Trauma in Dyadic Relationships and Couple Counseling as Treatment

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The American Counseling Association defines *trauma* as the emotional experience following an event that threatens an individual's life, physical, emotional, or social wellbeing. Examples of traumatic events include physical, sexual or verbal abuse; natural disasters; car accidents; exposure to violence in the military; oppression and discrimination; or the sudden, unexpected loss of a loved one (2018, April).

Trauma can have lingering effects. A 30-year longitudinal study that followed survivors of childhood sexual abuse (CSA) found an increase in negative outcomes throughout adult development: mental disorders, risky sexual-behavior, decreased psychological wellbeing, poorer physical health, and lower socioeconomic status (Fergusson et al., 2013). Clearly, the outcomes of trauma do not remain compartmentalized, but extend to many dimensions of survivors' lives. Consequently, counselors are increasingly being called upon to treat trauma. A variety of theoretical approaches are well suited for this task: cognitive-behavioral therapy, narrative approaches, and even eye movement desensitization and reprocessing therapy (EMDR). Other theories–feminist, multicultural, family systems, etc.—emphasize a systemic view: issues are best treated in the context they occur. How can these models best serve clients who are experiencing symptoms of trauma? Although individuals exist within many contexts and systems, this review will focus on dyadic relationships (romantic partners), and seeks to answer the following questions: 1) How do traumatic life events impact survivors and partners in dyadic relationships? 2) Is couple counseling an effective treatment for mental health or relationship issues when one or both partners have experienced trauma?

Literature Search Process

Initial searches using terms like "couple therapy (or counseling) and trauma" yielded close to 3,000 results. I only considered literature published since 2012 in a peer reviewed journal. To further narrow the scope of this paper, I excluded articles that focused primarily on highly specialized techniques (e.g., EMDR or sensorimotor therapy) or stemmed from less commonly practiced theories (e.g., psychoanalytic theory). I excluded studies that did not address the question from a dyadic viewpoint (e.g., family or individual counseling). Articles were not excluded based on country. I included a total of ten articles. Although there is some overlap, six articles focus primarily on trauma outcomes in dyadic relationships, and address my first question. Five articles address my second question, and center around the treatment of trauma. I included a mixture of qualitative and quantitative research. One study was a randomized control trial (RCT), one was quasi-experimental (pre- and post-treatment data collection), two utilized in depth interviews and thematic analysis, and one article was a collection of vignettes outlining treatment. The remainder were correlational. I describe these sources in depth in Appendix A.

Operational Definitions and Constructs Measured

Measurements of trauma can be broadly sorted into two categories: exposure to potentially traumatic events and the presence of trauma symptoms. For example, Anderson et al. used the Adverse Childhood Experiences (ACE) questionnaire to measure exposure to traumatic events (2020). The ACE questionnaire and similar inventories ask questions like "Did a parent or guardian ever threaten or actually physically harm you?", "Did you often feel you had to wear dirty clothes, you did not have enough to eat, or there was no one to protect you? "Were your parents ever separated or divorced?", etc. (CDC & Kaiser-Permanente, 2021, April 6). In this

way, the ACE scale and similar tools (i.e., Childhood Trauma Questionnaire, High Magnitude Stressors) measure the presence of potentially traumatic events. They do not evaluate the development of trauma symptoms, or the degree to which an event is potentially traumatic. Several of the studies specifically focused on the experience of childhood sexual abuse (CSA). Trauma symptoms were measured through inventories developed for that purpose, or through other related constructs (e.g., depression).

The most common measure of relational wellbeing was the Dyadic Adjustment Scale (DAS), a 32-item inventory designed to measure relationship quality. The DAS evaluates satisfaction through several subscales (e.g., sexual interactions, family dynamics, financial agreement), (Spanier, 1976).

Another important construct was “therapeutic alliance”, which is defined as a mutual trust between the client and counselor and a joint commitment and shared goal to resolve issues (Bordin, 1979). Therapeutic alliance is often regarded as one of the most important factors in the therapeutic progress (Mahaffey & Lewis, 2008).

