

Key Elements in Couples Therapy With Veterans With Combat-Related Posttraumatic Stress Disorder

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If a client dealing with combat-related posttraumatic stress disorder (PTSD) presents for psychotherapy, should you consider including his or her partner in treatment? How could couples therapy be beneficial? What framework do you have to conceptualize the relational issues and potential treatment? Although clinicians have long been encouraged to include families in the treatment of combat-related PTSD, few specific couple–family therapies exist, and outcome research is scarce. Because of the adverse effects of PTSD on relationships, couples therapy can be a powerful adjunct treatment; however, few receive this service. A new framework for conceptualizing couples therapy organizes treatment around the 3 PTSD symptom clusters (reexperiencing, avoidance, and arousal). Relationship consequences of each symptom cluster are summarized, followed by useful treatment interventions and a case study.

Keywords: posttraumatic stress disorder (PTSD), couples–family psychotherapy, trauma, veterans, military combat

Soon many armed forces personnel will be returning from intense combat experiences in the Middle East, and they may face altered and challenging family situations upon their homecoming. In contrast to its state after previous wars, the field of psychology is now better prepared to treat individuals dealing with the aftermath of trauma, including posttraumatic stress disorder (PTSD). Clinicians are armed with numerous professional resources ranging from empirical articles to detailed treatment guidelines to ideas from professional conferences to masses of theoretical writings and books. However, what about the veterans' families and their potential role in treatment? Common sense and clinical intuition

tell us that families are dramatically affected and are instrumental in the veterans' recovery. Unfortunately, clinicians have few resources available for guidance in serving these families. Well-designed couples therapy has the potential to help veterans cope more effectively with trauma-related distress, to assist partners to understand and empathize with confusing behavior, and to strengthen intimate relationships.

The inclusion of family members in the treatment of PTSD has been discussed in the clinical lore for years. For example, Figley (1988) has written extensively about PTSD and the family, including a five-phase treatment approach that draws upon systems, family stress, and family therapy theories. Other writers have described the common symptoms and behavioral problems in couples with PTSD and have suggested specific assessment strategies for these couples (e.g., Wilson & Kurtz, 1997). A few systemic family–marital therapies and psychoeducational marital therapies (focusing on communication and problem-solving skills) have been developed as adjunctive treatments for PTSD; however, systemic examination of their efficacy is generally lacking (Riggs, 2000) and few families receive such services (Sherman et al., 2005).

Given the large number of armed services members currently returning from Iraq and Afghanistan dealing with PTSD (Hoge et al., 2004), attention to effective treatment modalities is critical. This article begins by outlining the rationale for including partners in the treatment of combat-related PTSD, the potential benefits of intervening at the couples level, and the small literature on empirical evaluations of dyadic treatments. A new framework is presented to guide clinicians in conceptualizing the effects of PTSD on intimate relationships and on implementing effective couple therapy interventions. Specific treatment recommendations are provided for therapists, and a case study is described. (Because the large majority of the research has been with male veterans, this article focuses on male veterans and female partners [typically live-in significant others or wives]. Extrapolation of the research

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findings to female veterans with PTSD will be important future research.)

Rationale for Including Family Members in Treatment

Research has clearly documented adverse effects of PTSD on intimate relationships. Combat veterans experience a high rate of marital instability (Kessler, 2000), and veterans with PTSD and their spouses describe their marital problems in more severe terms than do veterans without PTSD (Riggs, Byrne, Weathers, & Litz, 1998). Further, Vietnam veterans with PTSD are twice as likely as those without PTSD to have been divorced and three times as likely to experience multiple divorces (Jordan et al., 1992). Further, these relationship problems among veterans with PTSD appear to be chronic, as suggested by a recent study of World War II ex-POWs (Cook, Riggs, Thompson, Coyne, & Sheikh, 2004). Ex-POWs with PTSD reported poorer relationship adjustment, poorer communication with partners, and more difficulties with intimacy than did ex-POWs without PTSD.

Further, female partners of patients with PTSD are often unhappy with the relationship and quite distressed. Partners of veterans with PTSD report lower overall satisfaction (Jordan et al., 1992), more caregiver burden, and poorer psychological adjustment (Calhoun, Beckham & Bosworth, 2002) than do partners of veterans without PTSD. These family members also experience high levels of caregiver burden (Beckham, Lytle, & Feldman, 1996). Recent research has also documented that these partners of veterans with PTSD are highly distressed. For example, a recent phone survey of 89 significant others of veterans with combat-related PTSD (Manguno-Mire et al., 2004) found that the average Global Severity Index of the Brief Symptom Inventory-18 (Derogatis, 1993) exceeded the 90th percentile. Further, over three quarters of partners in this study rate getting couples or family therapy as very important in coping with the stress of PTSD in the family (Sherman et al., 2005).

Intervening to help these partners manage their stress level and experience greater relationship satisfaction is important for the partner, the intimate relationship, and the veteran. Two lines of research highlight this fact. First, increased stress in the family (especially tension and hostility) can trigger the veteran's PTSD symptoms. High levels of expressed emotion in the family have been shown to impede improvement in patients with PTSD (Solomon, Mikulincer, Fried & Wosner, 1987; Tarrier, Sommerfield, & Pilgrim, 1999). Second, family members who are hurt by the veteran's behavior are often reticent to provide support. This loss of social support is critical, as intimate relationships are a primary source of support for most people (Beach, Martin, Blum, & Roman, 1993). Further, high levels of social support have been associated with decreased intensity of PTSD symptoms at 2 and 3 years postcombat. Longitudinally, increased social withdrawal has been associated with increased PTSD intensity, and increased social contact was associated with decreased severity of symptoms (Solomon, Mikulincer, & Avitzuer, 1988). In addition to withdrawing support, some partners become critical and hurtful; the survivors' interactions with unsupportive partners are associated with worsened mental health outcomes for the survivors (Byrne & Riggs, 2002). This stressful family environment can then adversely affect PTSD treatment (Tarrier et al., 1999).

