HANDBOOK OF

Counseling Military Couples

SAMPLE CHAPTER

Edited by Bret A. Moore
## Contents

Series Editor’s Foreword xi  
Contributors xiii  
Acknowledgments xxi  

1 Introduction to Counseling Military Couples 1  
   *Bret A. Moore*

### SECTION 1  MILITARY CULTURE

2 Understanding the Military Culture 7  
   *Michael R. DeVries, H. Kent Hughes, Harvey Watson, and Bret A. Moore*

3 Marital Functioning in the Military: Marital Quality, Infidelity, Divorce Intent, and Dissolution Trends Among U.S. Enlisted Soldiers Following Combat Deployments 19  
   *Lyndon A. Riviere, Julie C. Merrill, Jeffrey L. Thomas, Joshua E. Wilk, and Paul D. Bliese*

### SECTION 2  TREATMENT MODALITIES

4 Cognitive-Behavioral Therapy With Military Couples 37  
   *Robert P. O’Brien*

5 Solution-Focused Therapy With Military Couples 53  
   *Rebecca Tews-Kozlowski*

6 Using Emotionally Focused Couples Therapy With Military Couples 89  
   *Kathryn D. Rheem, Scott R. Woolley, and Neil Weissman*

7 Gottman Method Couples Therapy With Military Couples 113  
   *Robert P. O’Brien*
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>The Military Lifestyle and the Relationship</td>
<td>137</td>
</tr>
<tr>
<td></td>
<td>Lynn K. Hall</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Separation and Divorce</td>
<td>157</td>
</tr>
<tr>
<td></td>
<td>Walter R. Schumm, R. Roudi Nazarinia Roy, and Vance Theodore</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Posttraumatic Stress Disorder</td>
<td>183</td>
</tr>
<tr>
<td></td>
<td>Jason M. Lavender and Judith A. Lyons</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Depression</td>
<td>201</td>
</tr>
<tr>
<td></td>
<td>Kevin M. Connolly and Kathryn S. Hahn</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Infidelity</td>
<td>219</td>
</tr>
<tr>
<td></td>
<td>Douglas K. Snyder, Christina Balderrama-Durbin, Caitlin Fissette, David M. Scheider, J. Kelly Barnett, and Samuel Fiala</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Intimate Partner Violence</td>
<td>237</td>
</tr>
<tr>
<td></td>
<td>Nicole D. Pukay-Martin and Patrick S. Calhoun</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Substance Misuse</td>
<td>267</td>
</tr>
<tr>
<td></td>
<td>Sharon Morgillo Freeman</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Traumatic Brain Injury</td>
<td>279</td>
</tr>
<tr>
<td></td>
<td>Carrie-Ann H. Strong and Jacobus Donders</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Enhancing Resilience With Culturally Competent Treatment of Same-Sex Military Couples</td>
<td>295</td>
</tr>
<tr>
<td></td>
<td>Matthew Porter and Veronica Gutierrez</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Cultural Differences</td>
<td>321</td>
</tr>
<tr>
<td></td>
<td>Rebecca Tews-Kozlowski and Desireé King</td>
<td></td>
</tr>
</tbody>
</table>
SECTION 4 RESOURCES

18 Helping Military Couples Understand Their Legal Rights in Divorce 347
   Mathew B. Tully

19 Civilian and Military Programs in Psychosocial Rehabilitation for Couples With PTSD 355
   Walter Penk, Dolores Little, and Nathan Ainspan

Index 371
Using Emotionally Focused Couples Therapy With Military Couples

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INTRODUCTION

The impacts of deployment and combat-related trauma have once again been pushed to the fore due to the current conflicts in Iraq and Afghanistan. Similar to shell shock from the World Wars and combat fatigue from the Vietnam War, combat-related psychological symptoms have now impacted 31–38% of our postcombat deployed military service members (Munsey, 2007). Of those with psychological symptoms, 17% are diagnosed with posttraumatic stress disorder (PTSD), major depression, or generalized anxiety (Hoge et al., 2004). Typically, the military service member with PTSD or combat stress has been treated individually (APA Military Deployment Services Task Force Report, 2007), despite the known negative relational impacts of deployment and combat stress on the service member and the individual’s spouse and children (Sherman, Zanotti, & Jones, 2005). Just as deployment and combat stress are associated with mental health disorders such as PTSD, depression, anxiety, suicidality, and substance abuse (Hoge, Terhakopian, Castro, Messer, & Engel, 2007), marital distress often increases (Basham, 2008). Emotionally focused therapy (EFT; Johnson, 2004) for couples, with its focus on emotions as the leading elements in couple dynamics and with its ability to treat individual symptomology within a relational context, is particularly well suited for military couples facing the echoes of battle and the distress resulting from deployment and combat stress (Johnson, 2002; Johnson & Rheem, 2006).
THE ROLE OF EMOTIONS

From a systemic perspective, “emotions link self and system” (Johnson, 2004, p. 15). PTSD symptoms generally involve intense emotional deregulation. PTSD sufferers typically alternate between numbness, anxiety, depression, anger, and hypervigilance, which have an impact on and are impacted by couple relationships (Johnson, 2002). In EFT, the therapist helps structure and organize each partner’s emotional experience, which creates new emotional states and helps prompt new interactional cues and responses. “Emotion guides and gives meaning to perception; motivates and cues attachment responses; and, when expressed, communicates to others and organizes their responses” (Johnson & Denton, 2002, p. 229). Facilitating the expression of organized, expanded, and better-regulated emotional states loosens the grip of constricted, dysregulated emotional patterns and shifts the couple’s interaction patterns to create safe, healing connections (Johnson, 2004).

Attachment Theory

Attachment theory (Bowlby, 1969) holds the built-in answers to human vulnerability with its primary goals of protection and security. Seeking and maintaining contact with a significant other, as Bowlby (1988) postulated, “is viewed as the primary motivating principle in human beings and an innate survival mechanism” (Johnson, 1999). Threats (real or perceived) activate the attachment system, which compels proximity-seeking behaviors toward a protective figure. Proximity seeking and connection with a protective attachment figure help individuals cope with threats and regulate emotionally. The need to seek comfort and protection from attachment figures is a biologically hard-wired response that is integral to survival and emotional balance. It helps us understand the intense bonding that often happens among troops in combat, as well as the bonding and healing power that can happen in committed, romantic couple relationships.

When an attachment figure is responsive and attentive, the sense of threat and resultant unwanted emotional state is mitigated. The protection and comfort provided by the attachment figure provides the security that alters “undesirable emotional states” (Mikulincer & Shaver, 2007, p. 190) and facilitates changes in the emotional states that help individuals feel protected, secure, and nonthreatened.

