Counselors Helping Service Veterans Re-Enter Their Couple Relationship After Combat and Military Services: A Comprehensive Overview

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Abstract
This article provides an overview of the unique challenges combat service veterans deployed in Afghanistan and/or Iraq are dealing with today, and how these challenges can impact veterans’ reintegration into civilian life. Focus is also given to attachment; more specifically how the attachment bond between the combat service veteran and his or her spouse/partner often is impacted by the trauma of combat re-deployment/deployment/separation. The importance of couple counseling using Emotion-Focused Therapy (EFT) is addressed, as is a careful assessment at the onset of counseling.

Keywords
combat service veterans, re-entering society, couple relationships, attachment, emotion-focused therapy

Deployment to war zones in Afghanistan and Iraq has been a reality for many service veterans for over 9 years in the United States. Today, there are 1,409,861 service veterans (Army 569,604; Navy 327,993; Air Force 334,393; and Marine Corps 202,707; U.S. Department of Defense, 2010). The demographic for active duty-enlisted veterans is (a) mean age of 27 years, with over 80% younger than 35 years, (b) 14.8% female, (c) 32.9% of racial minorities, (d) 13.6% are dual service families, and (e) a rate of divorce higher than the general population (53% vs 49%; Department of Defense, 2010). These combat service veterans are sons and daughters, fathers and mothers, husbands and wives, and/or dual military couples (husbands and wives who are concurrently in the military). They are facing enormous stress and challenges, as today’s military force is smaller than past forces; and depending on the branch of the military, it has resulted in repeated deployment (up to 4 times, often receiving re-deployment orders before they return home) and extended deployment of 12–18 months at a time. These same combat service veterans often begin training for a temporary duty assignment (TDY) soon after they return home. In addition, they are often deployed in combat zones, where insurgents’ signature weapon is the improvised explosive device (IED) with the signature wounds being losses of limbs and traumatic brain injury (TBI; Tanielan & Jaycox, 2008). The survival rates of combat service veterans have been higher than what was seen in past wars, because of body armor and better care, with some receiving state-of-the-art care at one of the four Veterans Affairs Poly-Trauma Centers. Many of those wounded return to active duty within 3 days (posttraumatic stress disorder [PTSD] Support Services, n.d.). All of these stressors are new and unique and have not been encountered in previous wars.

In addition, U.S. service veterans deployed in combat zones of Afghanistan and/or Iraq are faced with environmental stressors, as well as physical, cognitive, and emotional stressors. Some environmental stressors faced by service veterans deployed in Iraq include summer temperatures up to 130°F and dangerous insects. Other environmental challenges are windstorms in the desert, which can be blinding, and mountainous terrain that can be rugged and cold. Physical stressors include limited sleep (during sustained military operations, sleep is a privilege of a few hours each night, catching a nap when possible) and carrying additional weight (40–50 pounds of weapons, ammunition, and personal protective gear) which over time becomes physically exhausting. In addition, sleep deprivation and physical exhaustion often impact the overall efficiency and proficiency of service men and women and put them at greater risk of decreased awareness and critical thinking, increased human error, higher risk of injury, and even death. They also deal with cognitive stressors such as needing to make life and death decisions for themselves and others.

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while in mortal danger. Another stressor for these troops is being in a high intense action/combat with intermittent lengthy (often frustrating) periods of little activity. Emotional stressors for service veterans include home-front issues (e.g., relationship problems, infidelity, child-rearing problems, financial problems, etc.) as well as health and psychological issues of their family and partner/spouse (e.g., illness, mental health issues, substance abuse issues, etc.). High-speed video conferencing with family about these issues has become another stressor and might destruct the combat service veteran from being focused. All of these stressors can add to the unique challenges, as described above, that U.S. service veterans encounter today.

**Post-Deployment Challenges**

Not surprisingly, when these service veterans return home after being deployed, sometimes repeatedly, to Afghanistan and/or Iraq, they might seem healthy, with no visible wounds, when in reality they are struggling on multiple levels, some with undiagnosed TBIs and looming mental health problems. For example, it is believed that there are tens of thousands of combat veterans dealing with mild-to-moderate TBIs that mimic the signs and symptoms of PTSD and is often misdiagnosed. As described above, IEDs are the primary cause of TBIs, that is, by repeated exposure to IED blasts. More specifically, it is repeated exposure to blast pressure, which is a two-phase process of injuring the brain. During the first phase, the blow of the blast causes whiplash contusions to the frontal brain and can result in tissue damage and bleeding closer to the brain stem. During the second phase, brain cells and nerve fibers are harmed, resulting in TBI of three areas: (a) the frontal lobe (which can result in volatility), (b) the cerebellum (which can result in balance problems, falling down easily, and dizziness), and (c) the temporal lobe (which can result in forgetting basic tasks and struggling with speaking). Combat service veterans with TBI and no visible wounds might present with irritability, depression, and lack of awareness of their impairment. They are often misdiagnosed as having mood disorders or PTSD since the symptoms are similar, or they might be believed to be intoxicated due to their struggle with balance and falling down (Arenofsky, 2008). These combat veterans need to be referred for rehabilitation services, to get the help they need, rather than being in counseling because they are misdiagnosed. Therefore, careful assessment and counselor awareness is very important to not losing valuable time in getting appropriate treatment started.