Rationale for Intervening at the Relational Level

Because of this complex interaction between veteran well-being and broader family functioning, the inclusion of family members in treatment increases the likelihood of creating positive, enduring change. Without helping the veteran address his individual trauma-related issues and simultaneously altering the family's expectations of and ways of interacting with him, families will continue to engage in familiar, dysfunctional patterns. 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.

The family experience of PTSD can become one-sided in that the entire family unit can expend considerable energy helping the veteran. Although this strategy may be functional at the time of diagnosis and/or acute crisis, this approach reinforces the identified patient role of the veteran and ignores the partner's needs. Couples therapy strives to move beyond this conceptualization and to balance the needs of both partners. Assisting both the veteran and partner to engage in perspective-taking behaviors helps them to recognize and empathize with each other's experience, thereby improving sensitivity to both parties' needs and restoring a healthier balance in the relationship.

Support for the efficacy of conjoint treatment in improving marital adjustment and improving psychiatric functioning can be found in research on depression (e.g., Beach, Fincham, & Katz, 1996) and substance abuse (O'Farrell, Cutter, Choquette, Floyd, & Bayog, 1992). Preliminary findings for PTSD also support the use of relational therapy. For example, female sexual assault survivors who were in relational therapy had greater reduction in symptoms of depression than did those in individual treatment (Bowling, 2002); the groups experienced equal decreases in PTSD symptoms.

Further support for the importance of relational interventions comes from the literature on supporting families of individuals with a serious mental illness such as schizophrenia. Caregivers who can cope effectively with the patient's behavior report fewer psychosomatic symptoms and a lower level of burnout (Cuijpers & Stam, 2000). An impressive literature on schizophrenia demonstrates the efficacy of family psychoeducation to significantly reduce the risk of relapse, enhance social and family functioning, and result in financial savings (Falloon, Roncone, Held, Coverdale, & Laidlaw, 2002). This mode of family intervention has been applied to a variety of other mental illnesses, including bipolar disorder, major depression, and substance abuse (Sherman, 2003).

Previous Programs

David Riggs (2000) delineated two major types of family interventions for PTSD, including using partners as a source of social support for the survivor in his or her recovery process and addressing systemic disruption in the relationship caused by exposure to trauma (e.g., learning about effects of trauma, communication skills, problem-solving skills). Riggs (2000) noted that these strategies are not mutually exclusive.

The only randomized clinical trial applying an empirically based family intervention (behavioral family therapy) to PTSD did not result in any further reduction in symptomatology beyond that

gained by previous exposure therapy. Furthermore, the study had a high dropout rate, both to enter and complete the family treatment component of the trial (Glynn et al., 1999). The authors attributed this problem to the nature of the couples because their relationships were "obviously fragile" and because "the foundation for making assumptions of cooperation, commitment and positive feelings on the relative's part was tenuous at best. Many of the female partners were clearly angry and burdened and had limited psychological resources available to support the veterans" (Glynn et al., 1999, p. 249). Although this investigation had a small sample, it raised the possibility that couples in which one member has PTSD have specific, unique needs that were not addressed in the behavioral family therapy. Perhaps the partners were so angry and overwhelmed that they were unable to learn, apply, and benefit from the behavioral skills.

Another relational PTSD intervention studied Israeli couples in which the veteran had PTSD because of experiences in the Lebanon War. As part of a day treatment program ("Ko'ach") for the veterans, several programs were provided for wives and couples, including education regarding symptoms, problem solving, communication, and coping skills. Data collected 9 months posttreatment revealed that 68% of the veterans felt their marital relationship had improved and 40% felt their PTSD symptoms were reduced (Rabin, 1995; Rabin & Nardi, 1991).

New Framework

In sum, PTSD couples experience significant discord, and the partners are distressed and dissatisfied. Social support from the intimate partner is key to the veteran's recovery, and literature from other diagnoses has demonstrated positive outcomes for family-based interventions. The only relational intervention for PTSD that has received rigorous empirical study yielded negative findings, raising the question as to the need for specialized treatment for these couples.

The relationship problems couples dealing with PTSD encounter can be linked to the three clusters of PTSD symptoms (reexperiencing, avoidance, and increased arousal). Previous research has documented many kinds of relationship difficulties among these dyads, but the current conceptualization provides a framework for organizing assessment and treatment. In contrast to previous treatments that have failed to address all of these areas, effective comprehensive treatment of these couples will require assessment and intervention for all three domains. The proposed couple therapy interventions would be useful adjuncts to the veteran's individual treatment. Couples counseling could precede individual therapy, wherein the strength found in the relationship could sustain the veteran through intensive treatment. On the other hand, couples therapy could follow individual treatment, thereby assisting in consolidating newly acquired skills and extending them to the specific dynamics for that couple.