Predictably, when an attachment figure is nonresponsive, “undesirable emotional states” (Mikulincer & Shaver, 2007, p. 190) persist, and emotional balance is not attained. The lack of emotional regulation can lead to intense affect, such as anger, sadness, and fear, which floods the nervous system. This intense affect can have control precedence (Tronick, 1989), which overrides other cues, even positive ones, and inhibits positive coping strategies while intensifying distress. This intense affect creates rigid, negative, interactional patterns between partners.

In short, attachment theory “addresses how relational partners deal with their emotions, process and organize information about the self and others, and communicate with loved ones” (Johnson, 2004, p. 36). Proximity to and connection with an attachment figure creates a safe haven and secure base (Bowlby, 1988),
which allows for the processing of threats in an emotionally balanced, nondefensive manner.

**EMOTIONALLY FOCUSED THERAPY**

Emotionally focused therapy views the relationship between partners as an emotional bond, not a bargain to be negotiated (Johnson, 2004, p. 7). Since affect dysregulation is a primary experience of those coping with the echoes of battle, providing treatment that can address the emotional climate within and between a service member and his or her partner makes sense. EFT, based on attachment theory (Bowlby, 1969), prioritizes “the crucial significance of emotion and emotional communication in the organization of patterns of interaction and key defining experiences in close relationships” (Johnson, 2004, p. 4).

The process of change in EFT has been delineated in nine steps within three stages. The first four steps involve assessment and the deescalation of problematic interactional cycles. In Stage 2, Steps 5 to 7 emphasize the creation of specific change events in which new bonding experiences occur and basic interactional positions shift. Stage 3, the last two steps of therapy (Steps 8 and 9), addresses the consolidation of change and the integration of these changes into the everyday life of the couple. These steps are described in linear form. In fact, the therapist circles through them in an interactive, spiral fashion.

The nine steps and three stages of EFT are as follows:

**Stage 1: Cycle deescalation**
- Step 1: Assessment and creating an alliance and explicating the core issues in the marital conflict using an attachment perspective.
- Step 2: Identifying the negative interactional cycle that maintains attachment insecurity and marital distress.
- Step 3: Accessing the unacknowledged primary, attachment-related, vulnerable emotions that underlie interactional positions.
- Step 4: Reframing the problem in terms of the cycle, the underlying emotions, and attachment needs.

**Stage 2: Changing interactional positions**
- Step 5: Promoting identification with disowned needs and aspects of self and integrating these into relationship interactions.
- Step 6: Promoting acceptance of the partner’s new construction of experience in the relationship and new interactional behavior.
- Step 7: Facilitating the expression of specific needs and wants and creating emotional engagement.

**Stage 3: Consolidation/integration**
- Step 8: Facilitating the emergence of new solutions to old problematic relationship issues.
- Step 9: Consolidating new positions and new cycles of attachment behavior.
The goal of the first stage of EFT is deescalation. After assessing if the couple is appropriate for couples therapy, treatment is started by building an alliance with the couple (Step 1). Step 2 is to formulate the couple's negative pattern of interaction, such as demand-withdraw, in which one partner is the critical demander and the other placates and withdraws. That is, when distress reaches a certain level, absorbing negative affect creates rigid patterns of response from each partner. As partners interact with each other, these rigid patterns tend to keep each partner stuck and disconnected from the other. Unexpressed underlying emotions, often driven by unmet attachment needs, keep the rigid response pattern intact. Accessing these underlying emotions and connecting how they fuel the interactions with their partner are the foci of Step 3 of EFT. The final step of Stage 1, Step 4, reframes the couple's distress in terms of their attachment significance and helps them see that their relationship has been caught in a vicious cycle. The cycle is framed as the enemy, rather than each other.

After achieving deescalation, the goal of Stage 2 is to restructure the couple's interactional pattern. The focus of Stage 2 of EFT is creating experiences of bonding, sharing, and responsiveness that redefine the couple's experiences of each other and changes the negative cycle to a pattern that involves the healing of accessibility, responsiveness, and safety.

To create a new interactional pattern, two main change events are necessary: withdrawer reengagement and pursuer/blamer softening. These two change events are the focus of Steps 5–7, which typically are done twice, the first time with the focus on the withdrawer and then with the focus on the pursuer. In Step 5, the most intrapsychic of EFT, the EFT therapist works with the withdrawer's disowned attachment needs, fears, and longings, helping deepen, distill, and disclose underlying experiences and integrating these into the interactions of the relationship. Withdrawn partners need to access primary, vulnerable emotions, feel entitled to their experience, and assert themselves emotionally. Step 6 involves helping the pursuing partner accept the withdrawer's assertions and emotional experiences. In Step 7, the new experience of the withdrawer crystallizes in the sharing of the withdrawer's needs from a position of vulnerability and asserting him- or herself emotionally to the listening, more accepting partner. In Step 7, these moments of mutual accessibility and responsiveness soothe the past pain and become the building blocks of the couple's new pattern of interaction. The EFT therapist then goes back to do Step 5 with the pursuing partner to deepen, distill, and disclose attachment vulnerabilities, needs, and fears. As pursuers access their softer, more primary emotions, the therapist promotes acceptance from the withdrawer (Step 6). As the withdrawer remains emotionally engaged with the pursuing partner, the pursuer shares deep fears, needs, and vulnerabilities and asks for basic attachment needs to be met (Step 7).

The final stage of EFT is Stage 3, consolidation (Steps 8 and 9). In Step 8, the partners are able to emotionally connect and start solving old relationship issues from this new place of connection and togetherness. Previous differences—differences that used to threaten the couple's connection and block problem solving—are now resolved with openness, compassion, and tenderness. In the final step (Step 9), the therapist helps the couple identify the changes that have
occurred and integrate them into all aspects of their lives. At times, the therapist will help the couple develop attachment rituals that help the couple continue to connect and find safety and healing in their relationship. Each partner has a new position in the cycle of the relationship in which there is clear expression of and response to attachment needs and signals.

THE STANCE OF THE EFT THERAPIST

Since EFT is systemic (Bertalanffy, 1968), Rogerian (Rogers, 1951) and experiential in nature, the EFT therapist identifies and tracks the couple’s pattern of interaction and the underlying emotion that fuels their interactions from a position of collaboration. With empathetic attunement and unconditional positive regard, the therapist helps each partner access and organize his or her underlying emotion and share these emotions from a place of vulnerability, rather than in a critical or a distant manner. “The EFT therapist is a process consultant who supports partners in restructuring and expanding their emotional responses to each other” (Johnson & Denton, 2002, p. 221).