These combat service veterans struggle with multiple mental health problems, such as suicide and PTSD. A recent study by Kaplan, Huguet, McFarland, and Newsom (2007) indicated that combat service veterans were twice as likely to die from suicide when compared with nonveterans in the general population. The study also indicated that such things as daily life limitations (e.g., TBI, amputation, hearing loss, etc.) as well as psychiatric disorders were found to increase suicide risk among combat service veterans. Recently there is also increased awareness of the rising post-deployment suicide rates by service members (Lorge, 2008). Another study conducted by Joiner (2005) concluded that combat veterans are at higher risk of suicidal behavior than civilians, based upon three factors: (a) habituation to pain—military training and combat experience both contribute to pain tolerance and/or decreased emotional responsiveness; (b) perception of being a burden, loss of self, and decrease of status and/or purpose upon return to civilian life; and (c) failed belongingness—having a strong bond with fellow combat service veterans and feeling disconnected from their family and civilian life. Research by Zivin et al. (2007) indicated a higher suicide rate among young depressed combat service veterans who are also diagnosed with PTSD. In addition, there have been research studies identifying that combat service veterans with co-occurring disorders, such as depression and alcohol abuse, or depression and PTSD, may also be at risk of suicide (Cornelius, Salloum, & Mezzich, 1995; Oquendo, Brent, & Birmaher, 2005).

Attending to service veterans with PTSD or combat traumatic stress disorder (CTSD) is important, as it has been linked to the increasing rate of suicides in combat veterans. There has been a growing awareness by the military of a significant increase in the rate of PTSD in combat veterans subsequent to Afghanistan and/or Iraq deployment, as research has shown that war zone stress, in and of itself, makes a substantial contribution to the development of CTSD in combat veterans (Fontana, Rosenheck, & Brett, 1992; King, King, Gudanowski, & Vreven, 1995; Kulka et al., 1990). This can be especially problematic for service veterans that are re-deployed before they have been able to seek mental health services (or have started counseling). It is important to remember that PTSD symptoms can develop during combat deployment or be delayed until the veteran has returned home, and for some it will not develop until after they have retired or are medically discharged from the military (Matsakis, 2007). While all combat service veterans are at risk of developing PTSD, it is more often seen in those who were in combat zones and in victims of sexual assault, as well as those who have been exposed to a traumatic event in which there was actual or threatened harm to self or others (a close relative or comrade) along with high levels of fear, helplessness, or horror, and those that were injured in combat. Symptoms of PTSD include emotional numbing, reduced awareness of surroundings, de-realization, depersonalization, and/or reduced ability to recall important details of the trauma event. Additional symptoms are reexperiencing the trauma in one of the following ways: recurring images, thoughts, and dreams; illusions; flashbacks; feeling as if one is reliving the event; and/or severe distress upon being exposed to a reminder. According to Matsakis (2007), for combat veterans:

PTSD is often associated with survivor guilt, substance abuse, a tendency to react under stress with survival tactics, fantasies of retaliation, alienation, negative self-image, cynical attitudes toward and problems with the government and authority figures, hypersensitivity to injustice, and a sense of being permanently damaged, inferior, or defiled (pp. 76–77).
PTSD can impact the combat service veteran’s ability to function in civilian life with their families and spouse/partners as well as at their job, because of their affect dysregulation and their altered ability to form interpersonal relationships and or intimacy. Instead, these combat service veterans might be preoccupied with self-destructive behavior, preoccupation with the war, frustration, outrage, guilt/survival guilt, and for some, mortal fear. Research (e.g., Mills & Turnbull, 2001; Riggs, Byrne, Weathers, & Litz, 1998) has suggested that there is an association between PTSD and intimacy in two of the symptom clusters: numbing and avoidance (avoidance of trauma triggers by shutting down the affective system), hyperarousal (sleep disturbances, profound hypervigilance and exaggerated startle response, poor concentration, and irritability), intrusive reexperiencing (dreams or intrusive thoughts and powerful emotions; Criteria C and D in the Diagnostic and Statistical Manual of Mental Disorders, Text Revision, Fourth Edition [DSM-TR-IV]; American Psychiatric Association, 2000). Several studies focused on the avoidance cluster (deficit in experiencing and expressing positive emotions such as loss of interest in activities, detachment, and alienation from others, restricted affects, emotional numbing) and impact on combat veterans (heroes and less valiant veterans) being in well-functioning relationships, dyadic adjustment, communication, satisfaction, and intimate exchanges (Cook, Riggs, Thompson, & Coyne, 2004; Evans, McHugh, Hopwood, & Watt, 2003).