The guiding principles that follow also challenge therapists to help couples move beyond a focus on the veteran's diagnosis as an explanation and/or rationalization for behavior. Because of veterans' fear of losing the financial compensation associated with the disability, they sometimes expend considerable effort to maintain their chart diagnosis of PTSD. Unfortunately, this scenario perpetuates the veteran's need to exhibit dysfunctional behaviors and can lead veterans to identify themselves according to their diagnosis.

Partners may also adopt this disability-based view of the veterans, which can result in tolerating and excusing unwanted behavior because the veterans have PTSD. This conceptualization often deters couples from making positive relationship change. Couple therapists face the challenge of respecting the couples' anxieties and difficulties associated with his traumatic experience and of simultaneously inviting both the veteran and partner into greater accountability for their behavior and the possibility of a paradigm shift. Couples can move beyond the conceptualization of the "PTSD partner" being married to the "PTSD veteran" to a new paradigm in which the woman sees herself as married to a man who has some challenges related to wartime experiences. The challenges he brings to the relationship are not qualitatively different from specific challenges she may bring that are associated with other chronic conditions such as diabetes, heart disease, or depression.

Further, because of the dramatic nature of some of the veteran's PTSD difficulties (especially the reexperiencing symptoms), therapists' immediate attention is often focused on symptom management. As outlined below, early stages of therapy can involve helping couples communicate their wishes for how to cope during specific phenomena (e.g., nightmares or flashbacks). However, solely focusing on managing the veteran's symptoms is superficial, reinforces a pathology perspective, and fails to address the deeper dyadic dynamics. As documented above, partners are typically distressed as well, but their symptoms are less conspicuous than are those of the veteran; a sole focus on partners' struggles would also be one-sided. In-depth couples therapy takes into account both parties' experiences and needs and challenges couples to make positive, sustainable changes in relational patterns to create more balanced, interdependent relationships.

As with most couples therapies, intervening with these couples requires that neither member is abusing substances and that the relationship is marked by physical safety (the issue of violence is addressed below). Although abusing substances to distance from overwhelming emotions is common among veterans with PTSD (Centers for Disease Control, 1988), the efficacy of couples therapy (in isolation) is compromised when this comorbid problem is not specifically addressed. In addition to addressing the couple's challenges described below, therapists should draw upon each couple's unique strengths. Further, therapists can emphasize the couple's ability to grow closer and strengthen their relationship through sharing this experience.

Finally, therapists would be well served by drawing upon the marital therapy concept of acceptance (Jacobson & Christensen, 1996) in working with these couples. Promoting acceptance in dyads involves helping partners to tolerate and respect relational differences rather than attempting to eliminate seemingly unsolvable problems. Although the general focus of this article is striving for behavioral change, enhancing partner acceptance is powerful and often results in behavioral change.

Reexperiencing Symptoms

Consequences for the Relationship

These reexperiencing symptoms are often quite distressing for both the veteran and partner. Upon waking from a nightmare or recovering from a flashback, veterans frequently feel ashamed,

embarrassed, and anxious. Partners who witness these unpredictable, uncontrollable acts often feel confused, afraid, and helpless. Oftentimes the veteran does not want to discuss the details of the trauma and/or reexperiencing phenomena, so the partner feels left out and afraid. Because of bad dreams, couples may sleep in separate beds or rooms, which can interfere with physical and emotional intimacy.

For some veterans, the intrusiveness and unpredictability of these symptoms render them unable to maintain steady employment. Consequently, partners assume more occupational, financial, and household responsibilities, which can result in feeling overwhelmed (Matsakis, 1989; Verbosky & Ryan, 1988) and experiencing high levels of caregiver burden (Beckham et al., 1996). Role ambiguity can arise with respect to delegation of household tasks, as veterans assume the identified patient role and other family members take on greater responsibility.

Implications for Treatment

Several important elements of effective dyadic PTSD treatment follow from these reexperiencing symptoms. Mental health professionals may choose to do any of the following:

Assist the veteran in educating his partner about reexperiencing symptoms. Framing the veteran as the expert in his experience of PTSD is useful in helping the partner understand his situation. Supporting the veteran in sharing his symptoms is preferable to a didactic presentation from the therapist because his confiding in his partner promotes intimacy and sheds light on his unique experience. When partners better understand the root of the reexperiencing symptoms, they can avoid personalizing the confusing behavior. Therapists may supplement the veteran's sharing by recommending bibliotherapy (e.g., Matsakis's *Vietnam Wives*, 1998b, or *Trust After Trauma*, 1998a).

Assist the veteran in teaching his partner how to support him during episodes. Therapists can encourage the veteran to share with his partner how to assist him while he is reexperiencing the trauma. Helping the veteran to articulate his desires and then tell them to the partner providing support is a powerful couples therapy intervention.

1. If the veteran is unsure how the partner could be of help, the therapist may educate the partner about grounding techniques to orient the veteran to the present situation.

2. Therapists can also use this situation as an opportunity to educate the couple about problem-solving skills. Through joint ownership of the problem and brainstorming of potential solutions, couples can develop effective strategies. Couples can also use the problem-solving skills in other situations.

3. If safety is not addressed by the couple, therapists need to address the primary importance of safety for both people during reexperiencing episodes. If the veteran becomes violent, the partner needs an escape plan and/or a means of securing assistance. If the veteran is acting bizarrely but not harming anyone, partners may benefit from engaging in self-care activities and obtaining support.