LITERATURE ON EMOTIONALLY FOCUSED THERAPY

The literature on EFT (Johnson, 2004) is robust. EFT is empirically validated; there are a growing number of published outcome studies (Cloutier, Manion, Gordon-Walker, & Johnson, 2002; Denton, Burleson, Clark, Rodriguez, & Hobbs, 2000; Johnson, Hunsley, Greenberg, & Schindler, 1999), and others in are progress. In a meta-analysis of the four most rigorous studies, Johnson and colleagues (1999) found a 70–73% rate of recovery for distressed relationships, and 86% showed significant improvement.

Many studies explored the application of EFT with specific populations. Four studies with couples impacted by trauma have been completed. Naaman, Radwan, and Johnson (2009) studied the use of EFT with breast cancer survivors in distressed relationships, Dalton, Johnson, Classen, and Greenman (in press) examined the effectiveness of EFT with female survivors of childhood sexual abuse, MacIntosh and Johnson (2008) studied couples in which one or both partners had a history of childhood sexual abuse, and combat veterans with PTSD and their partners in distressed marriages have been studied (Weissman, Batten, Dixon, Pasillas, Potts, Decker, & Brown, 2011) and are reviewed next.

An outcome study on the use of EFT in couples struggling with major depression has also been completed (Denton, Nakonezny, & Jarrett, 2009) that followed an earlier pilot study on EFT with depression (Dessaulles, Johnson, & Denton, 2003). A study of using EFT with chronic illness has been completed (Stiell, Naaman, & Lee, 2007), and a study of couples with chronically ill children with a 2-year longitudinal follow-up has been completed (Cloutier et al., 2002; Walker, Johnson, Manion, & Cloutier, 1996). EFT studies have begun to address areas of sexuality (Honarparvaran, Tabrizy, & Navabinejad, 2010; Johnson & Zuccarini, 2010), cultural diversity (Greenman, Young, & Johnson, 2009), and relationship enhancement and education (Johnson, 2008).
Along with outcome studies and studies with specific populations, the process research on EFT is extensive. After Johnson and Greenberg’s (1988) initial process study, two main process study threads have emerged in the EFT literature: the process of pursuer/blamer softening, one of the main change events in EFT (Bradley & Furrow, 2004, 2007; Bradley & Johnson, 2005), and the process of naming and repairing attachment injuries between partners (Halchuk, Makinen, & Johnson, 2010; Johnson, Makinen, & Millikin, 2001; Makinen & Johnson, 2006).

**Review of EFT Literature With Military Populations**

The Mental Illness Research and Clinical Center of the Veterans Affairs (VA) Maryland Healthcare System supported a pilot study examining the feasibility and effectiveness of providing EFT for couples to veterans with PTSD and their partners (Batten et al., 2011). The study explored whether participating in EFT can assist in reducing psychiatric symptoms and distress and increase marital satisfaction. Seven couples completed the protocol. Veterans were assessed pre- and post-treatment on measures of PTSD, depression, psychiatric distress, quality of life, and marital satisfaction. Partners completed pre- and posttreatment measures of psychiatric distress, quality of life, and marital satisfaction.

The couples presented with complex and complicated histories. The veterans had all experienced combat trauma, and one veteran also experienced military sexual trauma. In four of the seven couples, the partner, in the course of therapy, also reported having experienced severe interpersonal stresses prior to marriage, such as childhood abuse or neglect, domestic violence, or abandonment in previous marriages.

The couples attended an average of 30 sessions (range 19–34). The findings demonstrated statistically significant improvement in marital satisfaction and reduction in psychological distress. A decrease in severity of PTSD symptoms as measured by the PCL (PTSD Checklist) was also statistically significant. On the Clinician-Administered PTSD Scale (CAPS), a second measure of PTSD, total scores did not improve. Posttreatment interviews of the veterans and partners revealed comments such as the following: “I feel more trust in my spouse”; “Our communications are more open and effective”; “Conflict has decreased”; “I have greater appreciation of my spouse and the trauma and its impact on him”; “I don’t have to put up the wall”; “It brought us closer together.”

While the results are promising, further research such as a randomized controlled study would provide greater clarity regarding the impact of EFT on couples and veterans’ improvements.

**Importance of Treating the Service Member and Partner**

Sherman et al. (2005) highlighted the need to involve the partner in the treatment of combat stress for a military service member and the multiple benefits for both the soldiers and their partners. These authors also found that partners and caregivers of service members with PTSD experience higher relationship distress and less ability to cope with adjustments when war comes home. Providing effective interventions that help the service members and their partners as well as improving relationship
dynamics is imperative. Increased relationship tension and stress can exacerbate PTSD symptomology, and those who are hurt by PTSD symptomology are less likely to continue providing care (Sherman et al., 2005).

In her study on traumatized military couples and the application of attachment theory, Basham’s (2008) study highlighted the need for social support provided for the returning service member. She named two problems for the military marriage postdeployment: Deployment disrupts the attachment bond between spouses and family members. Second, the relational impacts of affect dysregulation, commonly characterized by emotional numbing and avoidance, are pervasive. Since the predictable expression of affect between spouses and family members helps build a secure bond between them, when relationships become characterized by poor affect regulation, the couple’s bond is threatened. When redeployed military couples can be treated with attachment-based couples therapy such as EFT, both partners receive the benefits of learning to regulate their affect and learning how to “be there” for their loved ones. These couples have a chance to work together and help each other cope with life after returning from war. In this time of war, multiple deployments are common, and “with each separation and reunion, the attachment systems of the partners are activated as they must face saying good-bye along with the whole range of feelings that accompany the farewell” (Basham, p. 90).

Treatment of Posttraumatic Stress Disorder The research includes many studies on the impacts of and treatment options for deployment and combat stress as well as for combat-related PTSD. The treatment of PTSD has typically been an individualized treatment focusing on changing behaviors by containing symptoms and setting and reaching goals (Monson & Friedman, 2006). The success of these treatments depends on many factors. In the context of the military, resources to treat PTSD have been scarce, yet the rates of military service members with PTSD continue to increase (APA Military Deployment Services Task Force Report, 2007; Hoge et al., 2004). The individual military service member with PTSD faces many challenges in receiving adequate treatment, which has an impact on the service member and his or her partner and family. When the impacts on partners and family members are not addressed or contained, the success of the treatment is diminished, and the service member could experience an increase in PTSD symptoms. EFT does the double duty of addressing the PTSD symptoms within the context of strengthening the couple’s and family’s cohesiveness and supportiveness (Johnson, 2002) as well as dealing with relationship issues and problematic interactions that arise as a result of PTSD (Sherman et al., 2005).