Table

In my table, I highlight the four studies that address treatment of trauma through couple counseling. These address my second research question: Is couple counseling an effective treatment for mental health or relationship issues when one or both partners have experienced trauma? Notably, three out of four of the studies included in the table include therapeutic alliance as a significant factor in treatment. The findings of the other six articles are included in my discussion section.

Table 1

Treatment of Trauma in Dyadic Relationships

References	Participants	Type of Study	Constructs Measured	Findings
Dalton, E. J., et al. (2013)	32 couples. Women in the relationships experienced childhood abuse.	RCT	Relationship quality[a], childhood trauma[b], therapeutic alliance[c]	Emotionally focused couple therapy significantly reduced relational distress (d = 0.62 for couples, and d = 1.00 for female participants). A change of 10 or more points on the DAS is clinically significant. A statistically significant portion of treatment participants crossed this threshold (χ^2 (1) = 18.00, p < .001). Therapeutic alliance was significantly related to relationship satisfaction (β .57, t (42) 2.72, p < .02).
Vanbergen, A., et al. (2020)	73 couples; among couples sampled, 72.2% had at least one partner with exposure to a potentially traumatic event	Data collection, qualitative analysis, ex post facto correlation	Traumatic events[d]	There were no significant differences between couples where one partner had experienced trauma, two partners who had experienced trauma, and couples with no trauma in number of sessions attended, termination status, or perceived therapeutic alliance. However, though not statistically significant, women in partnerships where both partners lived through traumatic events had a more negative view of their therapeutic alliance (M = 5.62, SD = .094) than female participants couples where only one partner experienced trauma (M = 6.35, SD = 0.59), F (2,37) = 2.93, p = 0.07, partial η^2 = 0.14.

References	Participants	Type of Study	Constructs Measured	Findings
Whitaker, K. J., et al., (2021).	36 couples and nine individuals; participants drawn from an inpatient psychiatric center.	Pre- and post-treatment data collection	Relationship quality[e], family functioning[f]	Participants with trauma experiences improved less in family (estimate -0.6, p <.001, d = .92) and couple (estimate=1.1, p =.01, d = .85) functioning from the beginning to the conclusion of treatment compared to clients without trauma.
Whitaker, K. J., et al., (2022)	Three couples who were not responding well to couple counseling; at least one partner had a history of trauma.	In-depth interviews and thematic analysis	Family functioning[f], perceptions of lack of therapeutic progress	Common themes included feeling responsible for their poor therapeutic outcomes, recognizing difficulty collaborating with both their therapist and partner, limiting the impact of trauma on the therapeutic process. Those who struggled the most perceived their spouse as having better rapport with the therapist than they did.

[a]Dyadic Adjustment Scale. [b]Childhood Trauma Questionnaire. [c]Couple Therapeutic Alliance Scale. [d]High Magnitude Stressors.

[e]Revised Dyadic Adjustment Scale. [f]Family Assessment Device.

Discussion

My goal with this review is to address how trauma impacts dyadic relationships, and how those effects can be adequately addressed in the context of couple therapy. I include ten studies in the final review.

Higher incidences of trauma correlated with lower relationship satisfaction (Vanbergen et al., 2021). Individuals who survived traumatic experiences perceived their interactions with their partner as less positive and more often critical or negative (Whisman, 2014). Although experiences of childhood abuse were unrelated to divorce, they were significant factors in lower marital satisfaction, regardless of partner characteristics. In other words, a relationship with a warm, supportive partner did not moderate the effects of childhood abuse on their partner's perception of marital satisfaction (Nguyen et al., 2017). Partner trauma was also correlated with sexual difficulties (Shi, 2021). This has important clinical implications: when a couple comes into counseling for relationship or sexual issues, the issue may not be due to incompatibility or negative character traits, but the lived experience of abuse victims. This highlights the need for a (at least) brief trauma assessment at intake.