Teach the couple a debriefing process to help deescalate the situation and to promote learning from the episode. Couples frequently struggle to find a productive, safe means of discussing these upsetting incidents, so therapy can involve educating dyads about a debriefing process. Each member of the couple can share

his or her observations and roles in the incident as well as their reactions and possible learning from the experience. Helping the couple to master a structured dialogue process can facilitate these oftentimes awkward discussions and can promote interpersonal learning and closeness; this process can then be used with non-PTSD-related relationship issues as well.

Help the couple in coping with upsetting reminders of the trauma that may trigger reexperiencing symptoms. Couples benefit from taking a team approach to coping with reminders. For example, they can anticipate the predictable difficult times (e.g., anniversaries of traumatic events) and plan in advance how to cope with the triggers. When partners are aware of potential challenges for the veteran, they can anticipate his increased anxiety and provide extra understanding and support.

Avoidance

Consequences for the Relationship

Because of the avoidance symptoms (e.g., efforts to avoid reminders of the trauma, anhedonia, emotional detachment, restricted range of affect), veterans often become quite socially isolated. Because the partner often feels guilty leaving the veteran home alone, her enjoyment of socializing may be diminished. When the partner does socialize independently, she often faces questions as to the veteran's whereabouts, which can be awkward. The partner may feel embarrassed by the veteran's absence or his desire for early or rapid departure from events. Oftentimes, a partner will tire of solitary socializing so she becomes reclusive as well, having few friends and social contacts. The partner may become resentful of the veteran for this isolated existence.

Not only do these couples become isolated from their extrafamilial contacts but the relationships are often marked by considerable emotional distance. Emotional intimacy, a prime predictor of marital satisfaction and stability (Gottman & Levenson, 1986), is often impaired in veterans with PTSD (Roberts et al., 1982; Rosenheck & Thomson, 1986), likely due in part to emotional numbing (Cook et al., 2004). Veterans with PTSD often have problems expressing caring (Egendorf, Kaduschin, Laufer, Rothbart, & Sloan, 1981), have low levels of self-disclosure and emotional expressiveness (Carroll, Rueger, Foy, & Donahoe, 1985), have problems with sexual disinterest (Litz, Keane, Fisher, Marx, & Monaco, 1992), and have ineffective interpersonal problem-solving skills (Nezu & Carnevale, 1987). Because of these factors, the intimate relationship may become emotionally dead or numb. Couples often describe themselves as cohabiting, living as roommates, or living as brother and sister. Clinically it has been observed that individuals in these emotionally distant relationships quite commonly engage in infidelity as a means of seeking connection.

Further, because of the loss of friends in wartime, veterans may experience survivor guilt and associate emotional connection with loss. During wartime, some veterans protect themselves by adhering to the motto of "it don't mean nothing." Although this mentality can be functional in a combat situation, it results in veterans avoiding and/or fearing intimacy. These difficulties with emotional closeness manifest themselves in distant relationships marked by low levels of trust. Research on partners of veterans with PTSD has supported this phenomenon. A study of counselors from 100

veterans centers (Matsakis, 1989) revealed that over 90% of partners of combat veterans perceived reluctance on the part of their partner to share emotionally, resulting in the partners feeling lonely and isolated. Other research of interest has found that partners of veterans with PTSD report greater fears of intimacy (Riggs et al., 1998) than do partners of veterans without PTSD.

Finally, because of their decreased interest in previously enjoyed activities, veterans with PTSD often spend a great deal of time in solitary, unfulfilling activities (e.g., watching TV, sleeping). Veterans who gained a strong sense of identity as a soldier protecting his country may be overcome with depression because of the seemingly meaningless existence. Given the veteran's depression and emotional withdrawal, the couple rarely engages in joint enjoyable activities, which deepens the chasm in the already distant relationship.

Implications for Treatment

Because of these avoidance symptoms, therapists may intervene with couples by doing one of the following:

Engaging the couple in assessing their readiness and commitment to the difficult work involved in strengthening their emotional bond. Sometimes both individuals cease efforts to create connection and increase the intimacy in the dyad, resulting in estranged relationships. In these situations, couples may be engaged in reflection on the pros and cons of the current arrangement. They may have settled into an unhappy but familiar situation, believing that emotional reconnection is unattainable or perhaps even undesirable. Therapy can involve discussion of the potential benefits and fears surrounding the risks of attempting intimacy with one another.

Empowering the couple to risk trust and openness with each other (if they commit to building intimacy in their relationship). Cognitive interventions with the veteran may be useful in helping him to realize that his approach during wartime of keeping others at bay is no longer necessary. A therapist may assist the partner in avoiding personalizing the veteran's distancing behavior, therein helping her to understand the veteran's use of distancing as a coping strategy. The specific interventions that may be useful in strengthening the emotional connection in the dyad may include the following:

1. Interventions based on Dr. John Gottman's work of helping couples respond to bids for emotional connection by turning toward each other rather than turning away or against (Gottman & Silver, 1999).

2. Interventions based on Dr. Susan Johnson's emotionally focused therapy (Johnson, 2002), which draws upon an attachment-based paradigm of using your partner as a secure base in navigating the challenges and traumas in life.

3. Basic communication skill training, which is especially important given the restricted range of emotions for veterans with PTSD. Therapists may assist both partners in the identification, labeling, and expression of emotions, followed by coaching of the listener in responding in a supportive manner. Education about the emotional numbing common to PTSD can also be useful.

