Book: Counseling Military Families

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1. Over the past eight weeks, we have discussed all the aspects of starting a military career and serving in the military and have looked at resources available when one leaves the military. Service in the military takes a large toll on families and the members. We have looked at such issues as PTSD, deployments and separations, single parenting, domestic violence and sexual assault. What are your thoughts about the current military system? What would you change?

**post needs to be at least 10-12 sentences of substantive information, written in proper APA format**

1. Evaluate the different treatment possibilities for PTSD and the families’ role in helping support the service member (Pages 223-230).

Assignments should be 2-3 pages in length, utilize Times new Roman, 12-point font, and double-spaced text. They should be formatted using APA style, cite borrowed material correctly, and include a reference page. **The author/textbook should be cited at least three times per written page as follows the proper APA citation for Hall is \*\*(Hall, 2016, pp. ##)\*\*.**

**Pages 223-230 Attached below**

[**9Effective Interventions**](https://jigsaw.vitalsource.com/books/9781134494927/epub/OEBPS/004_9780203761984_contents.html#ch9)

A Military OneSource article (Choosing a Counselor or Therapist, n.d.) helps military families find a counselor. In describing counseling, the article stated that counseling, therapy, and psychotherapy are often used to describe a process that usually involves a series of discussions with a trained professional who can help people identify their feelings or problems, talk about them, and find ways to cope with them or solve them.

During the counseling process, you may discover patterns of thinking and behaving that you want to keep or change. You are really retaining the time and expertise of a specialist who can help you understand more about who you are and how you can make changes in yourself or your life.

(Choosing a Counselor or Therapist, n.d)

Regardless of what we call our work, civilian counselors are needed to work with military families; the Military OneSource article encourages families to engage in the process of counseling to accomplish all of the mentioned possibilities. In [Chapter 1](https://jigsaw.vitalsource.com/books/9781134494927/epub/OEBPS/009_9780203761984_part1.html#ch1), I addressed the first two competencies, multicultural awareness, including understanding our own behavior, values, and biases, and understanding the worldview of the populations we work with. In this chapter we will address the third competency of developing and practicing appropriate, relevant, and sensitive strategies for working with this population. In respecting cultural differences when working with couples, Tews-Kozlowski and King (2012) share a multidimensional approach that includes the consideration of individual levels of development as well as dimensions of cultural differences, including “religion/spirituality economic class, sexual identity, psychological maturity, ethnic/racial identity, chronological challenges, trauma, family history, unique physical characteristics, language, and location of residence” (p. 322). Understanding each of these dimensions helps the practitioner understand that no two people ever share the exact cultural experiences and might be considered when working with all families, not just couples.

Individuals who choose to partner with our service members are already nontraditional when compared with their culture of origin and … these unique couples often break traditional molds even as they are still influenced by their culture of origin. This stance begins the therapeutic relationship from a perspective of mutual respect and discovery and sets the tone for a knowledgeable collaboration of discovering what will work for these individuals.

(Tews-Kozlowski & King, 2012, p. 322)

The following is an updated summary of the current literature, as well as information from the previous interviews that point to the most common therapeutic approaches used and currently recommended. An additional recommendation is to review and become familiar with the workbook by DeCarvalho and Whealin (2012) called *Healing Stress in Military Families: Eight Steps to Wellness*. While written for families themselves, the authors “advise the family to consider going through this book with a trained mental health professional” (DeCarvalho & Whealin, 2012, p. xvii). I highly recommend the book be used in counselor training programs, and by practicing practitioners.