STRENGTHS OF USING EFT WITH MILITARY COUPLES

To date, focus on the impacts of deployment and combat trauma on the soldier’s marital relationship and family has been sparse (Basham, 2008). If the echoes of battle are not contained, the result for military service members and their partners is increased impacts of trauma resulting from deployment and combat. In a securely attached relationship, partners become a protective factor against the echoes of battle and help the soldier contain, heal, and ameliorate the effects of
deployment and combat. In an insecurely attached marriage, deployment and combat exacerbate the lack of relationship safety and connection and typically increase distrust, vigilance, and fear (Basham, 2008), leading to greater stresses for both spouses. Most mental health services provided for soldiers and their families are based on cognitive-behavioral interventions (Armstrong, Best, & Domenici, 2006; Riggs, 2000), which fail to address the soldier’s marital and familial attachment bonds. Not only does a soldier bring the battle home, but also the battle lives on within the couple’s relationship, threatens their bond, and can add additional traumas to both members of the couple.

EFT, with its focus on attachment and affect, can be a good fit with military couples coping with the echoes of battle (Johnson & Rheem, 2006). Both partners are framed as warriors: one with a mission overseas and the other with the mission of protecting the home front. As both partners come together after deployments, the EFT therapist frames the new mission as one of fighting this new enemy of emotional disconnect and isolation and the negative cycle. This new mission supports the couple in working together just as each did with other comrades and battle buddies while deployed. We encourage each to think of his or her partner as their newest battle buddy, a concept that all military service members and their partners know and respect.

Another strength of EFT with military couples is the ability of EFT to work with each partner’s defenses. The Battlemind™ training that each soldier receives before deploying to a combat zone helps the soldier develop mental toughness and build defenses necessary to fight. These defenses are the best survival strategy for each military service member and are imperative to survive combat and stressors of life while deployed and endure multiple and back-to-back deployments. On homecoming, these defenses do not naturally go away. For many service members, living with these defenses feels more natural and provides more safety even after redeploying home. In couple therapy, the EFT therapist makes no attempt to “get rid of defenses” (Johnson, 2009, p. 275) but normalizes the need for strong defenses and helps the service member and partner make sense of their defensive stances. When these defenses come between partners, the EFT therapist helps each partner talk about his or her defenses, the event or emotion that fueled the need for the defenses, and the vulnerabilities behind the defensive walls. In this way, each partner can let the other in—let the other behind—the defenses to create connection between them. As fears and defenses are validated and developed, the meaning and context for each is explored. As this process unfolds, fears are better tolerated, and impermeable defenses become more porous and situation appropriate. These explorations and discoveries are integrated into the couple’s interactional pattern.

Particularly for military culture, emotional constriction has many advantages. Emotional avoidance has evolutionary benefits to protect society. Highly regulated emotional responses are adaptive for dangerous environments that demand a cognitive focus on tasks to accomplish the mission, which allows a service member to stay calm under duress. Values such as toughness, assertiveness, fearlessness, a focus on tasks and logistics, confidence, and perseverance become the measure for success. Anger feels empowering and mobilizes one out of fearful paralysis and helplessness. Other emotions, particularly the softer emotions, feel threatening.
Particularly at home, emotional constriction also has disadvantages. Success in combat can come with a price to pay at home. The emotional constriction needed from combat becomes a habit that is automatically applied at home or in other settings, which limits connection with a loved one and intimacy. In a secure, loving relationship, healthy and effective dependency is important. In my moments of need, for example, can I reach for you? Can I let you know that I am struggling so that you can be more patient and supportive? Being self-reliant leaves little room for healthy and effective dependency. The armor used to carry out the mission makes it difficult to connect and feel alive when not in combat. Other impacts of emotional constriction are increased risk for depression, anxiety, PTSD, substance abuse, domestic violence, divorce, and suicide (Johnson, 2002).

In EFT, the therapist normalizes the need to shut down to complete the mission as well as the need for flexibility to adapt to being home again. Shutting down emotionally is adaptive and makes perfect sense for combat, deployment stress, and the military culture. But, as all good leaders learn, the need for flexibility is paramount. Military couples in EFT learn to slow their interaction pattern to consider the context before responding to each other, much like a unit leader slows enough to choose a strategy for the firefight, placement of the troops to protect them, or the type of weapon needed to be successful. While we normalize and value the need to shut down emotionally, we also support and value the need for flexibility to increase success regardless of the type of mission.

Because the ability to shut down emotionally is not foolproof, often rapid shifts in emotions occur, such as moving from anger to numbing and back to anger. Knowing how to work with these shifts in extreme emotional states and understanding the context for these emotions can be very normalizing and helpful for the military couple. Within military culture, emotions are pathologized and misunderstood. Many couples present for therapy with one partner complaining of or misunderstanding the strength of the other’s emotions.

The role of adrenaline in these rapid shifts also needs to be understood. During deployment, the service member never lets his or her guard down. Doing so could be deadly in these ongoing conflicts in Iraq and Afghanistan, where there is no back line. Adrenaline helps solders keep their guard up and be ready to fight at any moment. After months of relying on adrenaline to feel safe, coming home and not feeling this intensity can be unsettling. Often, service members will find methods of feeling their adrenaline kick in, even when it makes their partner feel unsafe.

When deployed to a combat zone, the basic goal of the mission is to survive. This goal, among others, provides a sense of purpose and focus that is unparalleled in the nondeployment world. On redeployment, the military couple often needs to help each other find new purpose and meaning. When service members struggle to find purpose and focus after combat, this can lead to more distress for the couple.

Due to military culture and Battlemind training, showing fear can be particularly difficult. For a service member, admitting fear can be stigmatizing, can evoke shame, or can convey a sense of weakness or poor leadership. For the partner protecting the home front, showing fear can also be seen as a weakness or heard as a complaint about the mission that is frowned on. In the context of couple relationships, sharing fears and asking for comfort is necessary and part of building a
secure connection. For the military couple, however, sharing fears and asking for comfort can feel particularly risky and unfamiliar.