When it comes to treatment, Johnson et al. advocate for a narrative-based approach. They consider re-establishing identity a crucial aspect of recovery for trauma, and believe this can be especially healing when a loved partner is present to witness and affirm this reclamation (Johnson et. al., 2019). Emotionally focused therapy (EFT) stood out as a promising treatment for relational distress in dyads when the woman was a trauma survivor. Both men and women in these partnerships showed significant improvement on the DAS in an RCT. However, the women did not experience a significant reduction in trauma symptoms, possibly because they were recruited through trauma clinics, and had already received treatment (Dalton et al., 2013).

In a different study, clients received extensive inpatient care. Clients who had a history of trauma showed less improvement on the DAS than clients who did not have a trauma history (Whittaker et. al., 2021). For practicing counselors, this may indicate that relationship issues and trauma symptoms may need to be treated separately. However, in a client's lived experience, it is likely that the two do not fit neatly into separate categories, and improvement in one frees up time and energy to improve the other.

Therapeutic alliance correlated with relationship satisfaction, and explained some variance in DAS scores post treatment (Dalton, 2013). Men with higher ACEs scores also tended to have a more negative perception of their therapeutic alliance (Anderson et al., 2020). Women in dyads where both partners had a history of trauma had a more negative perception of their therapeutic alliance than women in dyads with one or no trauma histories (Vanbergen et al., 2020). In a qualitative study, couples who experienced poor therapeutic outcomes in their treatment for trauma commonly cited a poor therapeutic alliance as a significant factor in their lack of progress. Specifically, they often reported their spouse having a stronger rapport with the therapist than they did, and felt the counselor focused on one spouse more than the other (Whitaker et al., 2020). Clearly, there are signs that therapeutic alliance is an important moderating variable for dyads with trauma histories, and individuals within the dyads may be especially sensitive to a perceived poor alliance. Clinically, this is something for counselors to be aware of, and be prepared to address.

I will now discuss limitations. Consistently, studies excluded same-sex and gender/sexual minority couples. As counselors are becoming more and more conscious of a need for multicultural competence, this is a distinct lack. Concerns have also been raised about the generalizability of the frequently utilized DAS, which was strongly influenced by cultural norms

(Budd & Stuart, 1992). Also, items on the DAS are not equally applicable to trauma. Dissatisfaction with sexual interactions is probably more closely related to traumatic experiences than financial disagreements. Most of the studies focused primarily on childhood trauma, especially CSA. More research is needed on the relational effects of trauma that occurs in adulthood. It is important to note that many of the studies did not include a gradient of trauma. They merely noted the presence of traumatic events, without differentiating between the severity or persistence of the trauma. This makes those results imprecise; it is likely the impact of a traumatic event like rape or physical assault is very different than the impact a car accident or natural disaster has on a relationship. And it is likely that repeated physical assault (such as domestic violence) will have a more direct impact on relational functioning than a one time incident (like a mugging).

To summarize, effects of trauma in a dyadic partnership include lower marital satisfaction, a more negative perception of partner interactions, and sexual difficulties (Shi, 2021; Vanbergen et al., 2021; Whisman, 2014). Notably, the relationship between trauma and marital satisfaction was not moderated by partner characteristics (Nguyen et al., 2017). Narrative therapy and EFT are discussed as treatments, and EFT significantly improved relational distress (Dalton et al., 2013; Johnson et al., 2019). Treatment outcomes varied between studies, and the samples from included studies represent specific populations that might not be generalizable to all treatment settings. Therapeutic alliance is an important moderating variable for therapeutic progress in studies that measured it (Anderson et al., 2020; Dalton et al., 2013; Whitaker et al., 2020; Vanbergen et al., 2020).

