ABSTRACT

Title of Thesis: **THE SPILLOVER EFFECT: ASSESSING THE IMPACT OF DYADIC COHESION ON THE ASSOCIATION BETWEEN ANGER/IRRITABILITY TRAUMA SYMPTOMS IN FATHERS & FAMILY CONFLICT BEHAVIOR**

Rolonda Williams, Master of Science, 2018

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Prior research in the field of family science and family therapy has employed a narrative surrounding mother's contributions to family dynamics and family functioning. Researchers have also consistently examined the mental health experiences of the mother and their impact on family issues, yet we are left with little understanding of how the mental health experiences of fathers contribute to the development of family issues.

This study analyzed the link between fathers' reports of anger/irritability trauma symptoms and family conflict behavior through employing the spillover hypothesis. Father reports of marital dyadic cohesion were examined as a protective factor in this association. The study used data previously collected from a clinical sample of 186 fathers who sought therapy services at the Center for Healthy Families (CHF), an individual, couple and family therapy clinic at the University of Maryland, College Park. In support of the spillover effect, the results indicate a positive association between fathers' anger/irritability trauma symptoms and family conflict behavior. However, dyadic cohesion did not serve as a protective factor in this association.

THE SPILLOVER EFFECT: ASSESSING THE IMPACT OF DYADIC COHESION ON THE ASSOCIATION BETWEEN ANGER/IRRITABILITY TRAUMA SYMPTOMS IN FATHERS & FAMILY CONFLICT BEHAVIOR

By

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Forward

Dear reader,

As you begin to read this research, it is important to note my passion about this research. My passion in this research is reflective of the passion I have in my clinical experience. Based on my research and my clinical experience, I have seen that the role of a father gets very little recognition in the context of family issues. Fathers have important roles in the family system, however the role of the father doesn't seem as acknowledged as other roles within the family system. This research is a way to advocate for fathers and assure that their role in the family system is just as recognized as mothers.

Another major passion in this research stems from the desire to want to understand the development of family conflict. Family conflict can have a major effect on every individual in the family system. These effects can be detrimental to the mental and emotional processes of family members and impact their relationships with each other and even the relationships that they can develop in the future. Understanding how family conflict occurs or the things related to family conflict can contribute to changing the trajectory of family functioning. There is a great need to increase healthy functioning in families. An individual's family life can set the precedent for many other things that can occur in that individual's life later. The family environment has much significance influencing the realities that people experience. It can be the start of a person's reality. Therefore, while you are reading this work of art, I am hoping that these two passions will resonate through the writing and that the importance of this research will be made clear. Hopefully you find value in this work and think more intentionally about how we should view fathers and families.

Acknowledgements

This thesis reflects my entire graduate school experience. The time, mental and emotional energy placed into this research was immense. I advocated for this research, suffered and sacrificed in order to have this experience and see it through until the end.

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Lastly, to my cohort, for sharing tears, laughter and providing me with unconditional emotional support through this process. Thank you each for encouraging me to get through the research and acknowledging that it was much more than just research and that it was a representation of my resilience.

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CHAPTER 1: INTRODUCTION

Statement of the Problem

The development of family conflict has been an area of focus in research on family functioning that has progressed throughout the years. Researchers have investigated a variety of negative consequences associated with participation in or exposure to negative family behavioral interactions. For example, children and adults who are exposed to high levels of family conflict are at risk for critical mental health issues such as depression (Formoso, Gonzales & Aiken, 2000; Habib et al., 2014; Park, Unützer & Grembowski, 2014; Rice, Harold, Shelton & Thapar, 2006), anxiety (Tanaka, Raishevich & Scarpa, 2010; Herzer, Vesco, Ingerski, Dolan & Hood, 2011), lower levels of life satisfaction (Habib et al. 2014), and drug and alcohol dependence (Wu, Lu, Sterling & Weisner, 2004).

Researchers who have studied family functioning have provided varying definitions for what constitutes relational conflict. Conflict can be defined as differences between the goals, beliefs, or preferences of members of a couple or family (Kline, Pleasant, Whitton, & Markman, 2006). For example, two partners may have distinct ideas about responsibility of household tasks or issues regarding parenting. Conflict can also be defined as overt conflictual behaviors exhibited by members of a relationship, in response to the differences in their goals (Habib et al., 2014). Definitions of conflict that focus on overt behavior examine how family members behave toward each other and handle expressed differences or disagreements. Although any couple may engage in some negative interactions during conflict, non-normative levels of negative behavior can create dysfunction on an individual and/or systemic level. For example, Habib et al. (2014) define family conflict in terms of behavioral interactions that include arguments, as well as physically and psychologically abusive behavior. A study by Choe et al. (2014) on mental health

problems in young adulthood defined family conflict as negative parent-child interactions associated with young adults' adaptation to demands of parents during pivotal developmental transition periods.

Despite differences in how conflict has been defined, researchers have viewed it as an area of family functioning that can contribute to both individual and relational stressors (Aronson, Kyler, Morgan, Perkins, & Love, 2017; Burnstein, Stanger, & Dumenci, 2012). Negative family conflict behavior has been shown to increase the risk of mental and emotional disorders, which affects couples, individuals, and families across the lifespan (Amato, 2000; Bal, De Bourdeaudhuij, Crombez & Van Oost, 2004; Formoso et al. 2000). The systemic impact of negative family conflict behavior illustrates the importance of a sound empirical understanding of factors that influence the occurrence of such behavior. This research has implications for interventions and programs designed to reduce family conflict.

In the present study, family conflict behavior is defined as overt arguments, negative interactions, blaming, or competition between relatives. Fathers' level of psychological distress, specifically ongoing symptoms of trauma, is explored as a potential contributing factor to family conflict. There has been a long tradition of family research focusing on the role of mothers in family problems and development of child adjustment issues. This can be traced back at least partly to the concept of the "schizophrenogenic mother." During the 1960s, researchers theorized that mothers caused the development of schizophrenia in offspring by communicating in confusing and stressful ways to a child, sending conflicting messages to manipulate the child in an effort to satisfy her own needs (Mitchell, 1968). While this idea was eventually disproven, it popularized the systemic notion that the mental health and negative emotional processes of the mother can greatly affect the parent-child relationship. Over time, the focus on mothers as the

primary source of problems between and within family members has been maintained, particularly in studies that investigate links between maternal mental health problems and negative outcomes of children (Creswell, Apetroaia, Murray & Cooper, 2013; Duggan, Berlin, Cassidy, Burrell & Tandon, 2009; Guttentag et al., 2014). More specifically, studies have examined the impact of the emotional processes experienced by mothers as a result of their mental health condition (Granat, Gadassi, Gilboa-Schechtman & Feldman, 2017). What such studies have suggested is that negative emotional processes stemming from mental health conditions of a mother can have significant impacts on family functioning and child development. For example, a study conducted on maternal depression, emotional processes, and infant emotion regulation indicated that the negative affect of mothers diagnosed with depression was associated with disruption in infant emotion regulation (Granat et al., 2017).

While research focusing on maternal mental health and family processes has provided valuable information, it generally lacks an exploration of the role of the father on the family system. Moreover, it can encourage mother-blaming, a concept that has been perpetuated in research for many years and may be harmful to mothers (Jackson & Mannix, 2004). Although we have learned a lot from the research on mothers and their contributions to areas of family functioning, there is a gap in research on the contributions of fathers.

Although research investigating fathers' contributions to family system functioning has been limited compared to the research on mothers' influences, a significant body of research has explored the effect of post-traumatic stress disorder (PTSD) symptoms of fathers in the military on family stress. Studies on fathers suffering from PTSD have examined an array of negative emotional responses expressed by the father, such as elevated tension and anxiety (Dansby & Marinelli, 1999). Symptoms of PTSD have been found to affect an individual's functioning

within the family, including emotional avoidance and distancing, decreased positive affect, and increased irritability and hostility (Campbell & Renshaw, 2013; Cox & O'Loughlin, 2017; Lavee & Ben-Ari, 2004).

Research on fathers with PTSD has established a strong association between anger and intimate partner violence, which can be understood as an aspect of family conflict (Massa, Eckhardt, Sprunger, Parrott & Subramani, 2017). Jakupcak and Tull (2005) found that a history of exposure to trauma is associated with greater levels of hostility and violence. There is a high risk of perpetrating violence against family members in fathers diagnosed with PTSD and experiencing symptoms of hostility. Link and Palinkas (2013) found that father veterans who had experienced trauma via combat-related injuries experienced elevated levels of conflict in their families. They investigated dysfunction in each level of the family, including the individual level (the father's functioning), the parental level, and the child subsystem. In their sample of veterans of the Vietnam War, there were reports of high levels of conflict, hostility, physical aggression and poor family adjustment (Link & Palinkas, 2013). Many participants reported high levels of family disruption and vulnerability to family stressors. The study also examined the association between psychological injury and long-term family dysfunction through different stages of the veterans' deployments (Link & Palinkas, 2013). Similarly, Davidson and Mellor (2001) reported, **"**Australian Vietnam veterans with PTSD reported poorer family functioning, including poorer problem-solving, affective relatedness, communication, and mutual interest and involvement than Australian Vietnam veterans without PTSD and non-veterans" (p. 349).