Even though PTSD is a real issue for many U.S. service veterans after deployment, some believe that the numbers are exaggerated and that prolonged readjustment struggles are the result of multiple deployments and fear of losing their edge if re-deployed. Therefore, it is important to not diagnose PTSD too soon, and instead consider the possibility that service veterans have not transitioned their combat skills after returning home, which are also known as “battle mind skills.” These skills were important for service members to learn, especially those deployed in combat zones, so that they could survive (often repeated) deployment to combat zones in Afghanistan and/or Iraq. These skills are however, problematic in civilian life when being with family spouses/partners or on the job. There are 10 Battlemind (combat) skills that require transitions (Adapted from Walter Reed Institute of Research Battlemind Training II; Castro et al., 2006):

1. **Buddies (cohesion) versus withdrawal**—In combat, veterans develop close cohesive bonds with other veterans that will often last a lifetime. At home, combat service veterans might prefer being with their buddies who understand, rather than with family and friends who cannot relate. Transitioning means that combat service veterans reestablish a bond with family and friends.

2. **Accountability versus control**—In combat, it is important for service veterans to maintain control of the weapons and gear, to stay alive. At home, things are moved and not always put in the same place, which can be upsetting for the service veteran. Transitioning means that the combat service veteran relearns that at home space and things are often shared by several people.

3. **Targeted versus inappropriate aggression**—In combat, targeted aggression involves making split second decisions that are lethal in a highly ambiguous environment, which keeps the service members and their buddies alive. At home, combat service veterans may overreact to minor issues, with major aggression, assault, spouse-abuse, “snapping” at their children or authority figures. Transitioning means that the combat service veteran recognizes that there are no enemies at home.

4. **Tactical awareness versus hypervigilance**—In combat, survival depends on service members being aware at all times of their surroundings and reacting immediately to sudden changes. At home, combat service veterans might still feel all “keyed-up” with startle responses or are anxious. They may have difficulty sleeping, have nightmares, or be easily startled by loud noises. Transitioning means that combat service veterans learn over time that they can relax.

5. **Lethally armed versus “locked and loaded” at home**—In combat, service members carry weapons at all times, as it was mandatory and necessary. At home, some combat service veterans might bring a weapon with them wherever they go, believing that they need to protect their loved ones because they are not safe. Transitioning means that combat service veterans recognize that in combat, it is dangerous to be unarmed, however when at home, it is dangerous to be armed.

6. **Emotional control versus anger/detachment**—In combat, service members have to control their emotions. At home, it is expected that veterans display a range of emotions. Displaying only one emotion—anger—most likely will result in relationship problems. Transitioning means moving from feeling emotionally numb and controlling one’s emotions, to expressing a range of emotions.

7. **Mission versus secretiveness**—In combat, service members have learned that special missions are only discussed with those directly involved, that is, unit members. At home, combat service veterans might not talk much about their experience/experiences when they were deployed. Transitioning that should occur for veterans is to make family and friends become part of the “need to know” people.

8. **Individual responsibility versus guilt**—In combat, each service member has the responsibility to stay alive and keep their buddies alive. At home, combat service veterans might start thinking about their buddies who died that they were not able to keep alive, or those who were injured. Transitioning means that combat service veterans have been able to accept that they did the best job they could do and to not “second guess” themselves.

9. **Nondefensive (combat) versus aggressive driving**—In combat, driving is unpredictable, for example, fast driving, abrupt lane changes, and staying in the middle lane. Keeping other vehicles at a distance to avoid IEDs...
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and vehicle-born IED (VBIED) is essential to survival. At home, combat service veterans often drive aggressively and defensively, which can result in traffic tickets, accidents, and even fatalities. Transitioning means that combat service veterans are able to remember that there is no need to drive fast and/or aggressively, and that they must follow traffic rules and speed limits once again.

10. **Discipline and order versus conflict**—In combat, service members need to be disciplined and obey orders, to stay alive and keep their buddies alive. At home, combat service veterans might expect that their family and friends will follow orders and be disciplined, but this expectation can result in conflict. Transitioning means using a communication style of asking and collaborating versus ordering, as they are no longer part of a chain of command.

Using battlemind skills is one survival response of service members' brains in combat to prevent the recurrence of trauma. Some combat service veterans, after returning home, are afraid to let go of these skills and “lose their edge.” Others believe that they can control their battlemind skills by just “turning them down a little,” however that is not possible. Battlemind skills are learned survival responses that can be unlearned when they are no longer needed in civilian life, however this takes time.

