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Article 15

Military-Related PTSD and Working With Couples in Private Practice: Emotion-Focused Therapy, Psychoeducation, and Evolutionary Perspective

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Abstract

The aim of this article is to provide information and treatment suggestions to mental health services providers who work with couples with trauma-related problems. Post-traumatic stress disorder (PTSD) treatment dropout rates, evolutionary perspective of PTSD, emotion-focused therapy (EFT), emotionally focused couples therapy, and psychoeducational strategies are discussed. A hypothetical case example is provided to illustrate how psychoeducation and information pertaining to trauma responses and evolution can be integrated with emotion-focused therapy to work with traumatized persons/couples in a private practice setting.

Keywords: evolution, emotion-focused therapy, PTSD, psychoeducation

Being exposed to traumatic events and war can lead to the development of trauma-related conditions (Warden, 2006). Lately, there has been an increase of interest in post-traumatic stress disorder (PTSD) due to recent military involvements (Warden, 2006). These military engagements have led to a substantial number of service men and women developing PTSD (Hoge et al., 2008). A large scale U.S. epidemiology study found that about one third of those affected develop chronic PTSD and fail to recover even years later. It was found that combat exposure very likely leads to the development of PTSD (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995).

In terms of military-related PTSD, it is important to also consider traumatic brain injury (TBI), which occurs relatively frequently, especially through blast injuries. For example, mild TBI was one of the most frequent injuries sustained by military personnel engaged in Operation Enduring Freedom (OEF) in Afghanistan and Operation Iraqi Freedom (OIF; Taber, Warden, & Hurley, 2006; Warden, 2006). Mild TBI and PTSD were found to be strongly associated in soldiers returning from deployment in Iraq (Hoge

et al., 2008). Although there are some differences, symptoms of PTSD and concussion injuries can overlap. Co-occurring symptoms can include depression, anxiety, and problems with attention and concentration. It is important that individuals diagnosed with both conditions receive treatments addressing all problem areas (Warden, 2006).

Military deployment, especially multiple deployments, do not only impact service members but also impact their partners (Karney & Crown, 2007). For example, it was found that deployment of a spouse and greater length of the deployment increased mental health diagnoses for the wife. Diagnoses included adjustment disorders, depression, acute stress disorders, sleep disorders, and anxiety (Mansfield et al., 2010). Despite services provided by the Veterans Administration (VA) and other veteran organizations, some of these clients find their way into and prefer the private practice setting.

A longitudinal study pertaining to service members previously deployed to Iraq found that 20.3% of active duty personnel and 42.4% of reservists were in need of mental health treatment (Milliken, Auchterlonie, & Hoge, 2007). Depression and PTSD were identified as the predominant mental health conditions. Furthermore, reassessment showed that interpersonal conflict increased 4-fold compared to initial assessment results (Milliken et al., 2007). Based on the recommendations of a panel of experts in their seminal work, Foa, Davidson, and Frances (1999) suggested that simple PTSD is best treated with anxiety management techniques, cognitive therapy, and varying forms of exposure therapies. Anxiety management can include relaxation training, breathing retraining, positive thinking and self-talk, assertiveness training, as well as thought-stopping techniques. Exposure therapy can be conducted in vivo as well as imaginal. In vivo exposure therapy refers to confronting a person with situations that are now safe but which are avoided due to triggering fear. The goal is that over time the triggering situation will no longer induce fear or anxiety. On the other hand, imaginal exposure therapy refers to retelling the story of the traumatic event until it no longer induces anxiety and fear (Foa et al., 1999).

Peterson, Luethcke, Borah, Borah, and Young-McCaughan (2011) pointed to the practices of the U.S. Department of Veterans Affairs (VA), which suggests the use of cognitive processing therapy (CPT) and prolonged exposure therapy (PE). A recent review of the VA's Web site showed that this is still the case (Department of Veterans Affairs, 2016). CPT integrates two components, namely cognitive and exposure therapy. Here, exposure therapy takes the form of writing and reading about the traumatic event. This is combined with cognitive behavioral strategies that focus on maladaptive thought patterns and beliefs resulting from traumatic experiences (Resick, Nishith, Weaver, Astin, & Feuer, 2002). While reports vary, there is a general consensus that dropout rates for certain PTSD treatment modalities are high. For example, Garcia, Kelley, Rentz, and Lee (2011) reported a dropout rate of 67.5% of OEF/OIF Veterans receiving cognitive behavioral therapy (CBT). Likewise, a meta-analysis reviewing 55 studies utilizing CBT and eye movement desensitization and reprocessing (EMDR) treatment found dropout rates of up to 54%, and non-response to treatment rates up to 50%. Dropout rates for exposure therapy/prolonged exposure therapy were reported to be up to 50% and non-response rates up to 67%. Interestingly, one study reported dropout rates for emotion-focused therapy (EFT) as 0% and non-response rates as 46% (Schottenbauer, Glass, Arnkoff, Tendick, & Gray, 2008).