Empowering the couple to negotiate how much of the trauma is shared in the relationship. Although veterans sometimes avoid talking about the traumatic event, other times veterans choose to share some of their experiences with loved ones. Given that

traumatic experiences often involve great powerlessness, it is critical that survivors have control over if, how much, when, and how to share their experiences with their partners. The veteran can be coached to let his partner know how to support him during and after the sharing of his story. Systemic issues often arise surrounding trauma stories, and a therapist can help the partner respect the veteran's choices surrounding disclosure. The partner may need assistance in coping with the veteran's decision to perhaps share more about his trauma with fellow veterans than with her. Regardless of the veteran's decision regarding disclosure, therapists may help the veteran explain to his partner what meaning the trauma holds for him; the couple can then process the trauma's meaning for them as a couple.

Encouraging the pursuit of enjoyable activities (both individually and as a couple) because of the social isolation that commonly results from the avoidance. Therapists may choose to do any of the following:

1. Behavioral activation strategies are useful for veterans who demonstrate low interest in activities. As has been effective with individuals with depressive disorders, this intervention can increase the person's involvement with pleasurable activities and create opportunities for social connection. Therapy may involve brainstorming activities that have a high chance of success (e.g., participation in veterans groups) and help the veteran cope with social anxiety that may interfere with his participation.

2. To help partners cope with some of the solitude involved in living with a veteran with PTSD, the therapist may encourage partners to create and use their own support networks and enjoy hobbies. Systemic issues likely arise in these discussions, so therapists may ensure that the veteran supports the partner in pursuing individual activities. Therapy may involve helping the veteran attend to consequences of his isolative behaviors for his partner and their relationship. Further, the therapist may need to attend to the partner's guilt for enjoying herself when the veteran chooses to stay home.

3. Finally, therapy can involve encouraging couples to engage in joint activities, which can serve the dual function of helping with the veteran's avoidance and strengthening the relationship. Therapy may also involve the use of behavioral interventions to increase mutual expressions of care (e.g., caring behaviors, expressions of appreciation).

Teaching interpersonal problem-solving skills. Given that many veterans attempt to avoid facing relational problems directly, couples therapy can involve education, role plays, and rehearsal of these fundamental skills. Problem-solving skills may also be useful for helping couples negotiate many other relational issues such as finances and the sharing of household responsibilities.

Increased Arousal

Consequences for the Relationship

Many symptoms in this cluster can have significant effects on veterans' relationships. For example, his sleep disturbance and consequent fatigue may exacerbate his social withdrawal, anhedonia, and irritability. The hypervigilance and startle response commonly associated with PTSD may exacerbate the veteran's social withdrawal. Living in a chronic state of heightened arousal can also add tension and stress to the intimate relationship. Partners

may also “walk on eggshells” because of fear of upsetting the veteran.

Chronic low-grade irritability can erode the positive feelings in the relationship, resulting in partners becoming critical and/or emotionally disengaged from the relationship. Research has documented that displays of anger are linked to decreased motivation in others to offer support (Lane & Hobfoll, 1992).

As exemplified in the criterion of angry outbursts, the risk for perpetrating domestic violence is also elevated among veterans with PTSD (Jordan et al., 1992). For example, one study of Vietnam combat veterans and their partners (Byrne & Riggs, 1996) revealed that 42% of the men had engaged in physical aggression against their partners in the previous year, 92% had been verbally aggressive, and 100% had used psychological aggression. Among couples dealing with PTSD seeking marital therapy, the rates of veteran to partner physical violence are even higher (Sherman, Sautter, Jackson, Lyons, & Han, 2004). This increased risk of perpetrating intimate partner violence is logical given the high comorbidities between PTSD and several other variables (e.g., depression, substance abuse, relationship distress, impaired problem-solving skills) known to be related to heightened risk for perpetrating violence (Riggs, 1997).

Implications for Treatment

Given this increased arousal, couples therapy can address several important relational dynamics. Therapists may choose to do any of the following:

Assist the couple in giving feedback about their needs and setting limits on emotional involvement. On the basis of extensive research with well-adjusted couples, Dr. John Gottman defined the phenomenon of *flooding* as an experience wherein the individual is emotionally overwhelmed and physiologically aroused, rendering him or her much less effective in communicating with a significant other (Gottman & Silver, 1999). Combat veterans frequently refer to the experience of being emotionally flooded and unable to remain emotionally present; veterans admit to disappearing or mentally “tuning out” when unable to tolerate emotionally stressful situations. Similarly, partners can feel quite overwhelmed and distressed by emotionally stressful situations, including the veterans’ reexperiencing behaviors and the trauma stories. It is important that couples develop and implement a nonjudgmental means of setting limits on emotional discussions. Therapists can help the couple to let each other know when needing time or space. This boundary-setting process is important in all couples but may be especially relevant for dyads in which both have experienced traumatic events (Balcom, 1996).

Assess for domestic violence in every couple. Given the elevated rates of domestic violence in this population, a thorough, specific, multimodal assessment of violence with every couple is essential (O’Leary, Vivian, & Malone, 1992). If violence is detected, each individual should be referred to separate, specialized domestic violence services (e.g., hotlines, shelters, counseling; legal aid for the partner; batterers treatment programs for the veteran). Couples therapy is contraindicated in the presence of severe physical abuse, as it can place the victim at greater risk for additional injury (Gauthier & Levendosky, 1996). However, therapists specially trained in treating family violence may assist couples with lower levels of aggression to use nonviolent

means of conflict resolution (via nonviolence contracts or time-out processes).