In addition to the learned survival responses, there are three survival responses that are biological. The limbic system of the brain can be called survival reflex/survival central (Rothchild, 2000). This system responds to the extreme threat/stress/trauma that the combat service veterans in combat zones experience repeatedly and often becomes a chronic activation, releasing hormones that tell the body to prepare for action. This release of hormones occurs automatically and is not something the combat service veterans can control. More specifically, the hypothalamus activates the sympathetic branch of the autonomic nervous system and provokes it into (a) constant vigilance against threat, (b) physical tenseness and readiness for action, and (c) preparedness for flight and fight response (Rothchild, 2000). If a combat service veteran is in a situation when neither fight nor flight is possible, the limbic system simultaneously commands heightened arousal of the parasympathetic branch of the autonomic nervous system, resulting in a freeze response (tonic immobility), which is part of the survival reflex when threat is perceived (Gallup & Maser, 1977). The survival reflex is part of the ancient or “old brain,” which is not as intelligent and flexible as the “new brain” and therefore harder to change (Rothchild, 2000). The old brain gets programmed by experiences such as combat and not by thoughts. This also means that the brain of the combat service veterans has to be shown, by new and repeated experiences, that the traumatic threat has passed and that the survival reflex goes off only when absolutely needed (Rothchild, 2000). This is a slow process, since the survival reflex is naturally strong and is called self-perseverance. Therefore, it is not unusual for combat service veterans to overreact with too much force, as their brain is still activating the survival reflexes even though the service veteran is no longer in combat.

**Couple Reintegration**

Today’s combat service veterans who were deployed in Afghanistan and/or Iraq have been dealing with unique challenges previously unencountered by veterans, which has made their reintegration into civilian life more complicated. For example, as described above, veterans that have been re-deployed 3–4 times for 12 months at a time, with little time at home between re-deployments, are now trying to be part of their families and/or couple relationships. However, repeated deployment, especially to combat zones, has changed them, as well as their families and or spouses/partners. The returning combat service veteran might wonder whether the family and/or their spouse/partner still needs them, and whether they will still fit in (Channing Bete Co., 2004). In addition, a recent study of 250,000 army wives showed a clear relationship between their spouse’s deployment and their mental health problems. More specifically, this study showed that mental health issues were seen not only in the combat service veterans, but also in their spouses, and revealed: (a) less by those wives (one third of the sample) whose husbands were not deployed in Afghanistan or Iraq, (b) more often in those wives (one third of the sample) whose husbands were deployed in Afghanistan or Iraq for 1–11 months (anxiety disorder 25%, depression 18%, sleep disorder 21%, and acute stress 23%), and (c) increasingly seen in those wives (one third of the sample) when husbands were deployed for 11 and more months to Afghanistan or Iraq (anxiety disorder 29%, depression 24%, sleep disorder 40%, and acute stress 39%; Mansfield et al., 2010). It is believed that when combat service veterans deploy, their families deploy. More recently, studies (such as Mansfield et al., 2010) have brought attention to the impact of deployment on spouses/partners. There often is a hesitation for these spouses/partners to seek mental health services related to the deployment, as they fear the perceived stigma about seeking mental health services, that is, that it will have a negative impact on their spouse’s/partner’s military career (Zoroya, 2010). In addition, the family and/or the spouse/partner might be anxious about how they will be treated by the returning combat service veterans and how they might have changed. Combat veterans might be worried that family and/or couple issues (e.g., financial problems, job issues and unemployment, parenting issues, domestic violence, affairs, separation and divorce, substance abuse, etc.) will await them when they return home, as well as the family and/or spouse/partner. Reintegrating into family life and/or couple relationship is difficult to accomplish and takes time and patience on everyone’s part. When this process is rushed, important issues might not receive the appropriate attention and can lead to difficulties for the combat service veteran as an individual, as well as the family and the couple.

Combat-related trauma can be detrimental not only to the combat service veteran and his or her spouse/partner but to...
marital and other intimate relationships (Dirkwager, Bramen, Ader, & van der Ploeg, 2005; Nelson Groff, Crow, Reisbig, & Hamilton, 2007; Rugger, Wilson, & Waddoups, 2002). The literature on combat service veterans notes that witnessing or participating in abusive violence or torture creates multidimensional trauma and often a sense of feeling powerless, which can later permeate marital and other intimate relationships as anger and can “pose the most complex and difficult therapeutic challenges” (Fontana et al., 1992). According to Simon (2007), combat zones are a specific kind of horror, “which slowly chips away one’s sense of safety, emotional resiliency and character” (p. 30). Combat challenges include roadside IEDs, VBIED, sniper fire, suicide bombers, undistinguishable insurgency, buddies blown to pieces, mortar attacks, and rocket-propelled grenades (RPGs). All of this increases the risk of PTSD. Combat service veterans with PTSD and their spouses/partners report significantly higher rates of impaired relationship functioning than those without PTSD (Riggs et al., 1998). This is also true for service veterans deployed in combat zones (Kessler, 2000). Although combat veterans are getting better diagnoses of dealing with PTSD or battlemind skills, there is an increased need to also look at couple relationships, and especially their attachment patterns, as this is also very influential in the combat veteran’s reintegration and combat recovery process. Combat veteran’s habitual patterns of engagement with their spouse/partner are called attachment strategies or attachment style. This attachment style has to do with how the veteran processes and deals with emotions with his or her spouse/partner. When combat service veterans have secure attachment, they are better able to cope with their combat experiences, since secure connections with significant others serve as a powerful antidote to traumatic experiences, such as combat war (Johnson, Makinen, & Milliken 2001). Research has shown that those combat veterans who are in a couple relationship in which they are securely attached, the relationship attachments serve as hidden regulators (Coan, Schaefer, & Davidson, 2006). For example, the same research found that in threatening situations, the touch of a trusted person’s hand can calm jittery neurons in the brain. Insecure attachment is believed to intensify and perpetuate the effects of combat war trauma, since disconnection from the attachment figure tends to elicit “primal fear” (a struggle to regain access to loved ones; Panksepp, 2005). According to McFarland and van der Kolk (1996), “secure attachment is the primary protection against feeling helpless and meaningfulness” (p. 24). For many combat service veterans and their spouses/partners, deployment becomes a time of separate preparation in which the veteran becomes focused on his or her deployment and the spouse/partner on needing to function without the veteran, something that will continue until the combat service veteran has returned. However, even when the veteran has returned, this process can become prolonged in cases of redeployment, something which can occur multiple times for many. According to Johnson et al. (2001), this process of deployment and re-deployment, starting with pre-deployment can result in attachment injuries, with the couple being unable to comfort and support each other during a difficult time. Furthermore, these couples often have difficulty communicating their needs, not only during pre-deployment, but also during postdeployment, especially when an attachment injury has occurred. Whether a combat service veteran and his or her spouse/partner develop an attachment injury is dependent on the couple’s attachment bond. The four kinds of attachment bonds are (a) secure attachment bond, (b) anxious attachment bond, (c) avoidant attachment bond, and (d) disorganized attachment bond (rapidly cycles between the other three styles of attachment bonds and one is more dominant). The characteristics of attachment bonds found in combat veterans and their spouse/partners:

