When Trauma Hits Home: Understanding the Impact of Trauma on Couples and Families

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Psychological trauma is an affliction of the powerless. At the moment of trauma, the victim is rendered helpless by overwhelming force. When the force is that of nature, we speak of disasters. When the force is that of other human beings, we speak of atrocities. Traumatic events overwhelm the ordinary systems of care that give people a sense of control, connection, and meaning.

~ Judith Herman (Trauma and Recovery, 1997)
Trauma
Trauma

Military Combat
Trauma

Military Combat

Terrorist Attack
Trauma

Violence

Military Combat

Terrorist Attack
Trauma

Violence

Terrorist Attack

Military Combat

Disaster

School Shooting
Trauma

- Violence
- Neglect
- Military Combat
- Physical Abuse
- Rape
- Disaster
- Sexual Abuse
- Molestation
- Sexual Assault
- Terrorist Attack
- School Shooting
Trauma

- Violence
- Physical Abuse
- Terrorist Attack
- Hurricane
- Molestation
- Sexual Assault
- Sexual Abuse
- Mugging
- Rape
- Flood
- Robbery
- Disaster
- Building Collapse
- Military Combat
- Earthquake
- Divorce
- Automobile Accident
- Neglect
- Fire
- School Shooting
- Molestation
- Airplane Crash
Trauma

...a wound of the soul
21st Century:
How are Others Affected by Trauma?

- The spouse/partner, children, family, friends, professionals or others who have a close relationship to the primary trauma survivor may be indirectly affected by the primary trauma survivors’ symptoms or PTSD.

- These indirect effects on others close to a trauma survivor are referred to as “secondary traumatic stress.”
Secondary Traumatic Stress

“Secondary Traumatic Stress (STS) is the experience of tension and distress directly related to the demands of living with and caring for someone who displays the symptoms of post-traumatic stress disorder (PTSD)” (Figley, 1998)

Because of the emotional connection, being in close, prolonged contact with a traumatized person becomes a constant stressor.

Family members and professionals often experience symptoms of traumatization.
• Also referred to as compassion fatigue, vicarious traumatization, trauma transmission, burnout, witnessing
• Symptoms = “communicable” “infect” “mimic”
• Symptoms are considered “secondary” because they occur in those who have not directly experienced the event.
• May resemble PTSD-like symptoms, but may be less intense
• Individuals may not be aware of or they may deny secondary trauma effects
• May assume a “Savior”/”Rescuer” role
What is Systemic Traumatology?

- Most trauma research focuses on the individual (or “primary”) trauma survivor—the person who directly experienced the traumatic event.

- **Systemic Traumatology** focuses on understanding how traumatic experiences affect not only the primary survivors, but also others who may be indirectly impacted by the trauma.
  - Primary trauma
  - Secondary trauma
  - Interpersonal/relational effects of trauma
Individual Symptoms (PTSD, DSM-IV-TR Criteria)

• **Reexperiencing**
  – Intrusive memories and dreams of the event
  – Acting or feeling as if the event were recurring (e.g., flashbacks)
  – Psychological distress or physiological reactivity at re-exposure

• **Avoidance**
  – Efforts to avoid thoughts, feelings or conversations about the trauma; efforts to avoid activities, places or people that are reminders
  – Impaired memory about aspects of the trauma
  – Restricted range of affect

• **Arousal**
  – Impaired sleep
  – Irritability or outbursts of anger
  – Hypervigilance/exaggerated startle response

- Stressor event
  - Direct exposure
  - Witnessing
  - Indirect exposure
  - Repeated/extreme indirect exposure (professional duties)

- Intrusion (Re-experiencing)
- Avoidance
- Cognitions and mood
- Arousal/Reactivity
Secondary Trauma Symptoms (STS)

- **Intrusion**
  - nightmares, “memories”

- **Avoidance**
  - Polarized emotional roles (dismissing nontraumatized partner)

- **Cognitions/Mood**
  - Increased psychological symptoms in spouse/family: Somatization, depression, anxiety, loneliness, hostility
  - Anger/blame (primary survivor, perpetrator)
  - Extreme pursuer-distancer patterns
    - Rescuing of primary survivor
    - Parental role of the secondary survivor

- **Arousal**
  - Hypervigilance to primary trauma survivor’s reactions
Interpersonal Symptoms

• **Intrusion**
  – Issues of power and control
  – Sexual dysfunction
  – Conflict/violence
  – Triggers

• **Avoidance**
  – Withdrawal/isolation
  – Sexual dysfunction
  – Rule of secrecy

• **Cognitions/Mood**
  – Impaired emotional expression
  – Negative beliefs

• **Arousal**
  – Anger
  – Conflict/violence
Distrust

Distress

Distance

Defense

[Diagram showing a cycle with arrows connecting Distrust, Distress, Distance, and Defense]
Couple Adaptation to Traumatic Stress Model (Nelson Goff & Smith, 2005)