The EFT therapist normalizes how difficult and foreign it feels to touch our basic human fears and then to consider asking for comfort from a loved one. In session, the EFT therapist helps each partner tolerate personal fears and hear his or her partner’s fears and helps each ask for comfort from the other. In combat, battle buddies do a version of this with each other when they talk about the highlights of a firefight, share the intensity of battle over a cigarette, or clean their weapons and restock their vehicle together after a mission. These shared rituals provide a sense of connection and camaraderie necessary for cohesion and morale. At home, a felt sense of connection with a partner is one of the fundamental strategies of protecting against the common feelings of helplessness and meaninglessness when adjusting to being home again.

The attachment frame of adult love helps the EFT therapist make sense of a common point of distress for military couples: competing attachments between military command, obligations, and battle buddies and partner and family needs. These two main priorities for a service member often conflict, which can lead to misunderstandings and increased distress for each partner and the relationship. When a couple is caught in distress, these competing attachments can add fuel to the fire or pull loved ones away just when they are needed most by their partner or family members. Understanding military culture and framing these competing attachments as a bind the couple must work together on can be helpful in decreasing the stress and tension that result.

In our EFT-based postdeployment retreats (Johnson & Rheem, 2006), we discuss how the echoes of battle scramble the signals of the relationship. Signals sent between partners are not clear, needs are not expressed, it is hard to turn to a partner and seek comfort, and the silence, distance, and tension take up more space in the house. As a result, distress and escalation intensify and leave each partner emotionally isolated. Fear is reduced by a cohesive unit (Johnson, 2002). In theater, the cohesive unit is the battle buddy. At home, the cohesive unit is the partner or family member. Connection with a loved one—creating a cohesive unit—helps us cope and deal with our fears and the echoes of battle. It is easier to find courage when we are not alone. Deriving comfort from another is a sign of strength as it increases each partner’s personal strength and resilience as it strengthens the couple’s relationship.

**Strengths of EFT With Military Couples Struggling With Trauma**

EFT has a strong empirical base and has been proven successful for distressed couples. As Johnson and Williams-Keeler (1998) stated, “The marital relationship can be considered one of the most important elements of the recovery environment” (p. 27). In a secure marriage, the proximity of a soothing, loving partner (Schore, 1994), the immediacy of the partner during symptomatic times, and the longevity of the partner’s presence may all be important factors in a service member’s recovery (Rheem, 2008). An emotionally accessible and responsive partner can help service members regulate their affect, one of the main symptoms of PTSD (Johnson & Williams-Keeler, 1998). When partners can be responsive to
one another, especially during times of distress and vulnerability, bonding occurs, and the relationship can be strengthened. For this reason, among other reasons, treating the military service member suffering from PTSD and his or her spouse together can be an effective treatment for combat-related trauma (Johnson, 2002).

Previously, our field has lacked a theoretical framework for treating an individual’s PTSD in the context of couples therapy. EFT fills this lack as its “application is now used to address more and more ‘individual’ symptomatology, such as depression, anxiety disorders, and chronic illness” (Johnson, 2004, p. 3). The individual symptomatology of PTSD as an anxiety disorder with elements of depression fits this newer application of treating an individual’s symptoms within the context of couple treatment.

Typically, the partner knows the soldier he or she sent off to war is not the same one coming home. The partner sees and feels the impacts of combat trauma on their loved one as well as experiences the impacts directly. Often, the partners of military service members report being alienated, misunderstood, and targeted by their soldier’s unpredictable outbursts. The soldiers often do not understand their outbursts or their mood changes. They also report knowing and feeling they are different now but are as confused as their loved one about these differences. Including the partner in the treatment of PTSD allows the partner to become part of the healing environment necessary for the military service member’s recovery. By addressing the impacts of trauma on the couple’s dynamics and helping the partners become soothing forces in each other’s lives again, the soldier’s trauma symptoms may be better contained and eventually ameliorated.

**LIMITATIONS OF USING EFT WITH MILITARY COUPLES**

The military mind-set of not experiencing, revealing, or disclosing vulnerabilities can make doing experiential therapies difficult. The approach of not experiencing or revealing vulnerabilities served them well as combatants and to some degree helped them cope in some situations, albeit not effectively, with their PTSD symptoms. In the combat theater, not feeling or giving in to fear may have helped keep them alive but, as mentioned, once home it can become debilitating, particularly for intimate relationships. Revealing traumatic events or associated feelings (which can involve fear, sadness, and other vulnerable feelings) with others who “have not been there” can be difficult and can emphasize that the partner is an outsider. Service members at times find validation and safety with their peers. Often due to feeling shame and not being understood or accepted, talking with civilians, including partners, can be very difficult.

With this population, there is often an array of comorbidities, such as severe mood disorders, addictions, traumatic brain injury (TBI), and other medical problems, that need to be addressed. The couples therapy can be overloaded by these issues if they are not attended to in other venues. Often, the PTSD symptoms are so intense they prevent people from being present with emotional content. Ideally, the service member with PTSD would benefit by being in another primary treatment specifically for PTSD. For troops and veterans with PTSD, avoidance is both a defining symptom and perceived (erroneously) as a good coping strategy. If I feel, a soldier may think, I may get angry, and that would be bad for everyone.
The military, Department of Defense, and Department of Veterans Affairs have cultures of focusing on the veteran, while partners and family members remain an afterthought. Sometimes, partners or family members were considered an interference to care. Gratefully, this culture is changing. However, the frontline clinicians are not used to considering the need to involve family members and typically do not get the specific training (or make appropriate referrals) to effectively treat the service member and family members together.

In military or veteran settings accustomed to only seeing a client for four or six sessions, it can be an uphill effort to engage service member couples and clinicians in longer-term, experiential treatments, even though it can be effective and cost effective (Caldwell, Woolley, & Caldwell, 2007).

**THERAPEUTIC CONSIDERATIONS**

When working with military couples, the EFT therapist needs to carefully build and monitor the alliance. Transparency and collaborativeness are vital to convey respect for the service member and the relationship. Providing rationale frequently in the early stages of therapy is important and helps increase safety, predictability, and comfort. It is important not to make assumptions about military or combat experiences and to ask for more details when you are not sure. Each service member and military couple experience many unique experiences during their deployments. These uniquenesses are often misunderstood, not respected, and need to be explored for personal and relationship meaning and significance.

When working with military couples, the EFT therapist also needs to move slowly when helping each partner encounter his or her emotional experiences. Based on their military culture and mission, as previously stated, the need to shut down emotionally is a survival adaptation. “Because attachment needs are higher and at the same time emotional engagement is experienced as more dangerous, the steps toward more emotional engagement are smaller with more frequent blocks and impasses” (Johnson, 2002, p. 60).