Secure attachment bond
- Secure attached couples have a mutual dependency and interdependency.
- From the combat service veteran’s perspective, seeing the horrors of war can bring into question their basic assumptions of themselves, others, the world, and their spiritual/religious values/beliefs.
- If they, others, and/or the world is not as they believed, then the basic assumption about their worthiness for love and their ability to love can be brought into question.
- A secure relationship, however, can serve as a positive resource for both the combat service veteran and the spouse/partner.
- The balance between mutual dependence and trust that the other can function independently can serve to buffer the doubts and fears that challenge the relationship.

Anxious attachment bond
- Couples with an anxious attachment bond value dependence over independence.
- In this attachment style, combat service veterans and their spouses/partners may view deployment to combat with extreme fear, over the status of their relationship.
- While in theater, both the veteran and the spouse/partner are forced by the separation to seek other sources of support.
- The support may be corrosive to the relationship, by facilitating emotional as well as physical infidelity.
- Furthermore, there may be an increase in hostility to communication and behavior.
- The threat of deployment to the relationship and the life of the combat service veteran’s impact this attachment style particularly hard.
- The potential loss of the combat service veteran, on whom she or he so much depends, can spark radical coping strategies.

Avoidant attachment bond
- Those with avoidant attachment will view deployment as an opportunity to develop their own independence.
- Some may even welcome the deployment as a chance to strengthen boundaries; however, the perceived independence will more than likely hamper the reinteg
efforts of combat service veterans and their spouses/partners.

- As a combat service veteran develops a more avoidant style, it is likely that meaningful communication may decrease giving to a more superficial level, which in turn may foster feelings of intense anxiety.

- Furthermore, an avoidant attachment style may also become a coping mechanism to deal with fears of loss of self, as well as others, with the distance serving as a buffer to potential feelings of loss, loneliness, and despair.

Attachment is an innate motivating force in humans across the life span (Bolby, 1988). A person’s attachment bond is formed during infancy and modified by later experiences with their attachment figure, including their spouse/partner (Crawley & Grant, 2005). Positive attachment offers a secure bond, which creates a “safe haven,” which encourages autonomy and self-confidence. Johnson (2002) believes that secure attachment to a significant other (spouse or partner) creates resiliency in traumatic situations, such as combat trauma. However, the unresponsiveness of attachment figures is believed to impact the attachment behaviors negatively, heighten and intensify behaviors such as anxious clinging, pursuit, and even aggression, all in an attempt to get a response from their spouse/partner. Combat service veterans, because of the combat trauma they have experienced, can become habitually anxious (often clinging) or avoidant (often detached). These attachment styles are not pathological but rather are adoptive.

Service members train extensively with other service members to ready themselves for the experience physiologically, emotionally, and psychologically. Their spouses/partners also prepare themselves for the deployment, which is generally an individual process done with little support. The physical and emotional separation (and often repeated separation) of the service member from his or her spouse/partner becomes the couples primary attachment challenge (Figure 1).