This body of research indicates that fathers' military-related PTSD and problems with family relationships can initiate conflict, indicating that the father's functioning can influence the entire family system. However, little is known about whether or not trauma symptoms

experienced by civilian fathers have similar negative associations with family conflict. There is a significant gap in knowledge about the links between paternal psychological and emotional functioning and family functioning. The present study was designed to increase knowledge about the degree to which trauma symptoms in a sample of civilian fathers are associated with negative conflict behavior in their families.

Theoretical Base for the Study: Systems Theory

This study was guided by concepts from systems theory, which states that an individual's life experiences cannot truly occur and be understood in isolation of his or her relationships with other family members. Systems theory postulates that each subsystem in a family (e.g., parental or child subsystem) can and will have an impact on the entire family unit (Smith-Acuna, 2011). The "spillover effect" is a sub-concept of systems theory that provides a conceptual base for this study. The spillover hypothesis that derives from systems theory proposes that, "tension, mood/affect, and conflict can be transferred from one part of a family system to another" (Almeida, Wethington, & Chandler, 1999, p. 49). For example, conflict in the couple dyad can spill over into parent-child relationships.

The spillover effect has been examined most frequently in research on marital dyads and parent-child relations (Kouros, Papp, Goeke-Morey & Cummings, 2014; Stroud, Durbin, Wilson & Mendelson, 2011), with evidence that conflict in the couple's relationship is associated with harsher parenting of their children. Similarly, studies have found associations between a mother's psychiatric symptoms such as depression and difficulties in her parenting behavior (Brody & Flor, 1997; Davies & Windle, 1997; Duggan, Berlin, Cassidy, Burrell, & Tandon, 2009; Ferro, Boyle, & Avison, 2015). However, as already noted, there has been little research on possible spillover effects between problems in fathers' individual psychological functioning

and family functioning. This study focused on this idea and tested the hypothesis that paternal mental health symptoms (specifically trauma-based anger symptoms) can spill over into conflictual family functioning.

Based on the notion of a spillover effect, in addition to investigating the association between paternal trauma symptoms (specifically anger/irritability) and levels of family conflict, this study also investigated if dyadic cohesion, as an element from the couple dyad, could also be linked to family conflict. This investigator was also interested in investigating if dyadic cohesion could have a buffering effect on the association between fathers' anger/irritability trauma symptoms and family conflict. Dyadic cohesion is defined in this study as emotional bonding, support, and interests and activities shared by a couple (Spanier, 1976). The emotional resource experienced by fathers who share common interests, quality time, and activities with their partners may reduce the initial spillover of their internal experiences of trauma symptoms into family conflict.

Research has suggested that dyadic cohesion is linked to social and emotional adjustment of family members (Wentzel & Feldman, 1996). Olson (2000) summarizes his program of research indicating that dyadic and family cohesion and flexibility are essential to family functionality. Considering this process, dyadic cohesion could lessen the association between anger/irritability trauma symptoms on family conflict behavior.

Purpose

Research on anger/irritability trauma symptoms in fathers and their effects on family functioning has been conducted primarily with military samples and does not provide a representative context for understanding family consequences of father trauma experiences among civilian couples and families (Bachem, Levin, Zerach, Solomon, 2017; Cozza et al.,

2010; Dansby & Marinelli, 1999; Khaylis, Polusny, Erbes, Gewirtz & Rath, 2011; Link & Palinkas, 2013). The research on trauma symptoms in civilian fathers is already scarce, but especially scarce in the context of family relations. The outcomes of those prior studies indicated strong associations between individual psychopathology and elements of family dysfunction and family violence, including intimate partner violence.

Fathers exhibiting negative affect, including anger and irritability, in the family context may contribute to more family conflict. Their trauma symptoms can spill over into the experiences of other family members, such as partners or children. In turn, the hostility the father experiences due to his mental health condition can become exacerbated in a conflictual family context. In a clinical context, anger and emotional outbursts can become both normalized and damaging emotional processes exhibited throughout the family. In expressing anger and hostility, fathers can model dysregulation of emotions that not only can be learned by other family members, but also can interfere with the family's ability to resolve issues.

Dyadic cohesion is an element of couple interactions that has also demonstrated positive spillover into family functioning. Considering the strong association between dyadic cohesion and other family dynamics (Gehring, Wentzel, Feldman & Munson, 1990; Martin & Cole, 1993), it is possible that dyadic cohesion could moderate the association between anger/irritability trauma symptoms in fathers and family conflict behavior. Dyadic cohesion could serve as a major resource for multiple systems within the family. More specifically, it could be a resource for the individual suffering from trauma symptoms as well as for weakening the association between anger/irritability trauma symptoms and family conflict behavior. Dyadic cohesion may offer couples with a sense of connection that could be used in times of challenges with mental health as well as challenges that occur within the family unit. Additionally, this shared interests

and connection could potentially provide couples with a sense of solidarity that may be useful in resolving high conflict situations that occur at the individual, couple and family levels.

Therefore, the purpose of the present study was to use the spillover hypothesis from family systems theory as a guide in an effort to expand research on the association between fathers' anger/irritability trauma symptoms and conflict in the family system, expand our understanding of trauma outside of the military community, and understand dyadic cohesion as a protective factor within the association between fathers' anger/irritable trauma symptoms and family conflict behavior.

Research Questions

1. Is there an association between fathers' anger/irritability trauma symptoms and level of negative family conflict behavior?
2. Does dyadic cohesion in the couple relationship moderate the association between fathers' anger/irritability trauma symptoms and level of negative family conflict behavior?

Hypotheses

(1) Higher father reports of anger/irritability trauma symptoms will be associated with greater negative family conflict behavior.

(2) Couple dyadic cohesion will moderate the relationship between father's anger/irritability trauma symptoms and reports of negative family conflict behavior. Higher rates of dyadic cohesion will weaken the association between anger/irritability trauma symptoms and reports of negative family conflict behavior.

CHAPTER 2: LITERATURE REVIEW

Family Conflict Behavior

Conflict is a normative and expected part of family life, considering that individuals may have differing viewpoints at a given time. Families who are able to overcome conflict and adversity together can experience more comfort and confidence not only within their household but also in the issues they face outside of their home (Walsh, 2004). Family members can have healthy disagreements that do not negatively influence their functionality. Family conflict can arise in many different forms, ranging from work-family conflict to conflict regarding family roles. However, concern arises when conflict behavior is associated with family dysfunction, as well as when family members are exposed to risks for other mental health and emotional difficulties.

Family conflict behavior affects the quality of family relationships and the well-being of members of the family. Research shows that experiencing high levels of family conflict can be associated with the development of various mental health problems, such as depression, anxiety, and substance dependency (Formoso et al., 2000; Habib et al., 2014). High levels of family conflict behavior can affect multiple areas of the family dynamic, such as the family's ability to be emotionally available, be supportive of one another, and develop healthy attachment (Broman, Roba, & Trahan, 1996; Kadmon, Ganz, DeKeyser, Rom, Miri, & Woloski-Wruble, 2008; Whisman, 2014; Weiss, 2004). This can be particularly concerning for children. Without the ability to solve family disagreements without compromising the overall functioning of the family, high conflict behavior can continue to build up and lead to impairments in functioning. Habib et al. (2013) found that 33 percent of Australian children in 2006 were exposed to levels of family conflict that are likely to increase future risk for depression. Arguments, abusive

behaviors, name-calling, and forms of family violence are all family conflict behaviors that can predict a large number of negative outcomes. Research into different stressors that lead to family conflict behavior has found that one of the strongest predictors is the mental health experiences of the parent(s) (Creswell et al., 2013; Granat et al., 2017; Link & Palinkas, 2013; Massa et al., 2017).

Spillover Effect

It is understood that difficulties in mental health can create challenges not only for one individual but also for those around them. Parents in particular have an influence on the family system as a whole, and understanding their mental health can inform interventions and treatment plans with the goal of preventing or decreasing spillover effect from mental health issues of the parent(s) into the family life. As indicated by research on mothers, the functionality of a parent can be a major contributor to family relations and child development (Creswell et al., 2013; Granat et al., 2017; Guttentag et al., 2014). For military fathers, this contribution already has been demonstrated. Studies have indicated that families with military fathers suffering from PTSD have higher levels of family conflict and difficulties in family adjustment (Link & Palinkas, 2013).

The spillover hypothesis also can be tested to look at the contributions of civilian fathers to family conflict behavior. The spillover effect has been used in research to understand, for example, how characteristics and behaviors are carried over from one subsystem to the other. This theoretical framework has been utilized in studies on work-family conflict (Hill, Hawkins, Märtinson, & Ferris, 2003; Koch, 2002; Voydanoff, 2002). Spillover can have a positive or negative effect. Positive spillover improves functioning and promotes growth, while negative spillover creates consequences that adversely affect functioning and growth. Some studies on

work-family conflict have addressed aspects of positive spillover (Chen, Powell & Greenhaus, 2009; Masuda, McNall, Allen, & Nicklin, 2012). One study in particular found that work-family boundary management resources were associated with low levels of family conflict (Chen et al., 2009).