Assist the couple in coping effectively with irritability and/or expressions of anger. This multifaceted dynamic pertains only to nonabusive irritability. Therapy can involve exploration of one’s triggers for anger and education about ways of coping with frustration. Basic education about the experience of the emotion of anger and the choices one has in coping with it may be useful. Helping the veteran to identify times when he may displace his trauma-related anger onto his partner can be productive. Further, assisting the partner in respectfully providing feedback about his behavior can assist him in changing his hurtful acts and can promote intimacy.

Teach conflict disengagement strategies. A time-out process can be very useful in preventing escalation of conflicts and creating emotional safety in the relationship. Therapists may teach the couple this strategy, do role plays in session, and encourage rehearsal during the week as homework.

Educate the couple about anxiety management strategies and sleep hygiene tips. Given the ripple effects of the veteran’s anxiety to the broader relationship, both members of the relationship can benefit from learning coping strategies for anxiety and insomnia. The veteran may help the partner to understand his fears about being startled and his worries about letting down his guard; he may also solicit her support during times of high anxiety.

Case Study

To illuminate the usefulness of these interventions, we describe a case study that demonstrates positive therapeutic gains for a couple; several elements of this conceptual framework were incorporated in their treatment.

John, a 55-year-old African American man, has been married to a 46-year-old African American woman, Mary, for 8 years; this is John’s third marriage and Mary’s second marriage. John retired from long-haul truck driving 3 years ago and receives disability from the U.S. Department of Veterans Affairs for combat-related PTSD. Mary works full time and has adult children from her previous marriage. John recently completed an intensive PTSD program and feels proud of his progress; his case manager recommended couples therapy as part of his aftercare plan.

John and Mary present to couples therapy with four major concerns:

1. The couple feels like roommates and has minimal emotional connection; they discuss only superficial topics for fear of approaching potentially volatile issues (avoidance of intimacy).

2. John’s anxiety deters him from socializing; because of Mary’s discomfort with going out alone, she has discontinued many activities as well. Hence, John spends most of his time at home alone (social avoidance), and Mary occupies herself with her children’s activities.

3. John has a bad temper and feels guilty for his past verbal and physical aggression toward Mary; she feels like she’s always “walking on eggshells” around him. She wants to trust that he’s made progress in treatment but harbors painful memories of his past outbursts (increased arousal).

4. Because of John’s frequent distressing nightmares, the couple has slept in separate beds for most of their married life; they seek

information on how to cope with his nightmares and intrusive thoughts (reexperiencing symptoms).

Given the history of violence, treatment began with a thorough assessment of intimate partner violence and efforts to ensure the safety of both parties. Assessment data (self-report data collected before the intake appointment and clinical assessment in the first interview) revealed that there had been no physical violence in over 5 years. To prevent future violence and to help cope effectively with the friction that occurs in any relationship, the therapist taught a time-out process and engaged in problem solving with the couple regarding its use. Given the couple's history of highly emotional conflict, the therapist normalized occasional regression to volatile arguments but provided a new framework for an argument's aftermath. The couple learned a structured dialogue to guide them in debriefing from the incident. Through using this specific format, John and Mary learned that they are more vulnerable to explosive interchanges when they are tired or physically sick and that their communication is much more effective after having taken a time-out to calm down.

As the couple implemented these skills, their sense of interpersonal safety and trust increased. John and Mary wanted to learn how to talk about difficult matters more easily, so therapy next involved teaching communication skills to facilitate honest, respectful dialogue. As their communication became more open and comfortable, John expressed guilt for how his PTSD symptoms contribute to the couple's social isolation. Therapy then involved exploring activities that were previously enjoyable for the couple and the use of behavioral activation to increase pleasant activities for John and Mary. As the positive feelings between the couple grew, ambivalence arose about risking greater emotional intimacy, which was explored therapeutically by reviewing their hopes and fears about closeness. In so doing, both learned how they could risk being vulnerable with each other without feeling rejected or hurt. John and Mary felt more connected to each other and were able to discuss previously avoided intimate topics.

Finally, to support the couple in dealing with John's nightmares and intrusive thoughts, the therapist taught the couple grounding techniques. As John continued to work on coping in his individual treatment and as Mary gained a greater understanding of his past experiences, the couple coped more effectively with the reexperiencing symptoms. John gained skills in distracting himself from the intrusive thoughts such that he can stay more grounded in the present situation, and Mary learned to avoid personalizing his distancing and how to better support him during his nightmares. In so doing, the couple is less distressed and overwhelmed by John's reexperiencing symptoms.

Implications for Practice

Given the clear relational consequences of PTSD and the usefulness of partner support in the veteran's recovery, couples therapy can be a powerful intervention for these combat veterans and their partners. Psychologists working with traumatized veterans would benefit from considering this modality of treatment, as it attends to both individuals' specific needs and also addresses the broader relationship dynamics. Practicing clinicians can select from the numerous interventions outlined herein to develop an effective treatment plan for each couple. The couple's specific needs may differ depending on the timing of the trauma in the

family life cycle, whether the trauma preceded or followed the initiation of the relationship, and relationship length. The extent to which this proposed conceptual framework applies to noncombat trauma is uncertain; future literature will need to address whether certain kinds of interventions are also needed for specific traumas (e.g., addressing sexual issues after sexual trauma).