Both partners are caught in the ethos of separation during deployment, which often includes emotional isolation for couples who lack a secure attachment bond (Johnson et al., 2001). Postdeployment, combat service veterans often feel hopeless and helpless in their relationship, focusing on their personal safety and on protecting themselves rather than connecting with their spouse/partner. Therefore, it is not unusual that these couples become stuck in self-reinforcing relationship cycles, such as pursue/withdraw or attack/defend, and so on, which makes a positive couple attachment bond impossible. More specifically, according to Solomon et al. (1992) combat service veterans’ postdeployment relationships with their spouses/partners can be stressed, because veterans dealing with combat trauma often withdraw and immerse themselves in traumatic memories, leaving their spouses/partners extremely lonely and vulnerable to various psychological and somatic problems. In addition, each partner most likely changed as part of the often repeated and/or long separation. All of these things are challenges these couples often struggle with. Therefore, it is not surprising that these couples might seek out relationship counseling to help deal with their distressed relationship, as well as helping the combat service veteran deal with overwhelming negative affects (see above) such as anger, sadness, fear guilt, and so on and the spouse/partner with their range of emotions.

Couple Counseling/Emotion-Focused Therapy (EFT)

According to Johnson (2002), “... treatment aimed at the interpersonal context does the double duty of addressing the PTSD symptoms within the context of strengthening the family cohesiveness and supportiveness” (as cited in Sherman et al., 2002, p. 627). When using EFT early on in the process of couple counseling, the EFT counselor assesses the couple’s functioning through (a) the five factors, (b) couple/family assessment, (c) meaning making, (d) anger management, and (e) safety issues.

Five Factors

If couple counseling is sought out, there should be a careful assessment of the five factors when working with combat

Figure 1. Before deployment, combat service veterans and their spouses/partners grow together, however during deployment/re-deployment, these couples grow separately and are no longer in a parallel process. After deployment, often with the help of counseling services, they learn to grow together once again, however, their relationship has changed, as each partner has changed during the time/times of separation or re-deployment/deployment.
service veterans and their spouses/partners. The factors to assess are:

- personal factors (e.g., age, gender, race, ethnicity, marital/relation status, service connection [Reserve, National Guard, the branch of the military, etc.];)
- predisposing factors (e.g., previous history of trauma, marital/relationship problems and attachment issues, young spouses [level of commitment/maturity], young children, social isolation and dependency, families, families undergoing major transitions, frequent moves, couples/families with multiple needs and problems before deployment [e.g., infidelity, financial issues, parenting issues, etc.], history of PTS/D, history of depression and/or suicidality, repeated deployment for long durations [deployment cycle/adaptability problems], mixed units [veterans trained together are not sent out together but are mixed up, veterans and reserves are put into the same unit], substance abuse treatment is interrupted prematurely when re-deployment orders are sent, mental health services that are interrupted or prematurely ended when re-deployment orders are sent, sleep deprivation, etc.);
- peridisposing factors/deployment into combat zones, including seeing IEDs, VBIED, suicide bombers, RPGs, mortar attacks, exploded vehicles, firefight, sniper fire, injuries caused by IEDs, VBIEDs and collapsing buildings, flying debris, burns, inhaled gases and vapors, human remains, and sleeping, eating, living in war zones with no rest or relaxation, and so on. Another factor is duration (single vs repeated deployment);
- postdisposing factors (e.g., debriefings, attachment, family and spouse/partner support, community/U.S. support, available mental health services, accurate diagnosis [medical brain trauma vs. psychological trauma], available medical care [in cases of injury rehabilitation, etc.], employment possibilities and education possibilities, ability to transfer military skills and training into the civilian world [resume assistance and services], individual, couple and family counseling availability without stigma, finances [financial security vs. reduced income and financial stressors], etc.);
- protective factors, including (a) resiliency—the ability to bounce back from the experience of combat and cope with and overcome this experience and (b) stress buffers—which are well described in the social work literature and have to do with skills that veterans already have, which help them cope more effectively with the effects of combat (e.g., optimism, extravert, sense of humor, good health habits, etc.).

All of these factors are important to consider when assessing combat service veterans, as they will influence if and how they are coping with their (often multiple re-) deployment and reintegration into their family and couple relationships.

**Couple Assessment**

This can include administering empirically validated assessment instruments, such as the Dyadic Adjustment Scale ([DAS] by Busby, Christensen, Crane, & Larson, 1995), the Relationship Trust Scale (Holmes, Boon, & Adams, 1990), or the Relationship Questionnaire (Bartholomew & Horowitz, 1991) to list only a few. Another couple assessment tool often used is the traditional genogram, for such information as attachment bonds across time and across generations. A focused genogram, such as the Color-Coded Trauma Genogram (Jordan, 2004) or the Scripto-Trauma Genogram (Jordan, 2006) can be especially valuable in assessing trauma experiences across generations and across time, for both partners, including combat and separation of the couple during deployment.