Unfortunately, current research and practice trends seem to neglect emotional perspectives in favor of cognitive-behavioral approaches. This has not always been the case (LeDoux, 2000). Early in the twentieth century, there was great interest in researching emotions; however, cognitive approaches became more favored. This was in part due to the fact that cognitive research questions showed themselves more amenable to investigation (LeDoux, 2000). Also, with the advent of computer science, the brain was being conceptualized as computer-like in its functioning. Research into emotions was viewed as far too subjective (LeDoux, 2000). This development is problematic in that it may lead to significant limitations of empirically validated interventions available to practitioners when treating diverse clientele.

Emotion-Focused Therapy

EFT is a neo-humanistic approach built on the premises of person-centered, existential, Gestalt, and experiential therapeutic modalities. It is combined with cognitive and emotional dimensions as well as attachment theory (Greenberg, 2011). Emotions are viewed as the primary drivers for setting goals and priorities; people tend to make decisions based on emotions (Frijda, 1986). Emotions are situation specific and are based on a person's meaning structure (Frijda, 2007). Personal meaning is derived from organizing and explaining one's emotions. Emotions are understood as physically felt reflections of experiences, which can occur with or without cognitive awareness (Greenberg, 2006). The primary focus of EFT is targeting established emotional schemas in order to achieve more adaptive experiences, narratives, and emotional connections/attachments (Greenberg & Paivio, 1997). Primary and secondary emotions are viewed as operating within and outside of awareness (Greenberg, 2011). This is also true for those who are experiencing PTSD symptoms. PTSD reactions tend to deactivate those areas of the brain that are involved in formal thought processes, making rational cognition nearly impossible. This in turn allows for the activation of fear and arousal processes designed to keep an organism safe (van der Kolk & Najavits, 2013). One goal of EFT is to access and reinforce adaptive primary emotions. Another is to regulate and transform maladaptive ones by helping clients sort out their feelings, develop self-empathy, and choose more adaptive emotional responses (Greenberg, 2006).

Emotionally Focused Couples Therapy

Emotionally focused couples therapy (EFCT) has been effectively used to address individual problems in couples counseling (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). EFCT is one of very few empirically validated counseling approaches for couples. It offers psychodynamic-based intrapsychic dimensions, interpersonal systemic dimensions, and attachment-based perspectives to help couples improve their relationships through a 9-step intervention process. Part of the therapist's role is to assist partners in addressing their emotional experiences and to facilitate translating and understanding emotions within and between partners (Johnson, Hunsley, Greenberg, & Schindler, 1999). The primary aim of EFT/EFCT is to help individuals and couples expand, regulate, and express emotions in a more adaptive manner. Dysfunctional ways of engaging each other are replaced by an increase in comfort seeking, contact, and

empathy. As a result, attachment and support needs are met. In a more secure and supportive relationship, partners are able to function in a psychologically healthier manner (Blow, Curtis, Wittenborn, & Gorman, 2015). When these conditions are not met, a safe marital environment is compromised. Partners either hold in their emotions or lash out in order to express their irritations, frustrations, or anger, which further erodes the relationship (Blow et al., 2015).

EFCT is divided into three stages: (1) de-escalation and stabilization, (2) restructuring the bond, and (3) integration (Johnson, 2002). Step one involves building a working alliance with the couple and identifying the core concerns and attachment issues as well as negative interaction patterns. Another goal is to connect the couple with underlying and often unacknowledged emotions. This helps bring awareness to underlying roles assumed by each partner such as pursuer – blamer or withdrawer – placater (Johnson, 2004). Step two involves changing interaction patterns. The couple is tasked with accepting each partner's subjective experiences as well as developing new and more adaptive responses. Another goal of stage two is for partners to become aware of and integrate frequently ignored or cut-off emotions pertaining to attachment needs and other self aspects. The therapist helps the couple express needs and wants in a new, more effective manner. The goal is to foster emotional engagement and stronger attachment. Step three involves finding new and more adaptive solutions to old problems. It also involves solidifying new patterns and improved attachment behaviors (Johnson, 2004).