Obtaining training in EFT is paramount when using EFT in the treatment of military couples. The governing body for EFT, the International Center for Excellence in EFT (ICEEFT; http://www.iceeft.com), sanctions many training opportunities in North America and around the world. Individual and group supervision is available in person in many locations and around the world through distance supervision. Supervision provides helpful case-specific consultation to support the EFT therapist. Specialized advanced training in using EFT with trauma would also be useful since the therapist needs to be familiar with and prepared to work with the echoes of battle, combat stress, and PTSD.

**Case Vignette – Jackie and Mike**

Jackie and Mike, both in their mid-20s, were among the few couples in the family day program at the VA hospital to respond to an invitation to participate in a new couples therapy program. They knew their marriage of 8 years was in serious jeopardy. Mike, an army veteran, had returned 13 months earlier...
from his second deployment to Iraq. On his return home, there was the initial excitement of this family of five, two parents and three young children, being finally reunited. However, the joy and togetherness dissipated almost immediately. Mike began to drink heavily and was spending more time alone with his liquor bottle than alone with his wife. With the encouragement of family, the guidance and intervention of the VA, as well as Mike’s own resolute determination, he was able to stop drinking. During the recovery, Mike was diagnosed with PTSD. He joined a trauma treatment program and had been progressing, albeit slowly. Mike found steady employment, and it appeared that the family was regaining its balance. However, this was not the case for the marital relationship. Jackie and Mike remained distressed; their relationship was punctuated by arguments and periods of avoidance and isolation. Jackie told her husband, “I had to learn to depend on myself because you were not here. Now you are back but still aren’t here. If I need to I can and will manage on my own.”

Prior to the treatment, each partner completed the Dyadic Adjustment Scale (Spanier, 1976). Both partners revealed a high level of dissatisfaction in the marriage, but both also indicated a commitment to making it right. They were in emotional pain but were motivated to work on their relationship.

THE FIRST SESSION

Mike and Jackie arrived on time for their first session. They entered the office with evident trepidation mixed with an eagerness to begin their work. The therapist set up the chairs such that they were gently angled toward one another and at the same time facing the therapist. The therapist provided an overview of the treatment process as well as a brief discussion of the potential risks and benefits. Confidentiality and its limits were explained. The EFT therapist made sure to articulate that he respected and valued the experience of both partners and recognized that they were the experts on their own experience. The therapist framed his role as a consultant to their process. In this light, the therapist explained that he would consistently check with them to make sure his comments and observations accurately reflected their experience. He made it clear that the process was a collaborative joint partnership between him and them.

The therapist also assured the couple of transparency: He had no hidden agendas—all questions were welcome. When working with survivors of trauma, highlighting the collaboration and transparency of the process can help to allay the inherent anxiety and distrust a trauma survivor brings to new experiences, or any experience, that may feel out of his or her control. In the overview, the therapist explained the importance of an early task in treatment, that of discovering how and why the couple were stuck that led them to feeling unhappy and frustrated. He explained that it was critical they learn how trauma has an impact on each of them and their relationship. Indeed, this awareness would assist them in standing together against the negative interactions and the symptoms of trauma. The therapist then inquired about whether the couple had questions or concerns. Jackie and Mike thanked the therapist for the explanation and stated they were ready to begin the session.
Jackie was eager to share her dismay and frustration. She openly and emphatically described her own history of abandonment by her biological father and stepfather. She also described the emotional unavailability alternating with contention and disapproval that characterized her relationship with her mother. Mike was more reticent and described his family of origin as cold, distant, and devoid of closeness and affection. Jackie summarized, “We were both raised with no affection. He [Mike] is like his parents and shows no feelings, while I … I need more attention and love.”

The therapist asked about the history of their relationship. He inquired regarding their perception of the strengths of their relationship and asked for a description of what they were like as a couple when they get along and when they feel or have felt close and happy. The therapist was careful to attend to each partner, to join with each, and to convey in action and in words that they each would be respected and would have the opportunity to share personal views, feelings, and perspectives. The therapist then asked the couple to describe what happened when they disagreed, what they disagreed about, and how they disagreed. It was with this inquiry that the negative interactions that formed their negative cycle began to emerge.

**Wife (W):** I always feel so alone with the burden of fixing problems in the family. I just want to be able to ask him for help. I know it sounds like I am nagging or complaining. But, Mike is just not there. Ever since he came back from Iraq, he is so distant, and he gets so easily frustrated and even mean. It’s not fair. I walk on eggshells.

**Therapist (TH):** It’s so hard for you to continue to feel alone. You want to turn to Mike for support and for help at home … but he often seems upset with you or unavailable. … Is that right?

W: (Nods; tears start forming in her eyes.)

**TH:** what happens for you when you feel that loneliness?

W: I get angry. … I complain more. … I guess … get critical … loud. … I am so frustrated. … I just don’t know how to reach him. I say the wrong thing, and he is gone. Sometimes, I chase after him, really, room to room.

**TH:** You try to get his attention—when you can’t, you feel anger and frustration. Sure, it is frustrating for you. So, you keep on trying to get his attention, even room to room. What happens then?

W: Mike either shuts the door, turns on a videogame or something. Thank God he no longer drinks. Sometimes, he gets really mad, we argue, we fight … then we go our separate ways.

*The therapist reflects and summarizes Jackie’s experiences, validating her feelings. He then turns to Mike.*

**TH:** How would you describe the typical arguments at home?
Husband (H): Jackie is right. I have, like, no patience anymore. I have a really short fuse. When she starts complaining, I get all mixed up inside … so I try to stay away so I don’t do anything wrong. She complains, gets loud so often—I know I can be mean … (looks down and away).

TH: When Jackie gets upset with you, you get all confused inside … sounds like you also quickly feel angry, but you pull away so you don’t get into a fight. Is that what happens? (Husband nods, continues to look down.)

TH: Mike, what is it like for you now as you describe these events?
H: I don’t want to hurt Jackie. Sometimes I don’t even hear what she is saying. I get mad so fast; I just got to get away.

TH: You really care about your wife. It sounds like getting angry is hard for you, too. So you pull away, go into another room, to prevent a fight, yes?

TH: Jackie, when your husband pulls away, what happens for you?
W: I get more angry. … I'm like, where are you going? Why are you leaving me? I guess I get more down on him. It doesn’t help; he shuts me out more.

The therapist begins to see the problematic dance of disconnection fueled by anger, a stand-in for their hurt and fear. The therapist “explicates the cycle,” providing the couple with a new frame. This expanded understanding of their experience preempts blame and helps reduce defensiveness.