**Meaning Making**

Another important assessment that should occur early on is that of the combat service veteran’s combat recovery, which can be measured by assessing the degree to which the veteran has made meaning out of the combat experience. Meaning making becomes part of a larger life issue for combat service veterans, such as what matters in life and what to do after military duty. What about their family, children, spouses/partners? Was it worth being in combat? No one but the veteran can determine that. Meaning making is based on the belief that veterans hold certain core beliefs about themselves, others, and the world, as well as religious/spiritual beliefs/values. It is important to understand how the combat service veteran’s beliefs have been impacted by combat experience/experiences (single or multiple deployment) and then determine whether the core beliefs have been impacted. For combat service veterans, this involves accommodating or assimilating their combat experience into their basic belief system about themselves, their own self-capacity, and about others. Some combat service veterans will perceive that their deployment to combat in Afghanistan and/or Iraq was important, as is the present war, others might not be sure, or may question the purpose of war. It is important that combat service veterans can make some meaning out of their deployment, which could be having saved a life, helped Iraq children, and so on, believing that their deployment was not in vain. When combat service veterans are able to incorporate the combat experiences into their beliefs about themselves, others, the world, and their religious/spiritual beliefs through accommodation or assimilation, as well as find some meaning in their deployment/deployments, they are on the road to recovery and dealing with their combat experiences (Matsakis, 2007).

**Anger Management**

It is important to assess the level of anger the combat service veteran is dealing with, which can impact his or her couple relationship, as well as his or her job, and other areas of personal life. Combat service veterans have learned, during their often repeated deployments, that anger can be helpful in a self-defense situation. However, when returning to civilian life, it is this anger that often is their most salient problem, especially if confronted with combat cues. It is not surprising that
combat service veterans, by virtue of their life-threatening experiences, are more likely to perceive threats in their environment even in the absence of a realistic threat, especially when they were repeatedly deployed in war zones, and there were ongoing threats. In response to these perceived threats, the combat service veteran enters into a survival mode, characterized by heightened arousal and severe cognitive biases, including a hostile appraisal of events, an inclination toward threat confirmation, increased vigilance in recognizing a threat, and a lower threshold for responding to the threat. These processes negatively impact the veteran’s ability to regulate anger and engage in self-monitoring behavior or other inhibitory processes, resulting in an increased propensity toward aggression. Trauma cues/ triggers lead to heightened anger in veterans, and this anger is generally expressed through aggression. Anger is a physical, complex psychological and social experience that at times is expressed through yelling, hitting, punching, breaking things, and so on, but rarely improves the situation. Time out through such things as physically getting away from the conflict/exercise/journal can be helpful. In addition, relaxation techniques (progressive relaxation exercise), problem-solving skills, and communication (I statements) can all be helpful.

PTSD

Combat service veterans who reported symptoms of PTSD should be assessed using established assessment tools such as the PTSD Symptom Scale Self-Report (Foa, Riggs, Dancu, & Rothbaum, 1993) or the PTSD Checklist (Weathers, Litz, Herman, Huska, & Keane, 1993). In addition, a PTSD interview such as the Clinician Administered PTSD scale (Blake et al., 1995) can be used.

Safety Issues

The combat service veteran has lost, or is afraid of losing, physical, social, psychological, or spiritual security. In addition, there is (a) frustration, because the combat veteran’s needs are harmed, obstructed, or unsatisfactory; (b) misunderstanding, when the combat veteran mistakenly believes that the other person intended to harm; and (c) unrealistic expectations sets up the combat service veteran for frustration and at times, can result in safety concerns. These can range from suicidality to substance abuse to spouse/partner abuse or child abuse. All of these issues can be assessed as part of the initial intake assessment. A more comprehensive assessment should take place if any safety issues are identified.

EFT

When using EFT, the counselor’s goal is to help the couple deal with their attachment injuries from having felt abandoned by their present attachment figure (their spouse/partner) when one of them was re-deployed/deployed in a combat zone and the other was separated. Both spouses/partners were in need of comfort and closeness, however when that was not received and when the attachment bond was threatened but not severed, the spouses/partners might respond with being: (a) clingy, anxious, and in pursuit (anxious attachment) or (b) avoidant emotional engagement, suppressing their attachment needs (avoidant attachment). The focus of EFT is to change the emotional response cue of self and others through corrective experiences. Attachment needs and fears are addressed with the help of the counselor. More specifically, the goal is for the couple to learn to interrupt the interaction cycle that maintains the trauma symptoms experienced from re-deployment/deployment to combat zones and separation that constrains interactions.

Three Stages in EFT

Stage 1: stabilization. During this stage, the counselor creates a secure base in the counseling session, letting the couple know that they can confront the way the trauma from the re-deployment/deployment to combat zone/separation has defined their relationship and sense of self for each of them. The process of couple counseling begins with creating safety rules for the couple, as well as educating them about how the trauma of being re-deployed/deployed can impact the couple relationship and each spouse’s/partner’s self-concept. The counselor focuses on developing a strong therapeutic alliance with both spouses/partners in the couple system which is an ongoing focus for the EFT counselor. This also includes encouraging the couple to express hesitation about the counseling process. In some cases, the couple needs to challenge the counselor, to see whether she or he really is a safe person (testing for protection). The counselor must ask the couple to let him or her know whether she or he is pushing too hard or is asking overly difficult questions, and needs to provide realistic goals of what they can achieve.