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VanBergen, A. M., Bartle-Haring, S., Kawar, C., & Bortz, P. (2021). Trauma and relationship satisfaction in treatment seeking couples: A dyadic investigation of differentiation as a mediator. *Contemporary Family Therapy: An International Journal*, *43*(2), 140–153. https://doi.org/10.1007/s10591-021-09565-x

VanBergen, A., Blalock, J., Bryant, A., Bortz, P., & Bartle-Haring, S. (2020). Couples and trauma history: A descriptive overview of interpersonal trauma and clinical outcomes. *Contemporary Family Therapy: An International Journal*, *42*(4), 335–345. https://doi.org/10.1007/s10591-020-09548-4

Whisman, M. A. (2014). Dyadic perspectives on trauma and marital quality. *Psychological Trauma: Theory, Research, Practice, and Policy*, *6*(3), 207–215. https://doi.org/10.1037/a0036143

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Whittaker, K. J., Stänicke, E., Johnson, S. U., Solbakken, O. A., & Tilden, T. (2022). Troubled relationships: A retrospective study of how couples with histories of trauma experience therapy. *Journal of Couple & Relationship Therapy*. https://doi-org.milligan.idm.oclc.org/10.1080/15332691.2022.2053262

Appendix A

Anderson, S. R., Banford Witting, A., Tambling, R. R., Ketring, S. A., & Johnson, L. N. (2020). Pressure to attend therapy, dyadic adjustment, and adverse childhood experiences: Direct and indirect effects on the therapeutic alliance in couples therapy. *Journal of Marital and Family Therapy*, *46*(2), 366–380. https://doi-org/10.1111/jmft.12394

Therapeutic alliance is a well-documented moderating variable on the effectiveness of counseling in general; this study ($N = 351$ couples) indirectly relates to my research question, as it measures one of the most effective predictors of outcome (i.e., the therapeutic alliance) and how it relates to my moderators (i.e., trauma and couple counseling). This is a naturalistic study; counseling centers contributed anonymous data they routinely collected from couples who were seeking out counseling. The most relevant finding to my topic is that high ACEs scores for males attending couple counseling correlate slightly negatively with therapeutic alliance scores ($r = -.19$, $p < .01$). However, greater pressure to attend therapy was also related with poorer therapeutic alliance.

This study did not measure the frequency or severity of traumatic events, just the presence of ACEs. Both frequency and type of traumatic events could impact the results. Clients also rated therapeutic alliance using forms they knew their counselor would see; this may have influenced their answers.

Dalton, E. J., Greenman, P. S., Classen, C. C., & Johnson, S. M. (2013). Nurturing connections in the aftermath of childhood trauma: A randomized controlled trial of emotionally focused couple therapy for female survivors of childhood abuse. *Couple and Family Psychology: Research and Practice*, *2*(3), 209–221. https://doi-org.milligan.idm.oclc.org/10.1037/a0032772

Hypothesis: Men and women who receive emotionally focused couple therapy will experience a greater reduction in relational distress than couples in the control group. Secondary hypothesis: Trauma symptoms will decrease for women in the treatment group.

Couples were recruited through mental health programs. Inclusion criteria was that the woman in the relationship was a survivor of childhood abuse, and the man was not (N = 32 couples). Couples that experienced any physical abuse within the relationships in the six months leading up to the study were excluded. Twelve couples were assigned to the treatment group and ten were assigned to the control group. Data was collected through self-report questionnaires prior to treatment. Measures included were: Childhood Trauma Questionnaire, Childhood Maltreatment Interview Schedule, Dyadic Adjustment Scale, Trauma Symptom Inventory, Dissociative Experiences Scale, and Couple Therapeutic Alliance Scale. The treatment group received a total of 24 therapy sessions, 75 minutes each. Then they completed the posttreatment inventories. The control group was contacted 24 weeks after they completed pretreatment inventories to complete posttreatment surveys.