Kouros et al., 2014 conducted a study including a sample of 296 heterosexual couples with children and examined the spillover effect between dyadic quality and relationship quality in the parent-child system. Their results showed that spillover occurs in the context of family interactions where there is tension, negative affect, depressive symptoms and conflict in the dyadic dyad, and those types of interactions transfer to the parent-child dyad. Parents can become drained from the issues in their relationship and exhibit irritability when interacting with their child (Kouros et al., 2014). The study supports a spillover hypothesis for both mothers and fathers on parent-child relationship quality. The results of the study indicated that high levels of maternal depressive symptoms were related to lower levels of child reported parental acceptance and involvement. Additionally, it was found that fathers' ratings of dyadic quality positively predicted father-child relationship quality (Kouros et al., 2014).

One area of mental health that can be characterized by high levels of hostility or irritability is trauma (American Psychological Association, 2013). However, most of the research on trauma and its potential spillover effect on the family system has been limited to the experience of PTSD among military fathers (Cox & O'Loughlin, 2017; Davidson & Mellor, 2001; Goff, Crow, Reisbig & Hamilton, 2007). However, trauma in civilian fathers is an area of research that has been neglected. The spillover effect provides a theoretical basis on which to conduct this research and better understand the effects of fathers' mental health on the family system.

Father's Trauma Symptoms and their Effect on Families

Anger and irritability are common symptoms of trauma or trauma-related disorders. Additionally, research has identified anger as a prominent symptom of post-traumatic stress disorder (Franklin, Posternak, Zimmerman, & 2002). According to Beckham, Feldman, Kirby, Hertzberg and Moore (1997), 75 percent of combat veterans with PTSD perpetrated at least one act of aggression within the last year. Anger and irritability are commonly seen in research and clinical practice as both internal and external symptoms of PTSD, via the subjective experience of anger/irritability, and its expression through aggressive behavior, respectively (Posternak & Zimmerman, 2002).

The concept of anger-related trauma emerged in studies on Vietnam veterans (e.g., Beckham, et al., 1996; Chemtob, Hamada, Roitblat, & Muraoka, 1994; Frueh, Henning, Pellegrin & Chobot, 1997). It has continued to be investigated primarily within the military population. Anger as a symptom of trauma can cause several individual and interpersonal difficulties. Individuals who experience anger and symptoms of irritability from trauma may often experience impairments in daily functioning. The impairments can be psychological, emotional or physical, such as increased heart rate or blood pressure (Jakupcak & Tull, 2005). In addition to the individual impairments, individuals who experience anger and irritability from trauma report a number of challenges in their relationships. Due to these interpersonal difficulties, spouses and families who are closest to individuals suffering from trauma can often be the persons suffering the most negative spillover of that anger and irritation. Many studies have confirmed that veterans with PTSD exhibit aggressive behavior in close relationships, mainly toward their partner or children (Evans, Cowlishaw, & Hopwood, 2009; Lambert, Engh, Hasbun & Holzer, 2012).

Violent and aggressive outbursts are one of the major characteristics of PTSD. Expression of anger toward a partner can increase risks and lead to many additional individual and family issues related to intimate partner violence (Price, Bell & Lilly, 2014). Researchers have found that arousal symptoms of PTSD can be classified as behaviors reflecting anger outburst, acts of aggression, or expression of irritability. Based on this study, it was suggested that anger outbursts and expression of irritability are likely to be the aspects of arousal symptoms that are most problematic for relationships. A longitudinal study on pathways leading to explosive anger among adults 18 years and older (53 percent of which were women and 43 percent of which were men) in two villages, rural and urban, reported associations between explosive anger and indices of functional impairment and conflict with the spouse and family (Silove et al., 2017).

Experiencing anger/irritability from trauma can cause isolation, create difficulties in relationships, and intensify other challenges. A study examining family-directed anger of 143 traumatized Cambodian refugees (102 mothers and 41 fathers) provides evidence of the transmission of anger to family conflict behavior (Hinton, Rasmussen, Nou, Pollack & Good, 2009). The participants of the study were attending an outpatient psychiatric clinic, and fifty-six percent of them were diagnosed with PTSD. Forty-eight percent of the participants had anger directed toward someone in their nuclear family unit (Hinton et al., 2009). Participants also exhibited medical conditions resulting from their anger episodes, such as heart palpitations that met panic attack criteria and risks for rupture of neck vessels (Hinton et al., 2009).

Similar to the medical risks associated with expression of anger, there are psychosocial and emotional risks associated with the experience of symptoms of trauma. Anger as a result of traumatic experiences can often lead to emotional withdrawal and decrease in family support

(Ray & Vanstone, 2009). Additionally, anger/irritability symptoms can severely affect family relationships, predict dysfunction in the family, and make it difficult to maintain connection and emotional safety. Without the proper resources and support, anger symptoms from trauma can continue to damage an individual's overall functioning and interpersonal relationships.

Dyadic Cohesion

Dyadic cohesion was investigated in the present study as a possible buffer in decreasing the spillover between fathers' anger/irritability trauma symptoms and family conflict behavior. Dyadic cohesion has been researched in many different contexts, ranging from the impact of dyadic cohesion on parents of children with autism (Gau et al., 2011), to the impact of dyadic cohesion on medical conditions such as hypertension (Tobe et al., 2007).

The investigation of dyadic cohesion stems from Olson's circumplex model of dyadic and family systems. This model focused on assessing relational dynamics, relational diagnosis, and effective treatment planning for dyadic and family therapy (Olson, 1999). Olson's model focused on cohesion, flexibility, and communication as three core dimensions of family interactions. Olson, Sprenkle, and Russell (1979) conceptualized cohesion as a spectrum with a curvilinear relationship to family health. According to their research, too much cohesion leads to problematic enmeshment that interferes with individual members' functioning and well-being, whereas lack of cohesion leads to disengagement and lack of mutual social support, which could interfere with the couple's or family's ability to cope with life stresses together and compromise individual functioning. Olson et al. (1979) suggested that a balance in cohesion is a characteristic of healthy family functioning. This type of balance in cohesion should start in the couple relationship/parental subsystem. Cohesion, healthy functioning, and problem solving can be modeled at the parental subsystem and can initiate positive spillover within the family unit.

Cohesion can be a determining factor in strengthening each subsystem in the family relationship. This becomes more likely when there is a healthy level of cohesion modeled in the couple/parental subsystem. Cohesion is particularly important during times of family challenges. A lack of cohesion could predict more disconnect and less resiliency over family conflict. Olson (1999) reported that fathers who were disengaged from their wives were likely to be disengaged from their children, indicating the significance of spillover effect from family subsystems. This suggests that the degree to which a father feels close to his partner could mirror how close he feels with his children.

One study reviewed dyadic cohesion in the context of parenting a child with autism, and found that fathers of children with autism reported psychological distress and adaptation problems (Gau et al., 2011). The researchers suggested that parents of children with autism would display more psychopathologies, dyadic issues, and family dysfunction (Gau et al., 2011). This idea was based on the research regarding the psychological problems and dyadic distress occurring in both mothers and fathers of children with autism (Davis & Carter, 2008, Hastings & Brown, 2002). The fathers in this study demonstrated high levels of obsession, interpersonal sensitivity, hostility and paranoid reaction (Gau et al., 2011). The results indicated that mothers of children with autism perceived higher levels of cohesion in comparison to fathers (Gau et al., 2011).

High levels of cohesion in marriage could provide a sense of stability that makes negotiation and conflict resolution easier. This could also be described as positive spillover effect. Couples could negotiate dyadic and family conflict while still experiencing a sense of connection in their relationship. A father who is experiencing psychologically distressing trauma

symptoms such as frequent hostility could benefit from shared interests, emotional bonding, and connection with his partner.

Dyadic cohesion has also been investigated in terms of its implications for physical and medical health conditions. According to Tobe et al. (2007), dyadic cohesion has a strong negative association with ambulatory blood pressure. It has been suggested that on a broader scale, dyadic factors are related to cardiovascular functioning. Low levels of dyadic cohesion have been proven to exacerbate individual and family experiences ranging from mental to physical health (Baker et al., 1999; Gau et al., 2011; Tobe et al., 2007). This is also supported by a study by Droupy, Pello-Leprince-Ringuet, Perrot, and Descazeaud (2017) examining the relationship between dyadic cohesion and acceptance of disease and treatment. The perception of relationship cohesion has an impact on the quality of life of patients in treatment for prostate cancer. Based on analysis conducted with 459 prostate cancer patients, results indicated that patients' perception of cohesion in their couple relationship predicted the perception they had of their illness (Droupy et al., 2017). The patient's optimistic view of their illness was correlated with the patient's perception of cohesion of their relationship and performance status.

The findings from these prior studies suggest that if fathers are experiencing psychological distress in their trauma symptoms that spills over to family conflict, the presence of cohesion in their couple relationships may reduce the degree to which trauma symptoms affect the levels of conflict and distress experienced by the father and other family members. The strong sense of coherence between the members of the couple may ease conflict and tension as they arise.

The couple's dyadic cohesion can also serve as a positive model for the family to engage in mutual support and problem solving. It is necessary to have this balance in the couple

subsystem in order to be able to better handle issues individually and as a family unit. While high levels of family conflict are seen to negatively affect all systems and subsystems of the family across the life cycle, Olson (1999) suggests that couples and families who are balanced in terms of their connection tend to be more functional across the life cycle. Considering the potential negative long-lasting effects of family conflict behavior on overall functioning of family members, the present study was intended to increase knowledge about factors that could be associated with the development of family conflict behavior. This information could provide recommendations for and ultimately improve prevention and intervention work. Based on systems theory, particularly the spillover effect, the present study focused on fathers' experiences of trauma symptoms, their association with family conflict, and the possible moderating effect of dyadic cohesion in this association.