Given the growing understanding of PTSD and its impact on the family, development of evidence-based intervention strategies is important. Program development should be grounded in empirical research findings and clinically driven guidelines such as those offered herein. As assessment tools and treatment programs are developed, a comprehensive program of research is needed to evaluate their effectiveness.

In sum, in light of the many families dealing with the aftermath of insidious traumatic events, adjunctive couples therapy can foster interdependent, balanced intimate relationships and can be an important element in the comprehensive treatment of PTSD. As seen in the case of John and Mary, couples therapy has the potential to help both members of the couple function more effectively, to promote intimacy in the relationship, and to assist in reducing the intensity of the veteran's symptoms of PTSD.

References

- Balcom, D. (1996). The interpersonal dynamics and treatment of dual trauma couples. *Journal of Marital and Family Therapy, 22*, 431–442.
- Beach, S. M., Martin, J. K., Blum, T. C., & Roman, P. M. (1993). Effects of marital and co-worker relationships on negative affect: Testing the central role of marriage. *American Journal of Family Therapy, 21*, 313–323.
- Beach, S. R. H., Fincham, F. D., & Katz, J. (1996). Social support in marriage: A cognitive perspective. In G. R., Pierce & B. R. Sarason (Eds.), *Handbook of social support and the family* (pp. 43–65). New York: Plenum Press.
- Beckham, J. C., Lytle, B. L., & Feldman, M. E. (1996). Caregiver burden in partners of Vietnam war veterans with posttraumatic stress. *Journal of Consulting and Clinical Psychology, 64*, 1068–1072.
- Bowling, S. W. (2002). The clinical effectiveness of family therapy with female survivors of sexual violence. *Dissertation Abstracts International, 62*(10), 4773B.
- Byrne, C. A., & Riggs, D. S. (1996). The cycle of trauma: Relationship aggression in male Vietnam veterans with symptoms of posttraumatic stress disorder. *Violence and Victims, 11*, 213–224.
- Byrne, C. A., & Riggs, D. S. (2002). Gender issues in couple and family therapy following traumatic stress. In R. Kimerling, P. Ouimette & J. Wolfe (Eds.) *Gender and PTSD* (pp. 382–399). New York: Guilford Press.
- Calhoun, P. S., Beckham, J. C., & Bosworth, H. B. (2002). Caregiver burden and psychological distress in partners of veterans with chronic posttraumatic stress disorder. *Journal of Traumatic Stress, 15*, 205–212.
- Carroll, E. M., Rueger, D. B., Foy, D. W., & Donahoe, C. P. (1985). Vietnam combat veterans with posttraumatic stress disorder: Analysis of marital and cohabiting adjustment. *Journal of Abnormal Psychology, 94*, 329–337.
- Centers for Disease Control. (1988). Health status of Vietnam veterans. I. Psychosocial characteristics. The Centers for Disease Control Vietnam Experience Study. *Journal of the American Medical Association, 259*, 2701–2707.
- Cook, J. M., Riggs, D. S., Thompson, R., Coyne, J. C., & Sheikh, J. I. (2004). Posttraumatic stress disorder and current relationship functioning among World War II ex-prisoners of war. *Journal of Family Psychology, 18*, 36–45.

