivors of traumatic events and to prevent further individual and systemic damage from trauma.

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Figure 1. The Couple Adaptation to Traumatic Stress Model