CHAPTER 3: METHODOLOGY

Sample and Procedures

The present study was a secondary analysis of preexisting data collected at the Center for Healthy Families (CHF) from 2000 through 2015. The CHF is an outpatient training therapy clinic located in College Park, Maryland that serves individuals, couples, and families. As part of the regular procedure at the CHF, at the first appointment, all clients are asked to complete a set of assessments regarding aspects of their individual and relational functioning. All clients and research participants were informed of clinic research conducted, signed informed consent, and were given the opportunity to withdraw from services at the CHF. Consent forms were signed in a pre-therapy assessment session, after therapists reviewed confidentiality and other aspects of the research procedures with the clients. For the purposes of this study, data were analyzed from fathers who were 18 years of age or older, self-identified as heterosexual, were married or cohabiting with a significant other, and who have at least one child living with them in the same household. Information regarding the length of the relationship and number of children living in the household were also examined in this study. Income and age were considered as potential control variables.

Procedures

Considering that the data for this study were secondary data, most procedures involved compiling collected information from clients at the CHF. Using the information from the family's intake assessment, data on relationship status, family structure, age and length of relationship were examined. The demographic information of race and age were considered as potential control variables in the present study. Participants were screened during the intake process for severe violence, current danger of abuse, suicide or homicide before participating in

any therapy sessions. Next, clients were given assessment measures and additional paperwork to complete. In order to encourage truth and accuracy in reporting, members of couples and families completed assessments in separate therapy rooms.

Measures

Independent Variables

Fathers' trauma symptoms. The Trauma Symptom Inventory (TSI-A) (see appendix A) is a standardized self-report assessment for stress, trauma, and adaptation. It can be used to evaluate both acute and chronic posttraumatic symptomatology (Briere, 1996). This assessment is used for measuring current level of symptomatology of trauma, not specific type of traumatic events or their cause. The TSI-A is a shortened version to the TSI that includes 46 items on trauma symptomatology. The TSI usually is administered to adults over the age of 18. Each item asks about the respondent's experiences of specific trauma-related symptoms.

The TSI-A does not generate a mental health diagnosis but can be used in clinical practice in efforts to determine severity of trauma-related symptoms. There are eight clinical subscales on the TSI-A that address different aspects and symptoms of trauma: (1) anxious arousal, (2) depression, (3) anger/irritability, (4) intrusive experiences, (5) defensive avoidance, (6) dissociation, (7) impaired self-reference and (8) tension reduction behavior. The present study used only the anger/irritability subscale to identify trauma symptoms related to hostility. The anger/irritability subscale examines the extent to which the individual's symptoms influence daily functioning and interactions. This subscale is composed by 9 items that focus on internal and external experiences of anger. Internal experiences of anger are defined as cognitions revealing thoughts of hurting someone. External experiences are defined as yelling or picking fights. An example of the anger/irritability items on the TSI-A is as follows: "*In the last six*

months, how often have you experienced becoming angry for little or no reason, being easily annoyed by other people" (Briere, 1996). Respondents are asked to report on a four-point Likert scale the frequency in which each of the symptoms had occurred for them in the last six months (Briere, 1996). A total score for the anger/irritability scale was calculated by adding participants' responses to each of those nine items.

The anger/irritability scale of the TSI-A has been proven to be reliable across different populations. In the development of the measure, Briere tested the measure on four different samples: a standardized sample, a university sample, a clinical sample, and a sample of Navy recruits. For each of these samples, high Cronbach alpha coefficients were reported. The standardized sample included participants with a mean age of 28 who were either single, married or cohabitating, and the Cronbach's alpha coefficient for the anger/irritability subscale reported for this sample was .90. The clinical sample was made up of 233 participants recruited by therapists at an outpatient clinic. This sample included 203 females and 30 males, of which 82 percent were Caucasian, 10 percent Hispanic, 6 percent African American and 1 percent Asian (Briere, 1996). The Cronbach's alpha coefficient of the anger/irritability subscale reported for the clinical sample was .89, demonstrating that it is a reliable measure to be used on a clinical sample (Briere, 1996). Lastly, the measure was also used on a sample of Navy recruits comprised of 1,813 males and 1,846 females. The mean age of the sample was 20.3 years and the demographic information showed that the sample was made up of 67.7 percent Caucasians (Briere, 1996). The Cronbach's alpha coefficient of the anger/irritability subscale for this sample was reported as .88 (Briere, 1996). High reliability for the anger/irritability subscale was found for each of these samples. The Cronbach's alpha for the present sample also was high (α =.91).

The TSI was tested in prior research for construct, convergent, incremental, and discriminant validity. Each of the subscales was tested for participants in the clinical sample who either had a trauma history or no trauma history. This information was examined separately for females and males. The mean scores were much higher for males and females who had a history of trauma in comparison to those who did not, suggesting the validity of the measure (Briere, 1996). Convergent validity of the measure was established via a correlation between subscales of the TSI and the Brief Symptom Inventory's hostility subscale. The hostility subscale of the BSI and the anger/irritability subscale of the TSI were found to have a correlation coefficient of .77 (Briere, 1996). Overall, the TSI subscales predicted a diagnosis of PTSD in over 90 percent of cases (Briere, 1996) and have proven through many analyses and samples to be both a reliable and valid measure.

Dyadic Cohesion. The Dyadic Adjustment Scale (DAS) (see appendix B) is a standardized self-report measure created to assess for quality of marriages and other romantic dyads. The scale consists of 32 items normed on both married and unmarried/cohabitating couples (Spanier, 1976). The DAS was one of the first assessments to include non-marital and cohabiting couples. The measure seeks to evaluate the characteristics and interactions of the relationship from both partners (Spanier, 1976). The assessment only focuses on the state and quality of the relationship at the time that the measure is given. It includes subscales assessing (1) dyadic consensus, (2) dyadic satisfaction, (3) dyadic cohesion, and (4) affectional expression.

For the purposes of this study, only the dyadic cohesion subscale was used to analyze whether emotional connection and shared interests in the couple dyad is associated with lower levels of family conflict, as well as whether it serves as a moderator of the association between fathers' anger/irritability trauma symptoms and family conflict. The dyadic cohesion subscale is

composed of 5 items focused on common interests and activities in which the couple engages (Spanier, 1976). On a five-point Likert scale, participants are asked to indicate from 0 ("*never*") to 5 ("*more often*") the frequency in which they experienced those joint activities. Examples of the items include: "*do you and your partner engage in outside interests together,*" "*laugh together*" or "*have a stimulating exchange of ideas*").

The DAS was tested for validity and reliability on a sample of white, married couples and employees throughout Centre County, Pennsylvania (Spanier, 1976). The divorced participants were gathered in another sample of individuals in Centre County, Pennsylvania. The respondents were located through county divorce records. Lastly, a small sample of never married/co-habitating couples was gathered to test dyadic adjustment on dyads other than married couples. The measure was tested for internal consistency, and Spanier (1976) found that the internal consistency reliabilities for dyadic cohesion ranged between .72 and .86. Cronbach's alpha for the total DAS was .96 (Spanier, 1976). Spanier tested the measure for test-retest reliability and inter-rater reliability between husbands and wives. For dyadic cohesion, a correlation coefficient of .53 was reported for inter-rater reliability and .88 for test-retest reliability.

The DAS also was tested for convergent, discriminant, predictive, face, concurrent, and criterion validity. In testing convergent validity, the DAS was tested against another measure of dyadic adjustment, the Locke-Wallace Dyadic Adjustment Scale. A correlation of .86 was reported between the two scales for married couples and .88 for divorced respondents (Spanier, 1976). Group differences were reported in examining the use of the DAS in different studies and with different samples. Spanier (1976) reported that in one study, married couples who had cohabited before marriage had significantly higher cohesion than those who did not live together

before marriage. The Cronbach's alpha for the DAS dyadic cohesion subscale in the present sample was good (α =.85)

Dependent Variable

Family conflict. The Beavers Family Inventory (BFI) (see appendix C) is a standardized self-report questionnaire that evaluates each family member's perception of family functioning. The BFI has 36 items. There are five subscales in which participants provide describe specific areas of family functioning. Those subscales are (1) health/competence, (2) conflict, (3) cohesion, (4) directive leadership, and (5) emotional expressiveness. The inventory was created based on the Beavers Systems Model of Family Functioning, which describes what constitutes adequate, mid-range, borderline, and severely dysfunctional families (Beavers, 1982). The scale was normed for families of different demographics, different family members (e.g., adolescent, mother, father), and different ages.

The present study used seven items (i.e., items 5, 10, 14, 18, 23, 25, and 31) from the conflict subscale in order gather information from participants on family conflict behavior (e.g. "*family members pay attention to each other's feelings,*" "*grownups in the family compete and fight with one another,*" and *"one person controls and leads the family*"). Respondents were asked to rate their responses on a 5-point Likert scale ranging from 1 (*"fits our household very well"*) through 5 (*"does not fit our household at all"*). All items were reverse-coded and then added to make the overall score for the conflict scale. Higher scores indicate higher level of family conflict.