Therapeutic alliance was significantly related to relationship satisfaction (β .57, t (42) 2.72, $p < .02$). It also accounted for some variance in the posttreatment Dyadic Adjustment score ($R^2 = .33$, $F(1, 15)$ 7.42, $p < .02$). Researchers used ANCOVAs to determine whether emotionally focused therapy reduced relational stress, as measured by the DAS; it was significant ($F(1, 38)$ 4.73, $p < .04$). The treatment effect size across the entire sample was d = 0.62 (medium) and d = 1.00 for female participants (large). A change of 10 or more points on the Dyadic Adjustment Scale is considered clinically significant. A statistically significant portion of treatment participants crossed this threshold ($\chi^2(1) = 18.00$, $p < .001$). No participants in the control group experienced clinically significant progress.

There were no significant findings to support the secondary hypothesis, possibly because most of the women had received previous treatment for trauma.

A limitation of this study is that the control group was waitlisted, not given an alternative form of treatment to compare emotionally focused therapy to.

Johnson, D. J., Holyoak, D., & Cravens Pickens, J. (2019). Using narrative therapy in the treatment of adult survivors of childhood sexual abuse in the context of couple therapy. *American Journal of Family Therapy*, *47*(4), 216–231. https://doi.org/10.1080/01926187.2019.1624224

This article does not represent original research, but is a literature review of effects of childhood sexual abuse, Narrative therapy as a treatment, and vignettes of it applied in couple counseling. It cites research on the prevalence of childhood sexual abuse, associated symptoms, treatment methods, and outlines the guiding movements of narrative therapy sessions for couples with a trauma background.

The authors note the lack of empirical studies on Narrative therapy with childhood sexual abuse survivors. However, it is a helpful conceptualization for adapting a theoretical model to a couple session.

Nguyen, T. P., Karney, B. R., & Bradbury, T. N. (2017). Childhood abuse and later marital outcomes: Do partner characteristics moderate the association? *Journal of Family Psychology*, *31*(1), 82–92. https://doi.org/10.1037/fam0000208

Hypotheses: 1) Childhood abuse will have an effect on newlyweds' initial levels of marital satisfaction and changes in satisfaction over time. 2) The effect of abuse will be moderated by the positive or negative characteristics of their partner.

The sample for this study was 414 newlywed couples living in low-income neighborhoods, identified through marriage license applications. Data was collected four times over 36 months. Interviewers visited couples in their homes and orally administered self-reports to spouses separately. Then, both partners were videotaped together for three 8-minute discussions: one on problem-solving, one on husband social support, and one on wife social support. Follow up interviews took place at 9 months, 18 months, and 27 months. Videotapes were evaluated by coders trained in the Iowa Family Interaction Scale. Data was also collected on childhood abuse history, relationship satisfaction, intimate partner violence, observed communication, depression, substance abuse, parental divorce history, and individual income.

A chi-square analysis showed that individuals who had experienced childhood abuse were more likely to marry partners who had also experienced childhood abuse $\chi 2$ (1, $N = 431$) = 5.89, $p = .02$. APIM analyses indicated that wives' marital satisfaction was not impacted by their husbands abuse histories ($b = .78$), $t(852) = 1.77$, $p = .07$. However, non-abused husbands experienced lower marital satisfaction than husbands in relationships where both partners had histories of childhood abuse.

By the fourth follow-up, 37 couples were no longer in a relationship. Researchers used a chi-square test of independence to determine the relationship between divorce rates and histories of abuse. Childhood abuse was unrelated to divorce: wives, χ^2 (1, N=374) = 0.80, $p = .46$; husbands, χ^2 (1, $N = 374$) < 0.01, $p = .99$.

Husband abuse history was a significant predictor of lower relational satisfaction at the first data collection (b= -.69), $t(856) = -1.92$, $p = .05$, but not of changes in their relationship by three years of marriage. Wife abuse history predicted both lower relational satisfaction early in

their marriage (b = -1.13), t (856) = -3.37, p < .01, and decreased relational satisfaction as the relationship progressed, three years into marriage (b = -.97), t(852) = -2.32, p =.02 .

The relationship between marital satisfaction and childhood abuse was not moderated in any way by either positive or negative partner characteristics for either husbands or wives.