TH: You have both described well what you get caught up in, the interaction that keeps on reoccurring which causes such unhappiness. May I share my observations?

(They both nod and appear curious regarding what will follow. The therapist continues.)

Partners in a couple want to feel emotionally connected and valued by their spouse. When that feeling is threatened, each partner responds in a way, copes in a way, that makes sense for them. However, those reactions create more insecurity and reactivity in their partner. It is a cycle that both of you get caught in, almost automatically. Because it is a circle, there is no real beginning. For example, Jackie when you need Mike, reach for him and feel he is not there for you, you get angry. Actually, you described the deeper experience of feeling alone and then you get angry. You sort of protest, to get his attention, perhaps to pull him back. Mike, when you see Jackie get upset with you, anxiety begins to churn inside, you get that uneasy feeling, and to prevent your anger to erupt, you pull away. When you pull away, Jackie you feel the hurt and anger
and protest. This leads Mike to withdraw more … and now you are stuck in a cycle. Does that sound right to you? Is that what happens?

(The couple nods, and the therapist continues.)

There is an added dimension which fuels this stuck pattern even after. When a person has experienced trauma, their bodies and minds become more sensitive—more reactive. So, he or she is prone to more reactivity, such as anxiety or anger. They are also more prone to responding to that feeling with avoidance, emotional numbing, or withdrawal. Mike, when you feel that tension, which you did not seem to feel with Jackie earlier in your relationship, before your deployment, you do feel more confused … and you want to withdraw more. Mike and Jackie, the goal of this therapy is for you to learn to stand together against the cycle and against the symptoms of trauma—which as you can see—accelerates and deepens the cycle.

Jackie and Mike listened to this new frame. The therapist explored their reactions and inquired about their questions. At the close of the session, they were given a handout on the impact of trauma on a couple’s relationship and were asked to review it at home and to highlight for the next session the information relevant to their lives. The session closed on a hopeful note as the therapist explicitly honored their courage in being open and in listening to each other. The couple left with a new, expanded view of their own experience and of their relationship.

**STAGE I: DEESCALATION OF THE CYCLE**

The first stage of EFT focuses on identifying the cycle and the underlying attachment-related hurts and fears. Many times over the next several sessions, as the couple described arguments over different issues, the therapist slowed the process such that each could appreciate the emotions triggered, the ensuing behaviors, and the resulting cycle of negative interactions.

In one typical sequence, Jackie explained her unrequited needs and the resulting pain.

**W:** When I feel anxious, I look to hold onto someone … so I reach for my husband.

**TH:** You turn to your husband for comfort, for reassurance.

**H:** She gets so clingy. … It’s too much.

**TH:** What happens for you when she turns to you … when you feel she is too clingy?

**H:** I get this tight, pressured, tight feeling … so I try to get away or push her away.

**TH:** A tight feeling … where do you feel that?
"Right in my chest, like a knot of pressure, also in my throat."

"Tight feeling … sounds like tension, anxiety. … When else have you felt that … ?"

Mike spontaneously described an experience in Iraq when he went out on patrol. He described how he felt trapped, and while protected in his vehicle—he also felt fearful—vigilant of attacks. He never shared these fears with his peers or with his wife until that moment.

"You had the tight, pressing feeling when you were in real danger. Now safe at home, your body triggers the same reaction when you sense tension or conflict. Yes?"

"(Tearful.) But why am I a source of anxiety for him, not comfort? When will I ever be able to turn to him? You know I rode 50 miles here with Mike on the back of his motorcycle. I trust him with my life. … When will I be able to trust him with my feelings. When will he trust me with his?"

"You so much want to be there for Mike and need him there for you. It hurts, truly hurts and confuses you when he feels pressured—threatened by you, your needs."

"Jackie does not understand that I also want to be a good husband, a good father. I don't want to feel that tense and clinched-up feeling. … I don't want to numb out."

"Mike, you are explaining all this to let her in—so she can see that this is hard for you and not what you want. Can you tell her that? Can you tell Jackie directly that this is a struggle for you, but that you want to be there for her? Can you turn to Jackie; explain that to your wife?"

"(Awkwardly at first) Jackie, I don't like feeling tight. But it is not your fault … and it does not mean that I don't want to be with you. I just get that feeling when I feel stuck. … I am trying. … I do want to be there for you."

The therapist asked the husband to directly convey his heartfelt struggle to his wife. This exchange, called an enactment, can be difficult for some couples as it entails greater emotional contact and risk. This dialogue was enabled by the slowing of the cycle at home and in the session. Jackie was able to hear and to be momentarily soothed by Mike’s opening up to her about his inner experience as he did so directly and empathically. Small, more contained enactments are encouraged in the first stage of EFT, while deeper and more emotionally vulnerable enactments are facilitated in Stage 2 of the process. In each enactment, the therapist attempts to sufficiently “slice thin” the emotional content so as not to overwhelm either partner.

The couple discussed several topics over the following sessions. Two topics in particular generated a great deal of emotional intensity. Jackie had been carrying an emotional injury for several months but had never discussed it with
Mike. In session, Jackie reported that there was a several-week period while Mike was in Iraq that she had not heard from him. He had later explained in a letter that he did not call her because he did not want to wait in the lengthy line for the phone. Jackie was deeply wounded by his insensitivity toward her, the nervous and lonely wife back home. The couple never discussed the matter after his return until this session. Jackie revealed her feelings and her hurt. Rather than become defensive, Mike explained that actually he had been on several dangerous patrols during that period, and he felt he would not be able to talk with her without revealing his fears. This would worry her more. Mike explained he had never opted to explain this to her because he was fearful of her anger. As an indication of the progress made by this couple, they did not revert to their negative cycle, but instead shared their various experiences and feelings. Each was able to provide understanding and compassion to the partner.

The second issue did not go as well. Indeed, the issue and the way they each handled it at home resulted in a relapse, an exacerbation of their cycle. Jackie wanted another child; Mike did not. Jackie felt he was not responding to her, and he was not. Mike avoided her, closing himself in “his room”—playing video games and music.

W: I am so sick of not getting what I want. He just won’t deal with me (tearful).

TH: It really hurts, makes you feel so sad when you feel that Mike does not care about what you want.

W: He doesn’t … he shuts the door on me.

H: I am tired of talking about it (annoyed).

TH: Mike, what happened for you just now? The moment before you said you wanted to end this conversation. What was going on for you?

H: I can’t stand to see her upset … so I try to end the conversation … fast.