Internal consistency and test-retest reliability have been examined previously for this measure. Cronbach's alpha was calculated in order to determine internal consistency. The internal consistency for the scale was reported as between .84 and .88 (Beavers, 1985). Test

retest reliability was assessed over a 30-day period as well as a 90-day period. Results indicated adequate temporal stability, with coefficients ranging from .84 to .87 (Beavers, 1985). The Cronbach's alpha for the present sample was good (α =.86).

Control Variables

Age. Age of the father was controlled for, using data from father respondents between the age of 18 and 65. The recommended age for two of the assessments is 18 years old and older. Research has suggested that age is correlated with work-family conflict and also moderates the relationship between role stressors and work-family conflict (Matthews, Bulger & Barnes-Farrell, 2010). Additionally, populations such as children, adolescents and the elderly are at stages of development that are particularly vulnerable to particular stressors (Silva, Alpert, Munoz, Singh, Matzner, Dummit, 2000). This could affect perceptions of trauma and family conflict in ways different than the adult population.

Income. Previous research has found income to be associated with levels of family conflict, such that families with lower income may be at higher risk for presenting higher levels of family conflict in comparison to families with higher income (Coley, 2003; Hsueh & Yoshikawa, 2007). In addition, research has indicated that fathers demonstrate vulnerability to low-income stressors that affect the father-child relationship and family functioning (Lau, 2009). For these reasons, in the present study, income was entered as a control variable.

CHAPTER 4: RESULTS

Sample Description

This sample was drawn from fathers who were seeking family therapy services at the Center for Healthy Families. Each of the participants in the sample was either married or living together with their partner, either in cohabitation or in a domestic partnership. The sample consisted of 186 fathers who were 18 years of age or older. The mean age of the participants was 42 (*SD* = 9.53). The sample included 166 (89%) of fathers currently married and living with their partner, 19 (10%) participants were cohabitating and 1 (.5%) was in a domestic partnership. The race composition of the sample was 50% African American, 34 % White, 8% Hispanic and 6.6% identifying as other or multiracial. The average length of relationship was 11 years (*SD* = 8.20). Fathers included in the sample also identified having an average of 2 children living with them (*SD* = 1.06). The personal yearly gross income was highly varied in the sample. An average of 59.65% of participants had an income above $40,000. The mean income was $54,000 (*SD* = 36,225).

Univariate Analyses

Prior to testing the hypotheses for this study, univariate analyses were conducted for the independent variables (i.e., father's anger/irritability symptoms of trauma, and dyadic cohesion) and the dependent variable (i.e., family conflict). Results indicated that participants in this sample reported an average level of anger/irritability symptoms of trauma (*M* = 6.87, *SD* = 6.23), which is similar to the level found in the original study (*M* = 7.69, *SD* = 6.03) (Briere, 1996). The average level of dyadic cohesion for this sample was reported as *M* = 14.94, *SD* = 5.49, which was also similar to the one found in the original study (*M* = 13.4, *SD* = 4.2) (Spanier, 1976). Lastly, the average level of family conflict for this sample was reported as *M* = 17.67, *SD*

= 7.24. In the original manual for the BFI, the normative data are presented in categories of "healthiest", "mid-range", "least healthy", based on participants' means, not on overall average for the sum of the items, as it was done in the present study (Beavers, 1985). If we calculate the means for the conflict subscale, as done in the original study, we could say that our participants fall between the "healthiest" and "mid-range" categories.

Table 1. *Descriptive Statistics for Independent and Dependent Variables (N=186)*

	N	*Potential Range*	*Actual Minimum*	*Actual Maximum*	*Mean*	*SD*	*α*
Father's Anger/ Irritability	186	0-27	0	27	6.87	6.23	.91
Dyadic Cohesion	186	0-24	2	24	14.39	5.49	.85
Family Conflict Behavior	186	7-35	7	35	17.67	7.24	.86

Preliminary Analysis

Prior to testing the hypotheses of this study, Pearson's correlations were calculated among the study variables (see Table 2). Results revealed significant associations between the outcome variable, family conflict behavior, and the independent variables of father's anger/irritability trauma symptoms and dyadic cohesion. Age and income were initially intended to be included as control variables. However, the results suggested that these factors were not significantly associated with the outcome variable; therefore, age and income were not included in further analyses. There was a significant positive association between father's anger/irritability trauma symptoms and family conflict behavior ($r = .42$, $p < .001$), suggesting that higher levels

of father's anger/irritable trauma symptoms are associated with higher levels of family conflict, consistent with the hypothesis. Additionally, there was a significant negative association between dyadic cohesion and family conflict behavior (r = -.50, p < .001), indicating that higher dyadic cohesion was associated with lower family conflict, also as expected. Finally, there was a significant negative association between anger/irritability and dyadic cohesion (r = -.31, p < .001), indicating that higher anger/irritability was associated with lower dyadic cohesion.

Table 2. *Correlations among Study Variables (n = 186)*

	1.	2.	3.	4.	5.
1. Father's Anger/Irritability	--				
2. Dyadic Cohesion	-.31***	--			
3. Family Conflict Behavior	.42***	-.50***	--		
4. Age	-.12	.02	-.05	--	
5. Income	-.09	.00	-.01	.34***	--

Note: *p < .05. **p < .01. ***p < .001 (two-tailed).

Regression Analysis

The study hypotheses stated that 1) *men who report lower rates of anger/irritable trauma symptomatology will report lower rates of family conflict behavior;* and that 2) *dyadic cohesion would moderate the relationship between father's anger/irritable trauma symptomatology and reports of family conflict behavior. Higher rates of dyadic cohesion would weaken the association between anger/irritability trauma symptoms and family conflict behavior*. To test the study hypotheses, a set of hierarchical multiple regression analysis was conducted, in two steps: (1) the independent variables dyadic cohesion and father´s anger/irritability trauma symptoms

were entered, (2) then the interaction term father's anger/irritability trauma X dyadic cohesion was entered as the final step (see Table 3). Prior to creating the interaction term, both independent variables were centered around their respective means: Participants' scores on anger/irritability trauma symptoms and on dyadic cohesion were subtracted from their means, and the interaction term was created as the product between these two variables. For this analysis, family conflict was entered as the dependent variable. Results confirm hypothesis #1, as there was a main effect of anger/irritable trauma symptomatology on family conflict behavior (β =. 29, $t = 4.54$, $p < .001$). As it will be further addressed in the Discussion section, this result support the spillover effect between father's anger/irritability trauma symptoms and family conflict behavior. Together, anger/irritability trauma symptoms and dyadic cohesion explained 33% of the variance in family conflict (F (2, 183) = 44.68, $p < .001$). Contrary to hypothesis #2, the results indicated that dyadic cohesion does not moderate the association between anger/irritability symptoms of trauma and family conflict behavior ($\beta = .03$, $t = .51$, $p = .61$). This suggests that dyadic cohesion does not serve as a buffer for the spillover effect of fathers' anger/irritability symptoms of trauma on family conflict behavior.

Table 3. *Hierarchical Multiple Regression Analysis to Test for Dyadic Cohesion as Moderator*

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	*SE*	β	*t*	*p*
1.	(constant)	23.21	1.51			< .001
	Anger/Irritability	.34	.07	.29	4.54	< .001
	Dyadic Cohesion	-.55	.08	-.41	-6.49	< .001
2.	(constant)	23.17	1.52			< .001
	Anger/Irritability	.34	.08	.30	4.52	< .001
	Dyadic Cohesion	-.54	.08	-.41	-6.42	< .001
	Anger/Irritability X Dyadic Cohesion	.01	.01	.03	.51	.61

Note: Dependent Variable: Family Conflict

CHAPTER 5: DISCUSSION

Research on family conflict is of fundamental importance to those interested in conducting treatment services as well as prevention work, since previous research has suggested negative long-term consequences for the exposure of family conflict (e.g., Formoso et al., 2000; Habib et al, 2014; Tanaka et al., 2010). Mothers' mental health has been studied as a major contributor to the development family conflict behavior (Creswell, Apetroaia, Murray & Cooper, 2013; Duggan, Berlin, Cassidy, Burrell & Tandon, 2009; Guttentag et al., 2014; Mitchell, 1968). Most of the literature on family conflict, however, has been limited to investigating the role of mothers in family problems and child adjustment issues, as if blaming mothers for some of the negative outcomes presented by children (e.g., Granat, et al., 2017).

Considering the importance of adopting systemic lenses to the understanding of the family dynamic, further research on fathers' mental health issues and its associations to aspects of family functioning such as family conflict is deemed necessary. Research on fathers' mental health issues, however, has been primarily focused on PTSD symptoms of fathers that are in the military (Dansby & Marinelli, 1999; Link & Palinkas, 2013). Although the research on trauma in civilian males is extremely limited, the literature provided on trauma on military fathers and families has provided valuable information that can be used to guide research in other areas. The research on trauma issues in males has found that men experiencing trauma can have symptoms of increased hostility, irritability and decreased positive affect with their families (Campbell & Renshaw, 2013; Cox & O'Loughlin, 2017; Lavee & Ben-Ari, 2004). Considering that civilians could also be exposed to a variety of traumatic experiences and develop anger/irritability symptoms of trauma, the present study focused on that population. It investigated possible associations of those symptoms and levels of family conflict, as well as if dyadic cohesion would serve as a buffer of this association.