This study has many strengths. First, researchers took the racial demographics of the neighborhood they were researching into account, and kept their sample proportionate to the larger population. Second, the four-year study offers insight to how abuse effects relationships as marriages develop. However, their measures of childhood abuse did not include emotional harm and neglect. This study also did not differentiate between levels of trauma that result from abuse.

Shi, L. (2021). Trauma symptoms and relationship satisfaction: An examination of self and partner contribution in dual-trauma outpatient clinical couples. *American Journal of Family Therapy*, *49*(1), 1–15. https://doi.org/10.1080/01926187.2020.1845251

Nondirectional Hypothesis: To some extent, the trauma of both spouses will contribute to individual and mutual functioning. Are both self and partner trauma histories significant predictors of trauma symptoms and relationship satisfaction? Secondary hypothesis: there will be variations.

Participants were treatment seeking heterosexual couples who completed questionnaires about their trauma experiences before their first session. It was a relatively low-trauma sample. Males and females experienced the same level of emotional abuse, physical abuse, emotional neglect, and physical neglect. Females experienced more sexual abuse (20% of females and 24% of males recorded multiple types of abuse). Multiple forms of childhood trauma were not related to trauma symptoms for male. For females, multiple types of childhood trauma were correlated with dysphoric mood, post-traumatic stress, and self-dysfunction. For males and females, the

self's trauma predicted dysphoric and post-traumatic symptoms. However, partner trauma predicted symptoms of sexual difficulties. The largest effect on males was correlated with their female partner's experiences of physical neglect. For females, it was their male partner's experience of physical and sexual abuse. Scores of self-dysfunction were related both to self and partner trauma.

VanBergen, A. M., Bartle-Haring, S., Kawar, C., & Bortz, P. (2021). Trauma and relationship satisfaction in treatment seeking couples: A dyadic investigation of differentiation as a mediator. *Contemporary Family Therapy: An International Journal*, *43*(2), 140–153. https://doi.org/10.1007/s10591-021-09565-x

Hypotheses: 1) Interpersonal trauma history will be negatively associated with differentiation. 2) One's interpersonal trauma history will be directly related to their own relationship satisfaction through their own differentiation. 3) One's interpersonal trauma history will be indirectly related to their partner's relationship satisfaction through their own differentiation.

This study does not address treatment of couples, but rather some of the challenges couples who have been exposed to trauma may face. Data was collected from 104 heterosexual couples through questionnaires about demographics, relationship satisfaction, differentiation, depression, stress, emotional regulation, and trauma. when measuring just the presence of trauma. When measuring the mere presence of trauma, there were no differences between the three groups (two partner trauma, one partner trauma, and no partner trauma). However, when the number of traumas were taken into account, male trauma significantly positively correlated with depressive symptoms (0.284**), and significantly negatively correlated with relationship

satisfaction (0.311**). Male (-0.324**) and female (-0.308**) partner trauma both negatively correlated with their capacity for differentiation within the relationship.

VanBergen, A., Blalock, J., Bryant, A., Bortz, P., & Bartle-Haring, S. (2020). Couples and trauma history: A descriptive overview of interpersonal trauma and clinical outcomes. *Contemporary Family Therapy: An International Journal*, *42*(4), 335–345. https://doi.org/10.1007/s10591-020-09548-4

Research Questions: 1) Do couples with interpersonal trauma history experience differences in therapeutic alliance, number of sessions attended, and termination status than couples without interpersonal trauma history? 2) Are there differences in therapeutic outcome based on the gender of the partner who has a history of interpersonal trauma?

This study utilized two research designs (N = 73). Individuals gave accounts of their High-Magnitude Stressors (HMS; potentially traumatic events), and researchers qualitatively analyzed these for themes (e.g., injury, rape, abandonment). They also used an ex post facto design to correlated traumatic experiences with therapeutic outcomes.