TH: You care so much about her—you don’t want to see her upset. It’s hard for you, not sure what to do, so you try and end the conversation.

H: Right, but she doesn’t believe me … that I care about her. I really don’t know what to do.

TH: You do care about her feelings. Her pain is hard for you. But ending the conversation seems to make her more upset. I wonder if you can tell Jackie about what happens for you. Can you tell her about not knowing what to do but not wanting to see her in pain? Can you tell her directly what you struggle with?

H: (Hesitation.) … I don’t stop talking to you because I don’t care. … I don’t want to see you hurt … so I guess I do my old thing and shut down. Now you are still hurt, aren’t you?

TH: Right, right (turning to Jackie). What is it like for you to hear that actually Mike shuts down not because he doesn’t care—but because he cares so much, but doesn’t know what to do?

W: I know he doesn’t want me to be upset. I can see now that it breaks his heart to see me sad. That is so important for me to hear.
STAGE II: RESTRUCTURING THE BOND

In the second stage of EFT, once the cycle has deescalated, each partner is asked to reach deep within. They reflect on, discover, reveal, and share their fears, needs, and even longings for the other’s love and presence. This exchange of emotion and its mutual acceptance restructures the bonds between the couple. The withdrawer is more fully present, and the pursuer can reach in a softer, more empathy-inducing manner. In the process, a partner’s very sense of self is often strengthened and healed.

The following discussion occurred in the 18th session. Again, the veteran had distanced himself from his wife as he felt the “tightness” of pressure and anxiety. Jackie, in turn, felt rejected and reported feeling “guilty” that she is so shamefully needy that she pushes her husband away.

W: When Mike pulls away or pushes me back, I feel I am just too needy.
TH: Jackie, you describe the inner conflict of wanting to reach for him—but fearing that you will overwhelm him, and he will disappear. There are tears in your eyes, a sadness … what is happening for you now?
W: One time, I just wanted to tell my mom about my day. So, I guess I kept on trying to get her attention. Finally, she said to me, “Go to your room; you just talk too damn much.”
TH: Such a hurtful memory, hurtful message.
W: I could never approach my mom; I was always afraid of being pushed away. I was always walking on eggshells—I didn’t want to ask for too much. She was always angry, always in a bad mood.
TH: So painful. … Jackie, are you saying you sometimes feel the same way with Mike?
W: I do feel rejected—like there is something just wrong with me.
TH: You need so much to feel accepted. Whatever your needs may be. You long for acceptance and caring. It hurts you when you feel your husband is not available to you. You wonder is it me, am I worth it, am I too much? Too needy?

The pain is right there, in your heart right now. Can you please tell Mike what that feeling is like, the rejection from Mom and sometimes with Mike? Can you tell what it feels like when you need his attention—but fear his rejection?
W: (Turns to husband.) Mostly I feel rejected like I am not worthy of your attention, your love. I think your needs to not be pressured or whatever are more important than me.
TH: Sometimes you feel not worthy of Mike’s attention and love.
W: Especially when I am not feeling good. I do need more comfort and … (Silence, tears rolling down her cheeks. She looks down at the floor.)
TH: I know it hurts; I see that. Mike is here, and he is listening to you. Can you tell him what you really need from him?
W: I need your attention. I want to feel important to you. I need you to care about me … to take care of me!
TH: You deeply long to feel that you are worth his attention, his care, his love. This something that you did not feel with your mom. There is so much pain from the past … you take the risk to tell your husband of your pain and how he can comfort you.

W: Uh huh (gentle tears).

TH: You need to know you are not a burden and that Mike can and does care about you. Can you tell him that?

W: I do, I feel like a burden. I want to know how important I am to you—that you appreciate me. …

(Long silence; husband looks at wife, then at the therapist, then back to his wife.)

TH: Jackie, you have taken a real risk by telling Mike what you need, sharing a hurt—being vulnerable. … Mike, has been so attentive. … I want to check with him. … (Turns to Mike.) I can see how you are looking at your wife with deep attention; what is going on for you now? What are you feeling inside as you listen to her tell you of her fears and needs?

H: Jackie, I do value … love … appreciate you. Sometimes it just slips away from me, and then I consider my own feelings, that tight feeling—and I don't consider what you are feeling. I hear you, I understand you more. (Turns to therapist.) I just feel pressured, wound tight, even now, when I can't give her what she wants. …

TH: You feel that tightness even now … and when you feel not capable, not sure what Jackie wants and how to help her.

H: My chest feels so tight, my palms get sweaty, and I don't think straight.

TH: That is anxiety, which you explained before occurs when you feel you can't control the situation or when you feel you won't measure up, or that something bad is going to happen and you don't know what to do. … That's when you feel anxious, tight.

Mike, your body remains sensitized by the trauma, by the fears you experienced in Iraq. The flood of anxiety is triggered when you feel I can't do this, and I have nowhere to escape.

H: I don't want to feel this. Jackie, I don't want to hurt you. It is not that I don't want to be with you, or that you are too needy. I just need some time to calm my body down.

TH: You are telling your wife, the tight feeling does not mean you don't want to be with her—the opposite is true, but the tension does take over. Can you tell her that—so she knows what you struggle with inside.

H: I want the pressured feeling to go away so I can be with you. (He looks at his wife, waiting for a response.)

TH: It's so important to you that Jackie understands that you do love her, value her, want to be with her.

H: I do understand you. I would also feel rejected. Deep down it is not what I feel at all. I also need you, and I don't want to be away from you.
**STAGE III: CONSOLIDATION**

Jackie and Mike continued in therapy for a few more sessions over the following month. They reported an occasional tendency to enter the cycle but were able to avoid it and instead talk with one another heart to heart. Mike stated that he had asked for a “time-out” when he felt pressured and was able to reassure Jackie that they would talk at a later time, and they did. The couple jointly stated they felt ready to conclude the therapy. They each felt confident in each other’s presence and love. They stated they were ready and able to contend with their inevitable life challenges as life partners.

**CONCLUSION**

The individual military service member with PTSD faces many challenges in receiving adequate treatment that has an impact on the service member and his or her spouse and family. When the impacts on spouse and family members are not addressed or contained, the success of the treatment is diminished, and the service member could experience an increase in PTSD symptoms. “Treatment aimed at the interpersonal context does the double duty of addressing the PTSD symptoms within the context of strengthening the family’s cohesiveness and supportiveness (Johnson, 2002) as well as dealing with family problems that arise as a result of PTSD” (Sherman et al., 2005, p. 627).
REFERENCES