Through the lens of systems theory (Smith-Acuna, 2011), the current study applied the notion of spillover effect to examine the relationship between fathers' anger/irritability symptoms and family conflict behavior. Similar to previous studies, support was found for the notion of spillover effect of parent's mental health issues on aspects of family functioning, supporting the concept that the experiences of one individual in the family system can spill over into other subsystems or affect the family unit overall (Chen, Powell & Greenhaus, 2009; Kourous et al., 2014; Masuda, McNall, Allen, & Nicklin, 2012). This expands our understanding of how fathers' mental health may be associated with family functioning.

This study's results supported the initial hypothesis that there is a link between fathers' anger/irritability trauma symptoms and family conflict behavior. Similarly to previous research on fathers in the military (Link & Palinkas, 2013), results of the present study suggest that fathers' mental health is an important factor and is associated with family conflict. The results of the study indicate correlations which means that we cannot infer causation or direction of the relationship based on these results.

In addition to exploring the relationship between fathers' mental health and family conflict behavior, the present study investigated dyadic cohesion as a buffer in the relationship between anger/irritability symptoms of trauma and family conflict. Previous research on dyadic cohesion has suggested that there is a relationship between dyadic cohesion and healthy family functioning (Olson, Sprenkle & Russel, 1979), and it is a predictor of resiliency (Olson 1999). Dyadic cohesion was investigated as a means of decreasing the impact of fathers' mental health issues on family conflict. However, the results did not reflect dyadic cohesion as a moderator in the association between father's mental health symptomatology and family conflict behavior.

It is important to mention that the data utilized in the present study were collected from fathers seeking therapy services, either as a couple or as a family. It is important to highlight that our sample consisted of a majority of married men. The fact that the majority of the participants were married and had children living in the same household may be related to high level of commitment to the therapy process. Further, participants completed the assessments prior to receiving any intervention or therapeutic services. Without the presence of intervention, dyadic cohesion could have been at moderate or low levels, and increasing levels of dyadic cohesion may have affected the association that is seen between fathers' mental health and family conflict behavior. It is possible that if interventions were tailored toward increasing levels of dyadic cohesion, that could indeed serve as a buffer to the association between fathers' anger/irritability trauma symptoms and level of family conflict.

Considering that the sample for this study was a clinical sample, it is also important to note that the participants are experiencing a level of stress that is significant enough to seek help. Participants could be recognizing that their levels of stress are impacting them to the point where they are in need of outside help. There is some protective factor within that even with just fathers coming in to seek therapy. The levels of stress and mental health symptomatology are clinical yet still healthy. If the sample was not clinical, the results of the study could be different.

In terms of the protective factor used within this study, it is likely that the conceptual definition for dyadic cohesion did not align with how dyadic cohesion was measured. The preferred conceptual definition would have reflected cohesiveness in times of despair (whether at the individual couple or family level). However, for the DAS scale, dyadic cohesion is defined as shared interests and emotional connection between partners. There are multiple ways in which dyadic cohesion can be measured. Therefore, one specific dimension of dyadic cohesion was

measured instead of a measure more specific to addressing difficulties with mental health and family conflict.

Despite not finding moderation in this study, there is still the possibility of incorporating ways to address a partner's individual mental health symptoms within the couple subsystem of the family unit. There can still be focus placed on providing intervention for the couple to help with the individual partner's mental health symptomatology. One important factor to consider would be dyadic coping. Dyadic coping can be defined as the skills used by couples to manage difficulties in which both partners work together to resolve individual, marital and family issues. This is a variable that could still focus on aspects of the couple relationship that can be used as a protective factor. This could be explored as a protective factor that would focus specifically on the stressors occurring at each level of the family system.

Clinical Implications

This study supports the importance of thoroughly assessing and screening for mental health concerns among all family members, not just mothers. The study has also demonstrated areas of focus for individual, couple and family services. It may be an important focus for clients to build up coping strategies when one or both partners are experiencing mental health symptomatology. Therapy may need to focus on improving the couple relationship, by empowering both partners to address mental health issues and dedicate interventions to processing and providing tools that promote understanding, coping, problem solving and resiliency.

Having clients report average or higher than average levels of trauma and family conflict can be used as a basis for assessment and clinical intervention. Partners may need to not only feel connection and have important shared experiences but it may be just as important to have

couples learn to work through mental health issues that may spillover into their couple and family relationships.

Providing psychoeducation to clients on symptoms of trauma and family dysfunction can be important in shaping the clinical treatment and interventions provided. Psychoeducation on both factors can help to enlighten clients on identifying their own struggles with mental health and how it is possible for their individual symptoms to become symptoms of the family interactions.

This research supports the idea that clinicians must thoroughly and continuously assess for and work on intentionally involving fathers as a part of the therapeutic process. It is essential to have effective screening of symptoms in men and for those assessments to be taken and used to guide treatment. Research on fathers has been growing in more recent years, but is still limited in many ways and it is important to include fathers in research and clinical practice. Clinicians should also acknowledge the possibility of underreporting and taking that into account during the assessment processes. In issues of underreporting, observational data may be important to use as additional guideline.

Limitations

Although this current study has expanded knowledge regarding trauma in civilian communities and its impact on family dynamics, there are some limitations regarding the research conducted. One of the limitations of the study was that no variables could be controlled for in the study. There may have been additional variables that needed to be controlled for that went undetected within the study. Additionally, there is no clear understanding of the type or intensity of the trauma event that was experienced by the participants. This information is not

accessible from the TSI-A. The TSI-A also does not provide a diagnosis of trauma but can be used to aid a clinician in diagnosing an individual with a trauma-related disorder. Therefore, it is unclear how severe this sample's trauma symptoms were compared to individuals with PTSD diagnoses, and whether the level of their psychopathology was sufficient to have a negative impact on family functioning similar to the negative effects that have been found in military families.

Based on the way the data for this study were collected, it was not feasible to control for military status due to the lack of information on the dataset. Another limitation with the dataset was that, although we only included participants who had indicated having "*children living in the household*", participants were not asked if those children were their own; therefore, we did not have information of whether the respondent considered himself a father of the child or children living with them.

The measures used in the study were all self-report measures. Considering that we only used responses from fathers, we did not include the perspectives of other family members. Accordingly, it is important to note that based on the BFI's manual, the overall mean of participants of the present study would fall between the "mid-range" and "healthiest" categories. As previously stated, considering that participants were asked to complete those assessments prior to any therapeutic services, and that they were seeking family or couple therapy, it is possible that some of the participants underreported levels of symptomatology and family conflict. This could be due to social desirability or males' shame in reporting negative aspects of their own and/or their family functioning. Lastly, as indicated previously the conceptual definition of dyadic cohesion did not align with how the measure defined dyadic cohesion.

Recommendations for Future Research

Despite some of the important limitations of the study, these findings point to the need for important clinical issues and the need to future research. The fact we did not find a moderating effect of dyadic cohesion on the link between anger/irritability symptoms of trauma and family conflict is actually informative. Many times, clinicians are focused on enhancing dyadic cohesion by promoting the idea that it is an important element to enhance the quality of the couple relationship. Our results, however, suggest that couples may experience closeness in their relationship but may still lack something needed to address the mental health challenges and family issues. In other words, although the couples' level of dyadic cohesion was average, there was still a strong relationship between trauma symptoms and family conflict.

Therefore, we might say that more dynamics regarding the couple's relationship should be explored to further understand what other elements could serve as a protective factor in this context. For example, having a protective factor in this association could be more about understanding and coping with mental health symptomatology and not necessarily about shared interests, connection or shared activities (Gehring, et al., 1990). Although dyadic cohesion did not serve as a moderator, it could still be investigated as a mediator in future research.

Other protective factors could be levels of support, couples coping strategies or parenting strategies. Investigating protective factors such as these could provide couples with a sense of support needed to address symptoms of trauma or other mental health concerns. More specifically, dyadic coping could be a factor to address how partners support each other when faced with one partner's mental health symptomatology or family conflict issues. Parenting skills or cohesive parenting could be a factor to address the parenting strategies and specific parenting support that each partner provides to help resolve issues regarding family conflict. Dyadic

support and cohesive parenting could both be factors that could buffer the association between family conflict behavior and anger/irritability trauma symptoms. These potential protective factors can address how couples manage when things are rough.

APPENDICES

Appendix A

Trauma Symptom Inventory (TSI-A)

TSI-A

Gender: _____ Date of Birth: _____ Therapist Code _____ Family Code __ __ __

Instructions: The items that follow describe a number of things that may or may not have happened to you. Read each one carefully, and then indicate on the answer sheet how often it has happened in the last **6 months** by circling the correct number. Circling a 0 means it hasn't happened at all in the last 6 months. Circling a 3 means it has happened often in the last **6 months**. Circling a 1 or 2 means it has happened in the last 6 months, but has not happened often.