Among couples sampled, 72.2% had at least one partner with exposure to a potentially traumatic event. Overall, there were no significant differences between one partner HMS couples, two partner HMS couples, and no HMS couples in number of sessions attended, termination status, or perceived therapeutic alliance. However, though not statistically significant, women in both partner HMS couples had a more negative view of their therapeutic alliance (M = 5.62, SD = .094) than female participants in one partner HMS couples (M = 6.35, SD = 0.59), F (2,37) = 2.93, p = 0.07, partial η^2 = 0.14.

A major weakness of this study is that it does not account for the severity or type of trauma. It could be that there would be greater differences between couples that experienced

severe trauma (e.g., physical assault) or have one or more partner that qualify for a diagnosis of PTSD and couples who experienced fewer trauma symptoms.

Whisman, M. A. (2014). Dyadic perspectives on trauma and marital quality. *Psychological Trauma: Theory, Research, Practice, and Policy*, *6*(3), 207–215. https://doi.org/10.1037/a0036143

Hypothesis: 1) Trauma in either partner will be associated with poorer marital quality. 2) A history of trauma in one's partner would moderate the strength of the association between one's own history of trauma and his/her report of marital quality (dual-trauma couples will have lower marital satisfaction).

Unlike many of the studies, this sample (N = 2,161 married couples. Mean age for women: 64.5, SD = 9.8; men: 67.8, SD = 9.5) is not of couples already seeking counseling. Thus, it offers more general insight into trauma-exposed couples' marital satisfaction and mental health compared to non-trauma exposed couples. Data was collected through self-administered questionnaires on trauma exposure and marital quality, which was measured in terms of perceived "positive" and "negative exchanges" (e.g., "How much well does your spouse understand how you feel about things?" vs. "How much do they criticize you?"). In other words, it was measured based on reports of partner behavior. The mean for positive exchanges was 3.42 (SD = 0.61) for wives and 3.62 (SD = 0.61) for husbands. The mean for negative exchanges was 2.02 for wives (SD = 0.68) and 1.92 (SD = 0.61) for husbands. Between partners, there was a correlation of .36 ($p < .001$) for perceived positive exchanges, and .39 ($p < .001$) for perceived negative exchanges. The researcher measured the impact of trauma in two ways: actor effects and partner effects. Actor effects refer to the impact of an individual's trauma on themselves; partner effects refer to the impact of that individual's trauma on their spouse. In actor effects,

participants reported poorer marital quality if they had a history of serious physical attack/assault, physical abuse as a child, a life-threatening illness, or any trauma. In particular, individuals with a history of serious physical assault or physical abuse as a child reported less frequent positive exchanges and more frequent negative exchanges. People with a life-threatening illness/accident or any trauma reported more frequent negative exchanges. These results indicate that there is a significant association between Spouse A's history of trauma and Spouse A's perception of Spouse B.

In partner effects, participants reported poorer marital quality when their spouse had a history of physical abuse as a child or serious physical attack/assault.

However, the second hypothesis was largely unsupported. The significance of actor trauma was lessened by the partner's history of trauma, and vice versa.

The large sample size is an obvious strength of this study. It is also especially important to notice the mean age of participants, and the significant effect of childhood abuse on marital quality. Breaking down types of trauma into sub-categories is also especially helpful. However, it did not include any sexual trauma categories. And while the mean age is helpful in some ways, it is also important to consider that the effects of trauma may be different earlier in a marriage. The study also does not account for the number of participants who were in their second, third, etc. marriage, which may also have an effect.

Whittaker, K. J., Johnson, S. U., Solbakken, O. A., Wampold, B., & Tilden, T. (2021). Childhood trauma as a predictor of change in couple and family therapy: A study of treatment response. *Couple and Family Psychology: Research and Practice*. https://doi.org/10.1037/cfp0000181

Non-directional hypothesis: Survivors of childhood abuse will respond differently to couple and family therapy than clients without that history.