- Acute
  - Individual Level of Functioning
    - Primary Trauma Survivor
      - (e.g., age, previous trauma)
    - Resources
      - (e.g., coping, support)
  - Chronic

- Predisposing Factors
  - Attachment
  - Satisfaction
  - Stability
  - Adaptability
  - Support/nurturance
  - Power
  - Intimacy
  - Communication
  - Conflict
  - Roles

- Predisposing Factors
  - (e.g., age, previous trauma)
  - and
  - Resources
    - (e.g., coping, support)

- Acute
  - Individual Level of Functioning
    - Secondary Trauma Survivor
      - (e.g., emotional, behavioral, cognitive, biological symptoms)
  - Chronic
Couple Adaptation to Traumatic Stress Model - Revised
(Oseland, Gallus, & Nelson Goff, in review)
Close up of couple functioning in model

Communication

Safety & Stability
- Roles
- Role in the relationship
- Stability/Adaptability
- Boundaries
- Relationship Adjustment
- Conflict
- Relationship distress

Traumatic Process
- Awareness
- Understanding
- Recognition
- Omission of information/secrecy
- Other
- Triggers
- Extreme patterns
- Avoidance behaviors
- Trauma recognition

Connection
- Attachment
- Cohesion/Connection
- Closeness
- Support/Nurture
- Relationship Resources
- Support from partner
- Coping mechanisms
- Intimacy
- Sexual functioning
- Intimacy problems/issues
Context of the Current Model

Trauma Research, Education, and Consultation at Kansas State University

TRECK works to educate others about the effects of traumatic events on individuals, couples, and families.
The TRECK Program began in 1998 through the Marriage and Family Therapy Program in the School of Family Studies and Human Services at Kansas State University.

The TRECK Program focuses on developing research programs, providing education, and clinical consultation about issues related to trauma and traumatic stress.

TRECK Program members include graduate and undergraduate students at Kansas State University.
TRECK Research

• Phase 1:
  – 2002-2004
  – 14 Clinical Couples
  – Mixed method research (quantitative surveys + qualitative interviews)
  – Focused on the primary and secondary effects of trauma couples where one or both partners have been exposed to a previous traumatic event (e.g., childhood abuse, war trauma, severe accidents).

• Phase 2:
  – 2004-2005 (data collected); ongoing data analysis
  – 50 military couples (OIF/OEF deployment; single post-9/11 deployment)
  – Mixed method research (quantitative surveys + qualitative interviews)
TRECK Research Questions:

• In what ways are the individual trauma survivors and the partners of trauma survivors affected by the primary survivor’s previous trauma exposure (intrapersonal secondary traumatic stress symptoms)?

• In what ways are the couple’s interpersonal functioning affected when there is a history of trauma exposure (interpersonal/systemic secondary traumatic stress symptoms)?

• In what ways do trauma survivors and their partners describe the impact of previous trauma exposure on themselves, their partner, and the couple relationship? What mechanisms or moderating factors related to trauma exposure affect the couple system and functioning of the couple?
Methods—Bear with me! 😊

• Qualitative Interview Data:
  – Semi-structured interviews were conducted with each partner separately.
  – Interviews were guided by 30 open-ended questions that focused on participants’ trauma and deployment experiences, intra- and inter-personal effects of those experiences, and dyadic functioning.

• Quantitative Data:
  – Traumatic Events Questionnaire (TEQ; Vrana & Lauterbach, 1994)
    • Affirmative answers on the 17 TEQ items were tallied to provide a “TEQ Total” score, ranging from 0 to 17, with higher scores indicating more types of traumatic events experienced
  – Purdue Post-Traumatic Stress Disorder Scale-Revised (PPTSD-R; Lauterbach & Vrana, 1996)
  – Trauma Symptom Checklist-40 (TSC-40; Briere, 1996; Briere & Runtz, n.d.)
  – Dyadic Adjustment Scale (Spanier, 1976)
TRECK Phase 2
Quantitative Data: General Conclusions

• High levels of individual symptoms in soldiers and female partners significantly predicted lower marital/relationship satisfaction for both soldiers and their partners.
  – Soldiers’ sexual problems, sleep problems and dissociative symptoms had the greatest impact on relationship satisfaction

• Soldiers’ trauma symptoms predicted female partners individual (secondary) trauma symptoms
  – Soldiers’ avoidance symptoms had greatest impact (more than arousal, re-experiencing)
• Greater exposure to traumatic events (more traumatic events vs fewer) did NOT predict poor relationship satisfaction or increased trauma symptoms.