There are several techniques that are used by counselors in this first stage, such as reflection, to let the couple know that each of the spouses/partners was heard. It is also effective to “zero in” on things and can serve to slow things down. An example of reflecting is the counselor saying, “Mary, you are talking about not really understanding what it was like for John when he was in Iraq. Since you were not there, you cannot take some of that pain away.” Another technique used by counselors in this stage is validation, to affirm both spouse’s/partner’s pain, struggles, fears, and so on. This will increase the couple’s sense of acceptance and security. Another technique used is empathic interference, in which the counselor accompanies the couple to the edge of their experience and helps them to unfold and expand the experience. An important technique to use in this stage is collaborative problem solving about safety issues. More specifically, the counselor explores reoccurring events and issues that might be hazardous for the couple or undermine the counseling process. The counselor does that by helping the couple articulate a core emotion. For example, the counselor might say, “Bill, you are trying to get Cathy to understand how desperate you are, and sometimes getting angry seems to be the only way to do that.” Potential safety issues need to be explored and addressed, if not.

Potential safety issues need to be explored and addressed, if not
done previously. The counselor and the couple then focus on the effect that this anger has on the couple relationship. In addition, the counselor needs to provide education about the effects of combat zone re-deployment/deployment/separation trauma on both spouses/partners and their couple relationship. In addition, it needs to be said that spouses/partners change and grow separately during these times. The counselor who addresses these issues gives the spouses/partners permission to talk and explore how they and their relationship have changed and gives the couple permission to take control and change the counseling direction. As part of this process, the counselor needs to clarify the couple’s present interaction patterns, and more specifically, how the combat trauma, separation, and lack of security with their spouse/partner shapes the interaction pattern and attachment insecurities. Each spouse/partner has to deal with the attachment insecurities by learning to see their spouse/partner as a resource, and the couple relationship as a safe heaven. Throughout the first stage, the counselor tracks and summarizes both positive and negative interaction patterns, summarizing interactions into a coherent drama, across time and specific events. By the end of the first stage, the couple’s negative pattern of engagement becomes explicit.

Stage 2: restructuring. During this second stage, the focus is on expanding and restructuring the emotional experiences, because couples in this stage generally can handle more intense emotions. In addition, each partner is safe enough in this stage to own the way they protect themselves and are ready to explore the fundamental fears that constrain their relationship. During this stage, they clarify their attachment needs and engage with their spouse/partner in new ways. This new way of engaging by one spouse/partner results in the other spouse/partner responding differently. The process expands the couple’s pattern of engagement and is significant for combat service veteran’s sense of self, especially in the relationship with their spouse/partner. The new way of engaging will be less integrated at first, and the veteran might struggle and return to old patterns of engagement with intense emotions, such as survival guilt and anger. It is important that combat service veterans own these emotions and at the same time are responded to by their spouse/partner and the counselor with empathy and acceptance. This kind of response, especially from the spouse/partner, serves as an antidote to the combat service veteran’s sense of self and creates experiences of comfort and support. More importantly, the spouse/partner becomes the principle agent of the veteran’s subjective reality known as identity. At the end of the second stage, the couple is more aware and in control when old patterns of behavior reemerge. In addition, they fight united against the time spent apart and the hopelessness and pain they have experienced during combat re-deployment/deployment/separation. As the couple is working together their bond is growing as is their relationship.

Stage 3: integration. During the third and final stage, the counselor helps the couple integrate new emotional experiences and self-concepts, through reflection and highlighting. In addition, during this stage the couple learns to integrate the new ways of dealing with their pain and trauma, in themselves and their couple relationship. For example, a combat service veteran might say, “I know I can lean on you, I do not have to be alone with these memories, but can talk with you. (Pause) Just knowing that you are there and will listen, often is enough.” More specifically, during this stage the couple has learned how to use their problem-solving skills with very little help. They are able to regulate the combat re-deployment/deployment/separation and relationship insecurities. When the couple is ready to terminate their couple-counseling experience, they have created a safe environment for themselves, in which they can be real, relaxed, and continuously grow, all of which will result in more secure engagement. According to McFarland and van der Kolk (1996), it is the attachment bond of the couple which is “the primary protection against feelings of helplessness and meaningless” (p.24).

Conclusion

Using EFT in couple counseling is a promising way to help combat service veterans and their spouses/partners deal with the trauma of re-deployment/deployment to combat zones/separation. Both spouses/partners in the couple system are affected by re-deployment/deployment to combat zone/separation, with various distress, attachment, and relationship problems. They often change and grow separately and need to learn new problem-solving skills, regulating their emotions, couple relationship, and growing together again as a couple. For counselors to be affective working with these couples, they need to be knowledgeable about the unique challenges today’s combat service veterans are dealing with, such as IEDs, VBIEDs, and so on. They need to carefully assess each combat service veteran before starting couple counseling, to rule out TBIs and any potential safety issues. Counselors who understand the military culture and are knowledgeable about the unique challenges can be very helpful when doing EFT with these couples. Because the number of combat service veterans returning from deployment is growing, and is the number of suicides in this population, there is an urgent need to do research in the area of couples counseling, as well as family counseling, to help combat service veterans feel a sense of belonging and to reintegrate into civilian life, as well as heal from the trauma of combat.

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