Evolutionary Perspective of PTSD

As Judith Herman remarked in her landmark book, *Trauma and Recovery* (1992), research pertaining to trauma-related responses has a perplexing history in which a flurry of activity is frequently followed by periods of silence. As a result of recent combat engagements in the Middle East, there is a wealth of new studies in reference to trauma. Surprisingly, the literature, including the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) shows little discussion in terms of causation beyond immediate events preceding the development of trauma-related disorders. In order to fill this gap, evolutionary psychology offers a noteworthy perspective pertaining to trauma-related disorders. It combines psychological, social systems, and neuroscientific research results in order to gain a better understanding of PTSD and other trauma-related conditions. For example, PTSD is seen as being a fear-based emotional adaptation in response to a perceived threat to survival. These defensive behaviors are found in virtually all mammals, as a lack of a fear response in a species would preclude its survival (Cantor, 2009). The evolutionary view of PTSD is less inclined to pathologize trauma responses; rather these reactions to real or perceived threats are viewed as adaptive, ensuring survival of the individual.

PTSD may have its roots in an "enduring heightened defensive reorientation that has been adaptive" (Cantor, 2009, p. 1046). Fear triggers defensive actions in mammals, including humans. This leads to the use of a variety of defensive strategies with the ultimate goal of survival. Some of these survival strategies include "avoidance, attentive immobility, withdrawal, aggressive defense, appeasement, and tonic immobility" (Cantor, 2009, p. 1046). These strategies work in conjunction with vigilance and risk

assessment. From an evolutionary perspective, PTSD can be viewed as an enduring defensive reorientation initiated by an organism to ensure survival (Cantor, 2009).

It is of interest to note that research has found there is an overall higher resilience (i.e., not developing PTSD) to events such as fires or natural disasters (such as Hurricane Katrina) than to warzone exposure. It has been speculated that a correlation exists between neuro-evolutionary time-depths and the level of resilience to stress; meaning, the more time a species has had to adjust to life threatening stressors, the more likely it is that it has been able to "hard wire" specific resiliencies. It seems that violence perpetrated by humans elicits the highest PTSD rates (Bracha, 2006). Human violence, including combat situations, is the most recent in terms of time-depth and seems to cause the most trauma-related psychological problems.

Trauma, Shame, and Guilt

Trauma frequently results in isolation and loss of trusting relationships with others, which Herman (1992) described as a "violation of human connection" (p. 54). One concern that is often overlooked in treating PTSD is that some traumatized individuals develop shame and guilt in association with the traumatic event(s) (Lee, Scragg, & Turner, 2001). Individuals can also develop shame and guilt due to PTSD diagnosis and corresponding symptoms (Mittal et al., 2013). Shame can be defined as an intense experience that elicits behaviors such as the need to escape, hiding and concealing, and submission (Gilbert, 1997). Guilt can be viewed as a feeling based on a sense of responsibility for wrongdoing, or violating internalized values and beliefs such as causing harm to others (Barrett, 1995). Shame and guilt may be triggered by imaginal exposure treatment and may even worsen post-traumatic reactivity (Foa et al., 2002; Pitman et al., 1991). The *DSM-5* lists shame and guilt in the diagnostic criteria of PTSD as an extension of "negative alterations in cognition and mood associated with the traumatic event(s)" (American Psychiatric Association, 2013, p. 271). It is also of interest to note that shame has been associated with the development of depressive symptoms (Thompson & Berenbaum, 2006).

It is essential for clinicians who work with traumatized clients to address shame and guilt related to traumatic events prior to attempting exposure-focused PTSD interventions. In general, shame and guilt are negatively associated with mental well-being (Gaudet, Sowers, Nugent, & Boriskin, 2015), and frequently shame and guilt associated with the traumatic experience(s) lead to premature treatment termination or failure to seek help in the first place (Lee et al., 2001). This holds especially true for service members who developed PTSD due to military deployment. Many returning service members experience feelings of shame and guilt in connection to the traumatic event(s) for a variety of reasons (Leskela, Dieperink, & Thuras, 2002; Wong & Cook, 2006). Shame and guilt can also be the result of these service men/women viewing themselves as damaged, weak, and out of control due to PTSD symptoms. This does not correspond with military culture and the image of the invincible service member. Shame and guilt can also can be internalized and carried over into post-military life (Mittal et al., 2013) and may also lead to fears of stigmatization (Hoge et al., 2004). Psychoeducation pertaining to the etiology of PTSD in general and in reference to evolution in particular can be very helpful in alleviating some feelings of shame and guilt. Using

pychoeducation, it may be possible to transform a sense of weakness into a sense of survivorship. Psychoeducation has been deemed an effective and necessary aspect of treating PTSD (Cloitre et al., 2011; Foa et al., 1999). It can help the sufferer understand that the development of PTSD symptoms are very much a survival mechanism passed on from ancestors that managed to survive.