- Cuijpers, P., & Stam, H. (2000). Burnout among relatives of psychiatric patients attending psychoeducational support groups. *Psychiatric Services, 51*, 375–379.
- Derogatis, L. R. (1993). *The Brief Symptom Inventory (BSI): Administration, scoring, and procedures manual*. Minneapolis, MN: National Computer Systems.
- Egendorf, A., Kaduschin, C., Laufer, R., Rothbart, G., & Sloan, L. (1981). *Legacies of Vietnam: Comparative adjustment of veterans and their peers* (Vols. 1–5). New York: Center for Policy Research.
- Falloon, I. R. H., Roncone, R., Held, T., Coverdale, J. H., & Laidlaw, T. M. (2002). An international overview of family interventions: Developing effective treatment strategies and measuring their benefits for patients, carers, and communities. In H. P. Lefley & D. L. Johnson (Eds.), *Family interventions in mental illness: International perspectives* (pp. 3–23). Westport, CT: Praeger.
- Figley, C. R. (1988). A five-phase treatment of post-traumatic stress disorder in families. *Journal of Traumatic Stress, 1*, 127–141.
- Gauthier, L. M., & Levendosky, A. A. (1996). Assessment and treatment of couples with abusive male partners: Guidelines for therapists. *Psychotherapy, 33*, 403–417.
- Glynn, S. M., Eth, S., Randolph, E. T., Roy, D. W., Urbaitis, M., Boxer, L., et al. (1999). A test of behavioral family therapy to augment exposure for combat-related posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology, 67*, 243–251.
- Gottman, J. M., & Levenson, R. W. (1986). Assessing the role of emotion in marriage. *Behavioral Assessment, 8*, 31–48.
- Gottman, J. M., & Silver, N. (1999). *The seven principles for making marriage work*. New York: Three Rivers Press.
- Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine, 351*, 13–22.
- Jacobson, N., & Christensen, A. (1996). *Integrative couple therapy: Promoting acceptance and change*. New York: Norton.
- Johnson, S. M. (2002). *Emotionally focused couple therapy with trauma survivors: Strengthening attachment bonds*. New York: Guilford Press.
- Jordan, B. K., Marmar, C. R., Fairbank, J. A., Schlenger, W. E., Kulka, R. A., Hough, R. L., & Weiss, D. S. (1992). Problems in families of male Vietnam veterans with posttraumatic stress disorders. *Journal of Consulting and Clinical Psychology, 60*, 916–926.
- Kessler, R. C. (2000). Posttraumatic stress disorder: The burden to the individual and to society. *Journal of Clinical Psychiatry, 61*(Suppl. 5), 4–12.
- Lane, C., & Hobfoll, S. E. (1992). How loss affects anger and alienates social support. *Journal of Consulting and Clinical Psychology, 60*, 935–942.
- Litz, B. T., Keane, T. M., Fisher, L., Marx, B., & Monaco, V. (1992). Physical health complaints in combat-related posttraumatic stress disorder: A preliminary report. *Journal of Traumatic Stress, 5*, 131–141.
- Mangun-Mire, G., Sautter, F., Lyons, J., Perry, D., Han, X., Kibler, J., et al. (2004). *Psychological distress and caregiver burden in partners of veterans with combat-related PTSD*. Manuscript submitted for publication.
- Matsakis, A. (1989). Surveying the damage: The effects of PTSD on family life. *VA Practitioner, 69*–71.
- Matsakis, A. (1998a). *Trust after trauma*. New York: New Harbinger.
- Matsakis, A. (1998b). *Vietnam wives: Facing the challenges of life with veterans suffering post-traumatic stress* (2nd ed.). Towson, MD: Sidran Institute Press.
- Nezu, A. M., & Carnevale, G. J. (1987). Interpersonal problem solving and coping reactions of Vietnam veterans with posttraumatic stress disorder. *Journal of Abnormal Psychology, 96*, 155–157.
- O'Farrell, T. J., Cutter, H., Choquette, K., Floyd, F., & Bayog, R. (1992). Behavioral marital therapy for male alcoholics: Marital and drinking adjustment during the two years after treatment. *Behavior Therapy, 23*, 529–549.
- O'Leary, K. D., Vivian, D., & Malone, J. (1992). Assessment of physical aggression against women in marriages: The need for multimodal assessment. *Behavioral Assessment, 14*, 5–14.
- Rabin, C. (1995). The use of psychoeducational groups to improve marital functioning in high-risk Israeli couples: A stage model. *Contemporary Family Therapy, 17*, 503–515.
- Rabin, C., & Nardi, C. (1991). Treatment of post-traumatic stress disorder couples: A psychoeducational program. *Community Mental Health Journal, 27*, 209–224.
- Riggs, D. S. (1997). Posttraumatic stress disorder and the perpetration of domestic violence. *National Center for PTSD Clinical Quarterly, 7*(2), 22–25.
- Riggs, D. S. (2000). Marital and family therapy. In E. B. Foa, T. M. Keane & M. J. Friedman (Eds.) *Effective treatments for PTSD: Practice guidelines from the International Society of Traumatic Stress Studies* (pp. 280–301). New York: Guilford Press.
- Riggs, D., Byrne, C. A., Weathers, F. W., & Litz, B. T. (1998). The quality of intimate relationships in male Vietnam veterans: The impact of posttraumatic stress disorder. *Journal of Traumatic Stress, 11*, 87–102.
- Roberts, W. R., Penk, W. E., Gearing, M. L., Robinowitz, R., Dolan, M. P., & Patterson, E. T. (1982). Interpersonal problems of Vietnam combat veterans with symptoms of posttraumatic stress disorder. *Journal of Abnormal Psychology, 91*, 440–450.
- Rosenheck, R., & Thomson, J. (1986). "Detoxification" of Vietnam war trauma: A combined family-individual approach. *Family Process, 25*, 559–570.
- Sherman, M. D. (2003). *Best practices in family intervention for serious mental illness*. Retrieved October 28, 2005, from University of Oklahoma Health Sciences Center Web site: <http://w3.ouhsc.edu/bpfamily>
- Sherman, M. D., Sautter, F., Jackson, H., Lyons, J., & Han, X. (2004). *Domestic violence in veterans with PTSD who seek couples therapy*. Manuscript submitted for publication.
- Sherman, M. D., Sautter, F., Lyons, J., Manguno-Mire, G., Han, X., Perry, D., & Sullivan, G. (2005). Mental health treatment needs of cohabiting partners of veterans with combat-related PTSD. *Psychiatric Services, 56*, 1150–1152.
- Solomon, Z., Mikulincer, M., & Avitzuer, E. (1988). Coping, locus of control, social support, and combat-related posttraumatic stress disorder: A prospective study. *Journal of Personality and Social Psychology, 55*, 270–285.
- Solomon, Z., Mikulincer, M., Fried, B., & Wosner, Y. (1987). Family characteristics and posttraumatic stress disorder: A follow-up of Israeli combat stress reaction casualties. *Family Process, 26*, 383–394.
- Tarrier, N., Sommerfield, C., & Pilgrim, H. (1999). Relatives' expressed emotion (EE) and PTSD treatment outcome. *Psychological Medicine, 29*, 801–811.
- Verbosky, S. J., & Ryan, D. A. (1988). Female partners of veterans: Stress by proximity. *Issues in Mental Health Nursing, 9*, 95–104.
- Wilson, J. P., & Kurtz, R. (1997). Assessing PTSD in couples and families. In J. P. Wilson & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD* (pp. 349–373). New York: Guilford Press.

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