Never 0 1 2 Often 3

Please answer each item as honestly as you can. **Be sure to answer every item.**

*In the last **6 months**, how often have you experienced:*

		Never			Often
1/1.	Nightmares or bad dreams	0	1	2	3
2/2.	Trying to forget about a bad time in your life	0	1	2	3
3/3.	Irritability	0	1	2	3
4/4.	Stopping yourself from thinking about the past	0	1	2	3
5/8.	Flashbacks (sudden memories or images of upsetting things)	0	1	2	3
6/10.	Feeling like you were outside your body	0	1	2	3
7/12.	Sudden disturbing memories when you were not expecting them	0	1	2	3
8/15.	Becoming angry for little or no reason	0	1	2	3
9/20.	Your mind going blank	0	1	2	3
10/22.	Periods of trembling or shaking	0	1	2	3
11/23.	Pushing painful memories out of your mind	0	1	2	3
12/26.	Feeling like you were watching yourself from far away	0	1	2	3
13/27.	Feeling tense or "on edge"	0	1	2	3
14/29.	Not feeling like your real self	0	1	2	3
15/31.	Worrying about things	0	1	2	3
16/34.	Being easily annoyed by other people	0	1	2	3
17/35.	Starting arguments or picking fights to get your anger out	0	1	2	3
18/37.	Getting angry when you didn't want to	0	1	2	3
19/38.	Not being able to feel your emotions	0	1	2	3
20/41.	Feeling jumpy	0	1	2	3
21/42.	Absent-mindedness	0	1	2	3
22/45.	Yelling or telling people off when you felt you shouldn't have	0	1	2	3
23/51.	High anxiety	0	1	2	3
24/54.	Nervousness	0	1	2	3
25/57.	Feeling mad or angry inside	0	1	2	3
26/59.	Staying away from certain people or places because they reminded you of something	0	1	2	3

- over please -

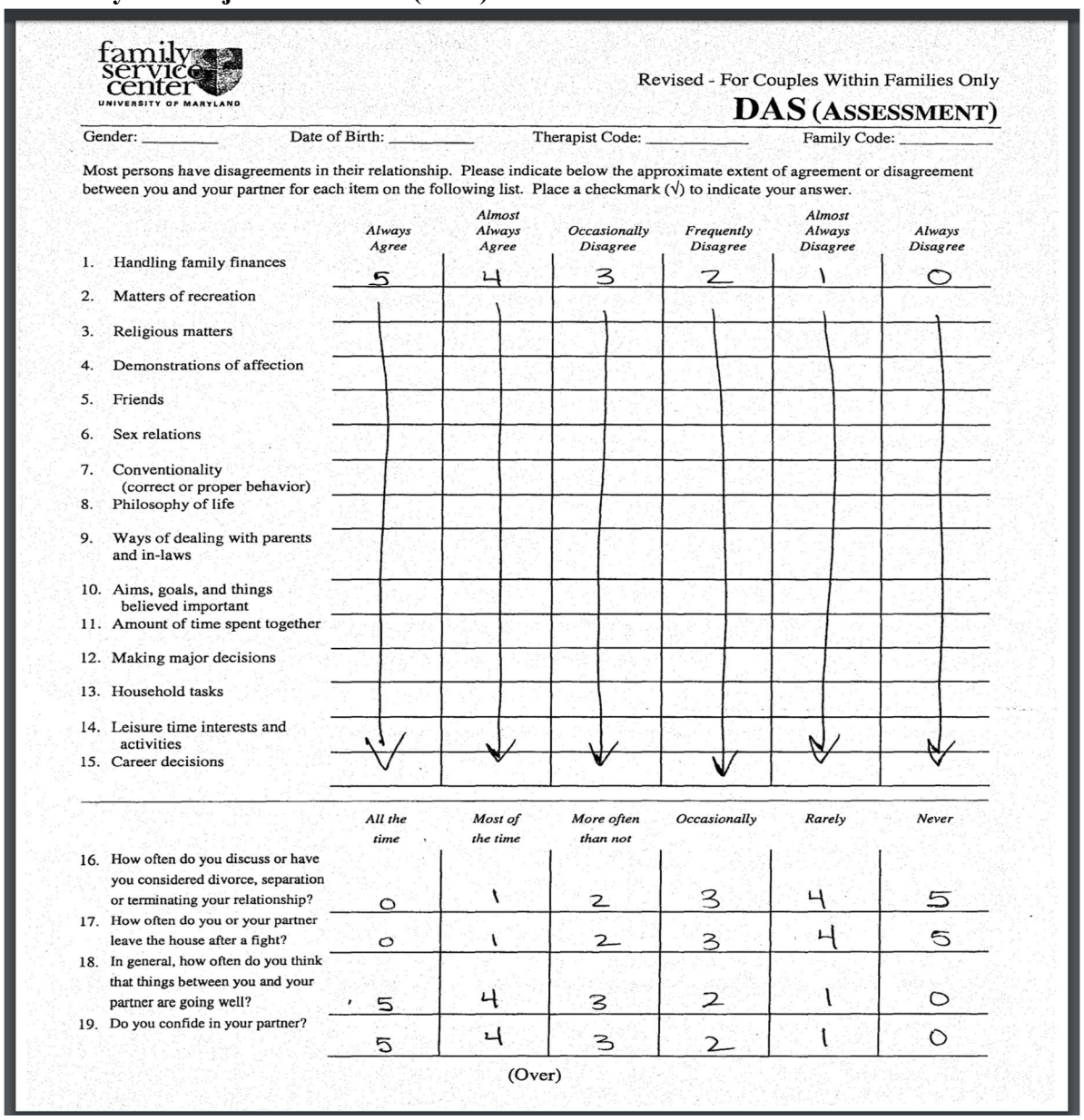
*In the last **6 months**, how often have you experienced:*

		Never			Often
27/62.	Suddenly remembering something upsetting from your past	0	1	2	3
28/63.	Wanting to hit someone or something	0	1	2	3
29/66.	Suddenly being reminded of something bad	0	1	2	3
30/67.	Trying to block out certain memories	0	1	2	3
31/70.	Violent dreams	0	1	2	3
32/72.	Just for a moment, seeing or hearing something upsetting that happened earlier in your life	0	1	2	3
33/74.	Frightening or upsetting thoughts popping into your mind	0	1	2	3
34/83.	Not letting yourself feel bad about the past	0	1	2	3
35/84.	Feeling like things weren't real	0	1	2	3
36/85.	Feeling like you were in a dream	0	1	2	3
37/87.	Trying not to have any feelings about something that once hurt you	0	1	2	3
38/88.	Daydreaming	0	1	2	3
39/89.	Trying not to think or talk about things in your life that were painful	0	1	2	3
40/91.	Being startled or frightened by sudden noises	0	1	2	3
41/93.	Trouble controlling your temper	0	1	2	3
42/97.	Feeling afraid you might die or be injured	0	1	2	3

TSI-A 4/01

Appendix B

Dyadic Adjustment Scale (DAS)



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Revised - For Couples Within Families Only

DAS (ASSESSMENT)

Gender: _____ Date of Birth: _____ Therapist Code: _____ Family Code: _____

Most persons have disagreements in their relationship. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list. Place a checkmark (√) to indicate your answer.

	Always Agree	*Almost Always Agree*	*Occasionally Disagree*	*Frequently Disagree*	*Almost Always Disagree*	*Always Disagree*
1. Handling family finances	5	4	3	2	1	0
2. Matters of recreation						
3. Religious matters						
4. Demonstrations of affection						
5. Friends						
6. Sex relations						
7. Conventionality (correct or proper behavior)						
8. Philosophy of life						
9. Ways of dealing with parents and in-laws						
10. Aims, goals, and things believed important						
11. Amount of time spent together						
12. Making major decisions						
13. Household tasks						
14. Leisure time interests and activities						
15. Career decisions						

	All the time	*Most of the time*	*More often than not*	*Occasionally*	*Rarely*	*Never*
16. How often do you discuss or have you considered divorce, separation or terminating your relationship?	0	1	2	3	4	5
17. How often do you or your partner leave the house after a fight?	0	1	2	3	4	5
18. In general, how often do you think that things between you and your partner are going well?	5	4	3	2	1	0
19. Do you confide in your partner?	5	4	3	2	1	0

(Over)

	All the time	Most of the time	More often than not	Occasionally	Rarely	Never
20. Do you ever regret that you married (or lived together)?	0	1	2	3	4	5
21. How often do you or your partner quarrel?	↓	↓	↓	↓	↓	↓
22. How often do you and your partner "get on each others' nerves"?	↓	↓	↓	↓	↓	↓

HOW OFTEN WOULD YOU SAY THE FOLLOWING EVENTS OCCUR BETWEEN YOU AND YOUR MATE? CIRCLE YOUR ANSWER.

23. Do you kiss your partner?
4 EVERYDAY 3 ALMOST EVERYDAY 2 OCCASIONALLY 1 RARELY 0 NEVER

24. Do you and your partner engage in outside interests together?
4 ALL OF THEM 3 MOST OF THEM 2 SOME OF THEM 1 VERY FEW OF THEM 0 NONE OF THEM

25. Have a stimulating exchange of ideas?
0 NEVER 1 LESS THAN ONCE A MONTH 2 ONCE OR TWICE A MONTH 3 ONCE OR TWICE A WEEK 4 ONCE A DAY 5 MORE OFTEN

26. Laugh together?
0 NEVER 1 LESS THAN ONCE A MONTH 2 ONCE OR TWICE A MONTH 3 ONCE OR TWICE A WEEK 4 ONCE A DAY 5 MORE OFTEN

27. Calmly discuss something?
0 NEVER 1 LESS THAN ONCE A MONTH 2 ONCE OR TWICE A MONTH 3 ONCE OR TWICE A WEEK 4 ONCE A DAY 5 MORE OFTEN

28. Work together on a project?
0 NEVER 1 LESS THAN ONCE A MONTH 2 ONCE OR TWICE A MONTH 3 ONCE OR TWICE A WEEK 4 ONCE A DAY 5 MORE OFTEN

THESE ARE SOME THINGS ABOUT WHICH COUPLES SOMETIMES AGREE AND SOMETIMES DISAGREE. INDICATE IF EITHER ITEM BELOW CAUSES DIFFERENCES OF OPINION OR HAVE BEEN PROBLEMS IN YOUR RELATIONSHIP DURING THE PAST FEW WEEKS. CHECK "YES" OR "NO."