Case Example

The goal of the following case example is to illustrate issues and treatment strategies discussed above. This illustration does not reflect a specific case; rather, it represents an aggregate and hypothetical couple's counseling scenario based on the cumulative counseling experiences of the author.

Frank and Mary came to see Joanne, a mental health counselor in private practice, because they were experiencing problems in their marriage. The couple had been married for 12 years and they have two children together, ages 8 and 10. They met in high school and were married while Frank was at his first duty station in the Armed Services. He enjoyed the military and was planning on making it a career. Before long, Frank was deployed to a recent military engagement in the Middle East and served two tours as a combat medic. During his two tours, he experienced secondhand combat exposure due to encountering combat injuries and casualties while fulfilling his duties as a combat medic. Frank also experienced firsthand enemy engagement when his convoy was hit by an IED. He sustained severe lacerations as well as serious back injuries, causing him to be medically discharged from the military.

The couple sought out counseling as requested by Mary who was becoming increasingly frustrated with the deterioration of their marriage. In session, Mary stated that Frank had changed significantly since returning from his last tour of duty in the Middle East. She reported that his personality had considerably changed from the kind and carefree husband that she married to being reclusive, frequently angry, and impatient. Frank and Mary were having difficulties communicating with each other. The couple reported frequent arguments highlighted by periods of tension and low levels of connections and communication. Both stated that they loved one another; however, Mary admitted that she had been considering leaving the relationship.

Not until the third session did Joanne discover that Frank had been seen by the VA for combat-related PTSD symptoms with possible traumatic brain injury due to being exposed to explosions. Mary initiated the discussion and voiced concerns regarding Frank's diagnosis. Frank was visibly uncomfortable with Mary's disclosure and stated that he briefly participated in group counseling for veterans who had been diagnosed with PTSD as a result of military service. He did not feel comfortable with group counseling and recalled that he had a difficult time listening to the trauma stories shared by other group members. He reported developing high anxiety and an overwhelming urge to bolt from the group counseling room. Frank also expressed his reluctance to return to the VA for additional services nor did he want to talk about it at the present moment—setting a strong boundary. Subsequently, Frank shut down for the remainder of the session. Joanne decided to respect Frank's wishes and did not follow up on Frank's diagnosis of PTSD and treatment refusal; however, she made a mental note to revisit the topic at a more opportune time. Joanne suspected that Frank was experiencing PTSD symptoms such as

severe anxiety, re-experiencing, or emotional numbing when faced with trauma content or VA-related subject matter.

In line with EFT's person centered underpinnings, Joanne chose to focus on establishing a good working relationship with the couple, offering unconditional positive regard, and respect for Frank's resistance. In subsequent sessions, Mary stated that Frank never talks to her about his experiences during deployment nor his symptoms. According to Mary, Frank's main response to adverse situations was to emotionally shut down. Mary reported that Frank had become a stranger who was not interested in connecting with her on a meaningful level. She indicated that this and the periodic anger outbursts were the main driving forces for her thoughts of divorce. Joanne explored with Mary how her attachment needs were not being met in her marriage. This helped Mary better understand the important role healthy attachment patterns play in her primary relationship. Frank participated little in the first few sessions but he kept returning to couples counseling even though more times than not he was too guarded to risk opening up.

During the fifth session, the couple reported a significant fight that had occurred a few days prior and Frank spoke up. He explained that through the emotionally focused counseling process and being able to listen to Mary's work, he started to realize how much his withholding and angry behaviors hurt his wife and their relationship. He revealed that he secretly felt deep shame because he suffered from PTSD. He explained that he viewed himself as weak and flawed. Frank indicated that his self-loathing led him to withdraw from his wife, family, himself, and life in general. Joanne seized the opportunity to provide psychoeducational information pertaining to PTSD, including evolutionary perspectives of this disorder. As a result, Mary and Frank began to gain insight into the challenges experienced in their relationship due to Frank's diagnosis. Frank was able to connect to the survivor imagery provided by Joanne's explanation of PTSD and in subsequent sessions he was much more willing to discuss difficult emotions and content matter. He acknowledged that his avoidance of emotions had not served him well. The couple was able to become aware and let go of some of their rigid, self-reinforcing, and at times subconscious interaction schemas. The couple was also able to express and experience feelings of grief and loss regarding their relationship and themselves. Frank was also able to vocalize for the first time that he perceived significant changes in Mary after returning from deployments. He reported that this caused him emotional distress and at times he felt not needed and alone. Mary agreed that having to cope on her own for an extended period of time changed her. Through emotionally focused therapy, the couple was able to process feelings pertaining to changes in both partners. In addition, Frank and Mary were able to construct new and more adaptive narratives pertaining to their difficult individual and shared experiences. In openly talking about his feelings of shame and guilt, and receiving compassionate feedback instead of judgment and rejection, Frank was able to undergo an emotionally corrective experience. This helped alleviate some of Frank's negative emotions, especially towards himself. Joanne also seized the opportunity to discuss secondary emotions with the couple. Mary and Frank over utilized secondary emotions, especially maladaptive ones such as anger, in their interactions with each other. The couple frequently employed anger in an attempt to emotionally protect themselves and to mask primary emotions such as fear, shame, sadness, and guilt.