• Provides additional information about specific trauma-related symptoms beyond PTSD that affect relationship satisfaction in couples.

• Individual symptoms reported are directly related to their previous traumatic experiences and not necessarily general symptoms or problems.

• Secondary or indirect traumatization may not be an accurate term to understand the partners’ experience of war.
  – Female partners also reported extensive trauma histories
  – 1 in 4 female partners identified the soldier’s deployment as their most traumatic experience.
Phase 2: Qualitative Study 3

• Single and Dual Trauma Military Couples
  – “Traumatic load” may be a root cause of both chronicity and severity of PTSD symptoms (See Kolassa et al., 2010).
  – Single Trauma Couples (STC) \( (n = 5 \text{ couples}) \)
  – Dual Trauma Couples (DTC) \( (n = 6 \text{ couples}) \)

– Qualitative Results:
  • Both groups:
    – INCREASED AWARENESS
    – SUPPORT
    – COPING STRATEGIES
  • DTC:
    – COMMUNICATION PROBLEMS
    – TRAUMA-RELATED TRIGGERS
  • STC:
    – ENHANCED/POSITIVE COMMUNICATION
Phase 2: Current Research

• Trauma/Deployment Disclosure
  – Participants coded as “high disclosure” \( n = 55 \) included participants who reported directly disclosing their trauma history to their spouse during their interviews.
    • 25 male and 30 female participants
  – Participants coded as “low disclosure” \( n = 16 \) reported little or no disclosure of their trauma history to their spouse.
    • 11 male and 5 female participants

– 3 studies currently in process
  • Focused on different interview questions
    – 1\textsuperscript{st} focused on relationship impact of trauma disclosure
    – 2\textsuperscript{nd} focused on deployment experiences
Disclosure Study 1:

- **Hypothesis:** Participants who reported low trauma disclosure to their spouse will report greater trauma symptoms and lower relationship functioning than participants who report high trauma disclosure.

  • **Quantitative Data:**
    - Low disclosure group reported more trauma symptoms and lower relationship satisfaction than the high disclosure group.
    - Greater avoidance, arousal, and sleep problems in the low disclosure group.

  • **Qualitative Data:**
    - High disclosure group participants indicated better interpersonal functioning, including better communication, adjustment, personal and interpersonal awareness and relationship cohesion.
    - Low disclosure group indicated more impaired communication, greater levels of conflict, and role strain.
Disclosure Study 2: Deployment Experiences

- High disclosure group:
  - Positive communication
  - Support
  - Couple resilience
  - Active connection

- Low disclosure group:
  - Greater conflict
  - Stress
  - Role strain
  - Intimacy problems
Couple Adaptation to Traumatic Stress Model - Revised
(Osland, Gallus, & Nelson Goff, in review)
Modifications in CATS-R Model

- Elaboration on previous model
  - Revision to Couple Functioning component
  - Communication is component critical ("umbrella") across all phases of systemic treatment

- Inclusion of empirical support for model which was previously not available
Other Important Notes:

• Model is not linear, but circular/systemic
• Model does not suggest “replacing” individual treatment for trauma/PTSD
  – Couple/Family approaches are often viewed as “adjunct” treatment
  – Empirically supported systemic approaches should be part of comprehensive treatment plan for trauma survivors
• Model provides a “map” or guide of what the couple relationship may look like in presenting for treatment, but no specific steps of treatment protocol (based on individual therapeutic clinical approaches).
Next steps… There’s always more to do 😊

- Family Systems Adaptation to Traumatic Stress Model – in process

- Low Trauma Disclosure couples

- 10 year follow-up with original 50 military couples

- Military Support Retreats for Service Members, Veterans and Families
Secondary Traumatic Stress:
Self-Care for Caregivers and Professionals
Self-Care

- Physical self care
- Psychological self care
- Emotional self care
- Spiritual self care
- Professional self care
Family Stress Test:

Is your family stressed? 😊

1. Conversations often begin with "Put the gun down, and then we can talk."

2. The school principal has your number on speed-dial.

3. The cat is on Valium.

4. People have trouble understanding your kids, because they learned to speak through clenched teeth.

5. You are trying to get your four-year-old to switch to decaf.

6. The number of jobs held down by family members exceeds the number of people in the family.

7. No one has time to wait for microwave TV dinners.

8. "Family meetings" are often mediated by law enforcement officials.

9. You have to check your kid's day-timer to see if he can take out the trash.

In conclusion, when one thinks about how a traumatic event impacts an individual and then begins to piece together the number of people with whom that individual has contact throughout his or her life, the realization that a single event does not have a single victim becomes clear. The repercussions from trauma are infinite. Beginning to identify and understand these repercussions on trauma survivors is critical to prevent further loss of innocence.
Thank you!