29. Being too tired for sex. Yes 0 No 1

30. Not showing love. Yes 0 No 1

31. The dots on the following line represent different degrees of happiness in your relationship. The middle point, "happy," represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

0 EXTREMELY UNHAPPY · 1 FAIRLY UNHAPPY · 2 A LITTLE UNHAPPY · 3 HAPPY · 4 VERY HAPPY · 5 EXTREMELY HAPPY · 6 PERFECT

32. Which of the following statements best describes how you feel about the future of your relationship? Check the statement that best applies to you.

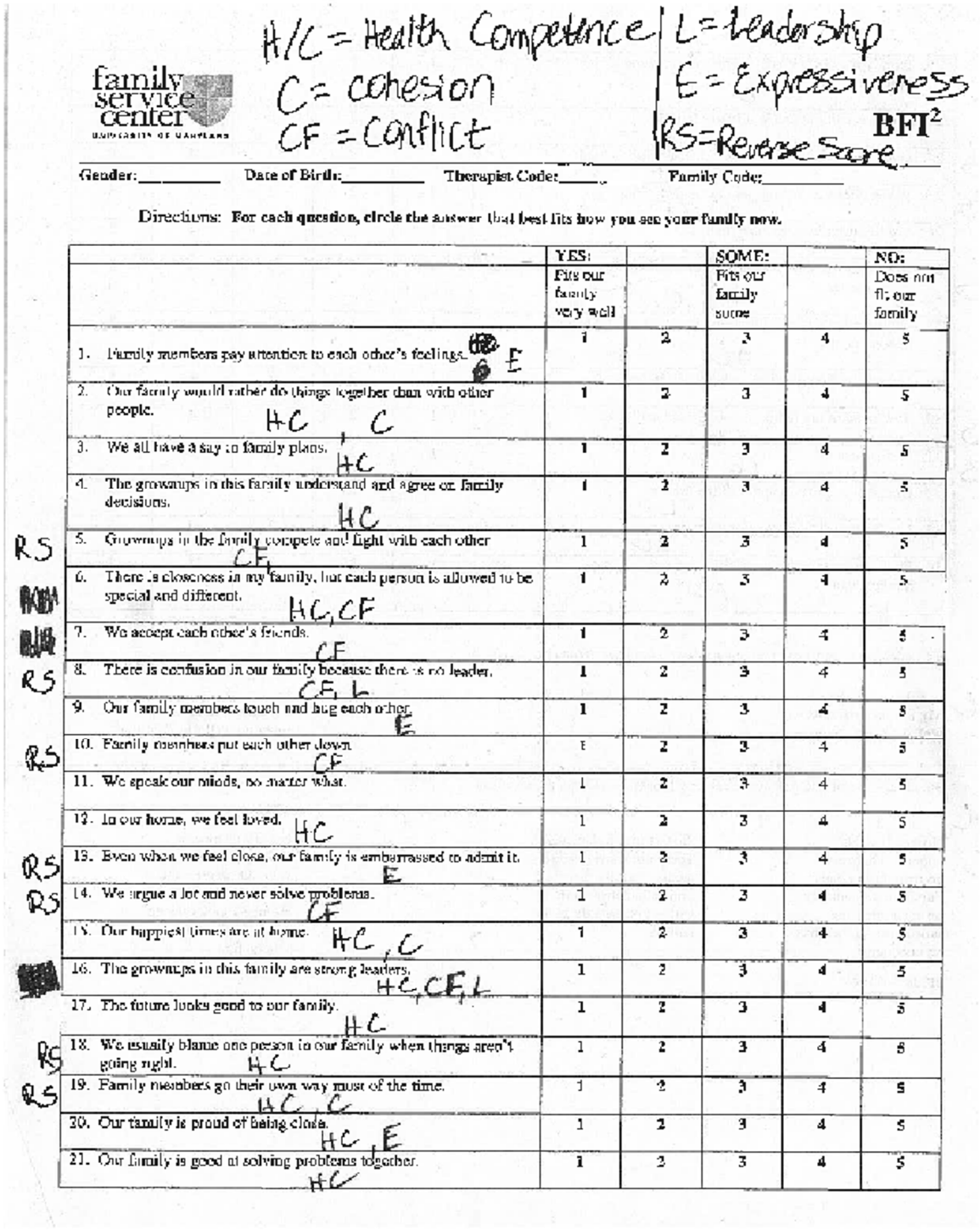
5 6. I want desperately for my relationship to succeed, and would go to almost any length to see that it does.
4 5. I want very much for my relationship to succeed, and will do all I can to see that it does.
3 4. I want very much for my relationship to succeed, and will do my fair share to see that it does.
2 3. It would be nice if my relationship succeeded, but I can't do much more than I am doing now to help it succeed.
1 2. It would be nice if my relationship succeeded, but I refuse to do any more than I am doing now to keep the relationship going.
0 1. My relationship can never succeed, and there is no more that I can do to keep the relationship going.

DAS.Rev.05/01/04

Disregard any numbers on form during data entry.

Appendix C

Beavers Family Inventory (BFI)



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H/C = Health Competence
C = cohesion
CF = Conflict
L = Leadership
E = Expressiveness
RS = Reverse Score

BFI[2]

Gender:_____ Date of Birth:_____ Therapist Code:_____ Family Code:_____

Directions: For each question, circle the answer that best fits how you see your family now.

	YES: Fits our family very well		SOME: Fits our family some		NO: Does not fit our family
1. Family members pay attention to each other's feelings. H/C E	1	2	3	4	5
2. Our family would rather do things together than with other people. H/C, C	1	2	3	4	5
3. We all have a say in family plans. H/C	1	2	3	4	5
4. The grownups in this family understand and agree on family decisions. H/C	1	2	3	4	5
RS 5. Grownups in the family compete and fight with each other CF	1	2	3	4	5
6. There is closeness in my family, but each person is allowed to be special and different. H/C, CF	1	2	3	4	5
7. We accept each other's friends. CF	1	2	3	4	5
RS 8. There is confusion in our family because there is no leader. CF, L	1	2	3	4	5
9. Our family members touch and hug each other. E	1	2	3	4	5
RS 10. Family members put each other down. CF	1	2	3	4	5
11. We speak our minds, no matter what.	1	2	3	4	5
12. In our home, we feel loved. H/C	1	2	3	4	5
RS 13. Even when we feel close, our family is embarrassed to admit it. E	1	2	3	4	5
RS 14. We argue a lot and never solve problems. CF	1	2	3	4	5
15. Our happiest times are at home. H/C, C	1	2	3	4	5
16. The grownups in this family are strong leaders. H/C, CF, L	1	2	3	4	5
17. The future looks good to our family. H/C	1	2	3	4	5
RS 18. We usually blame one person in our family when things aren't going right. H/C	1	2	3	4	5
RS 19. Family members go their own way most of the time. H/C, C	1	2	3	4	5
20. Our family is proud of being close. H/C, E	1	2	3	4	5
21. Our family is good at solving problems together. H/C	1	2	3	4	5

	22. Family members easily express warmth and caring toward each other E	1	2	3	4	5
	23. It's okay to fight and yell in our family.	1	2	3	4	5
RS	24. One of the adults in this family has a favorite child. HC, CF	1	2	3	4	5
RS	25. When things go wrong, we blame each other. HC, CF	1	2	3	4	5
	26. We say what we think and feel.	1	2	3	4	5
RS	27. Our family members would rather do things with other people than together. HC, C	1	2	3	4	5
	28. Family members pay attention to each other and listen to what is said. HC	1	2	3	4	5
	29. We worry about hurting each other's feelings.	1	2	3	4	5
RS	30. The mood in my family is usually sad and blue. CF,	1	2	3	4	5
RS	31. We argue a lot. CF	1	2	3	4	5
	32. One person controls and leads the family. L	1	2	3	4	5
	33. My family is happy most of the time. HC	1	2	3	4	5
	34. Each person takes responsibility for his/her behavior CF,	1	2	3	4	5

35. On a scale of 1 to 5, I would rate my family as: (Circle the number)

HC

1	2	3	4	5
My family functions well together				My family does not function well together at all

36. On a scale of 1 to 5, I would rate my family as: (Circle the number)

HC, C

1	2	3	4	5
No one is independent. There are no open arguments. Family members rely on each other for satisfaction rather than on outsiders.		Sometimes independent. There are some disagreements. Family members find satisfaction both within and outside of the family.		Family members usually go their own way. Disagreements are open. Family members look outside of the family for satisfaction

BFI.SOC 06.15.04

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