This study evaluated 36 couples and nine individuals ($N = 81$). The sample was drawn from patients and spouses of patients hospitalized in a psychiatric center; these were planned hospitalizations, not crisis admittances (i.e., participants were not actively suicidal, homicidal, psychotic, or experiencing an ongoing addiction). The majority of participants who had been hospitalized had at least one mental health diagnosis; only 25.9% had no psychiatric diagnosis. 30.3% of participants had survived childhood physical or sexual abuse. Clients completed pre- and posttreatment assessments; treatment was holistic, family/couple focused care that included multiple individual and family counseling sessions, weekly art therapy sessions, weekly psychoeducation sessions, and semi-weekly physical exercise sessions.

The data includes frequent assessments that run from the beginning to the end of treatment; these were analyzed using longitudinal mixed modeling as a two-level structure: weekly observations within individual participants. Researchers used paired *t*-tests to show significant improvement from pre- to posttreatment assessments on all measures (Beck Depression Inventory, Symptom Checklist, Inventory of Interpersonal Problems, Posttraumatic Check List for DSM-5, Patients Health Questionnaire Depression Module, Generalized Anxiety Disorder Screener, Revised Dyadic Adjustment Scale, and Family Assessment Device). Cohen's *d* ranged from small ($d = .31$ for the Generalized Anxiety Disorder Screener) to large ($d = .92$ for the Family Assessment Device).

Participants with trauma experiences improved less in the domain of Family Assessment (estimate -0.6, $p < .001$) and Dyadic Adjustment (estimate = 1.1, $p = .01$) from the beginning to the conclusion of treatment compared to clients without trauma. There was no difference

between clients with and without trauma on measurements of Generalized Anxiety and Patient Health; both groups showed similar improvement.

This study has very strong clinical implications; it showed effective treatment for all participants, regardless of background, while also highlighting particular difficulties for clients with trauma histories. Obviously, there was no control group, and it is impossible to isolate treatment methods to determine which are most effective. There are also concerns about generalizability; this study took place in Norway, where mental health care is much more accessible than in the United States. Most participants were treated in this in-patient facility with housing for their families for twelve weeks on sick leave; this level of care is simply unobtainable for most Americans. So, it is unclear how these results would translate to a client receiving weekly hour-long sessions, with or without their family. Also, data was collected through therapist report, and does not include the client's own perception of their mental health. Data was also only collected on the client who was hospitalized; although spouses and parents were present in some dimensions of treatment, their own perceptions and changes are not documented.

Whittaker, K. J., Stänicke, E., Johnson, S. U., Solbakken, O. A., & Tilden, T. (2022). Troubled relationships: A retrospective study of how couples with histories of trauma experience therapy. *Journal of Couple & Relationship Therapy*. https://doi-org.milligan.idm.oclc.org/10.1080/15332691.2022.2053262

This is a qualitative study that utilizes in-depth interviews and thematic analysis. It focuses closely on three couples ($N = 6$) who were selected because they were not responding well to therapy. It is a follow up to the findings of Whittaker et. al., 2021; participants were patients of the same psychiatric hospital. Inclusion criteria was meeting the clinical cutoff on the

Family Assessment Device, which measures interpersonal difficulties, by the end of their therapeutic treatment and at least one partner had a history of childhood trauma. Researchers focused on three questions: 1) How does the participant perceive the couple counseling outcome? 2) How does the participant perceive the collaboration with their partner and their therapist? 3) How does the participant perceive the influence of past trauma on the therapeutic process?

Several common tendencies emerged between couples. Many participants felt they were responsible for their poor therapeutic outcome. The participants also tended to recognize difficulty collaborating with both their partner and the therapist. Those who struggled the most perceived their spouse as having better rapport with the therapist than they did. All participants tended to limit the impact of their trauma on the therapeutic process.

Also, all the couples attributed some of the poor outcome to the sessions shifting from couple-focused care to one individual in the relationship. Participants believed this occurred because they could not agree on the focus of the counseling, and the therapist did not renegotiate to accommodate both.

This study focuses on a very niche sample and is not generalizable. There were also concerns about language barriers for some participants. However, it partially answers the second question of my review (when is couple therapy effective for adults who have experienced trauma?) by addressing when couple therapy is *not* effective.