Emotionally focused couples counseling continued and in time the couple reported a closer bond, improved communication, and greater marital satisfaction. Frank also agreed to seek individual help for PTSD and possible TBI in order to discuss and process some of the wartime experiences with which he did not want to burden his wife. He expressed hope that additional individual therapy would improve his life and marriage.

Discussion

The hypothetical case outlined above demonstrates the use of EFT/EFCT in combination with psychoeducation pertaining to the evolutionary perspective of PTSD. The couple was in considerable distress when seeking help from a therapist. Problems revolved around deployment and reintegration into civilian life after several lengthy deployments. Research has found that many returning service members experience an increase in interpersonal conflict, which in part is due to service-related depression and PTSD (Milliken et al., 2007). This is reflected in the case example as well.

Frank returned from repeated deployments with PTSD symptoms and his primary coping mechanism was to shut down. In terms of couples dynamics, he became the withdrawer. As Frank was looking for emotional refuge from PTSD symptoms and from conflict in the marriage, Mary's attachment needs were no longer met and she became increasingly frustrated, leading her to adopt the role of the pursuer. Frank initially agreed to attend couples counseling in order to placate his wife. In the meantime, the therapist recognized this and accepted Frank being unengaged in initial sessions, understanding the psychological safety it provided to this client. However, even while passive Frank was cognizant of the dialog between the therapist and his wife. Over time, counseling was successful in helping Frank feel safe enough to risk opening himself up to other possibilities. The therapist worked with Mary on softening the blamer's position, which frequently leads to further withdrawal or negative emotional outbursts of the withdrawer. The goal becomes to create space for corrective emotional experiences in order to foster closeness and bonding (Johnson, 2004).

Partners in distressed relationships tend to hide their vulnerabilities not only from each other but also from themselves (Johnson, 2004). Frank and Mary's marital problems were compounded by Frank's traumatic experiences and subsequent PTSD symptoms. The relationship was further burdened by Frank alternating between verbal aggression, withdrawing into himself, or being frozen in terror (i.e., fight, flight, or freeze). These responses are adaptive under stress such as military engagement; however, they can become liabilities in everyday life. Frequently, the sufferer feels out of control when confronted with these reactive responses to stress or trauma triggers. Trauma survivors tend to feel that they have little control over mind and body. Psychoeducation pertaining to trauma responses (Johnson, 2002) and the role evolution plays in their development can be very helpful in working with couples.

For Frank, it was a relief to learn that he was neither weak nor crazy; rather, he came to understand that body and mind followed an ancient and effective survival script. This emotionally corrective experience allowed him to see himself as a survivor and competent agent in his life rather than viewing himself as fragile or a failure as a service member and husband. Having come to this more adaptive and less shame inducing

conclusion about himself, it became easier for Frank to hear and understand Mary's suffering. These factors opened the door for the couple to be more effectively engaged in the counseling process.

Conclusion

Because there are a high number of service women and men returning from deployment with psychological problems such as PTSD, it is important that practitioners in private practice settings are informed and equipped to provide effective services to these individuals and couples. Rarely are practitioners and clients educated beyond the immediate etiology of PTSD, and diagnostic as well as treatment literature frequently falls short of explaining the evolutionary perspective of PTSD.

PTSD can contribute to relationship distress as well as potentially undermining couples counseling efforts. EFT and EFCT can be effectively combined with psychoeducation that focuses on the evolutionary etiology of PTSD. The goal is to lessen confusion, shame, and guilt associated with trauma-related disorders. This can aid in lowering dropout rates and increase treatment success for individuals as well as couples affected by trauma-related conditions.

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