A therapist near a major Army base in Arizona shared that through counseling one Vietnam veteran began to see that the only way he could heal and the only way his spouse could really understand him was to tell her what went on in his head, but “the last thing he wanted was for her to know what went on in his head.” Sometimes the actual process of counseling becomes the therapeutic intervention, in and of itself, because family members learn to talk to each other and find new ways of coping. Of course, as with all therapy, it is usually the therapeutic alliance that becomes the most powerful part of any intervention. In addition to looking at the most common approaches to working with military families, I have also included hints and suggestions on ways to work with significant issues found while working with different subgroups of military families, including the concerns faced by the family following deployment, the unique concerns of stepfamilies, the issues found when working with post-traumatic stress disorder (PTSD) survivors and their families, and perspectives on working with military men.

The majority of therapists interviewed for this book believed they were most successful when they came from a strength-based approach in which they were able, early in therapy, to engage the parents, family, or couple in finding solutions that made sense, to help empower each member of the family, and to use goal-oriented techniques so therapy would be a reasonably short process. Obviously there will be issues, concerns, and circumstances that arise when following these guidelines is not possible, and more long-term interventions, possibly even hospitalization or medication therapy, must be considered.

[**Cognitive-Behavioral Therapy (CBT)**](https://jigsaw.vitalsource.com/books/9781134494927/epub/OEBPS/004_9780203761984_contents.html#ch9.1)

Throughout the literature, the most consistent approach to therapy when working with the military is some variation of cognitive-behavioral therapy (CBT) (Sneath & Rheem, 2011). Virtually all of the therapists interviewed for this book used either a cognitive approach or a cognitive-behavioral approach, even though at times it was used in conjunction with other approaches or techniques. A therapist in Tucson, Arizona usually comes from a cognitively based approach because the majority of his military clients are what he called “thinkers” rather than “feelers.” At the same time, this therapist also encourages and finds many military service members open to more existential questions about life, about what is meaningful in their world, and about their personal mission, beliefs, and values as they confront the reality of living in the military world.

Another therapist who works from a CBT perspective also shared that helping her clients become aware of their spiritual or religious background was important, as this greatly influences much of their thinking and attitudes as well as the potential adjustment to the possibility of military combat stress. Figley and Nash (2007) said, “The experience of veterans of prior wars indicates that war-zone trauma frequently impacts the spirituality of survivors” (p. 7), so using spirituality as a healing resource is important for a full recovery. The inclusion of spirituality into counseling is, obviously, an individual decision based on the practitioner’s own background, experience and comfort level. However, Baroody (2011) points out that “when one recognizes the spiritual nature or basis of the presenting symptoms, then interventions that infuse hope into the therapeutic process can lead to resilience and a greater sense of well-being” (p. 165). It is an area gaining greater acceptance in counseling, moving away from earlier days when practitioners were warned to keep “personal values as well as religion out of the 50-minute session” (Baroody, 2011, p. 167). Practitioners would do well to acquaint themselves with Baroody’s and others’ writing and helpful suggestions about incorporating a spiritual component into all therapy, but particularly when addressing military family issues around trauma. While soldiers and their families may not express their symptoms or concerns in religious terms, they often do relate to “meaning, ultimate concerns, and the ability to perceive multidimensional relationships” (Broody, 2011, p. 189), which could be the definition of spirituality.

Although the most well-researched therapy, particularly for trauma victims, is CBT (Dass-Brailsford, 2007), consideration must always also include the clients’ cultural and social background. In addition, Sneath and Rheem (2011) caution those working with family units by only using CBT might mean the practitioner could “fail to address the soldiers’ marital and familial relationships as an attachment bond” (p. 129). It is important to remember that trauma work may come well into the therapeutic process, as this material may not surface until considerable work is done and a very trusting relationship is built. In CBT both cognitive and behavioral approaches are combined, so clients learn how to weaken the connection between thoughts and their habitual reactions to them and how their thinking patterns cause difficulties by giving them distorted mental images leading to anxious, depressed, or angry feelings. Dass-Brailsford (2007) outlined a number of useful CBT approaches, especially when treating trauma, including exposure therapy, systematic desensitization, anxiety management, relaxation techniques, and stress inoculation therapy.

Addressing the concern shared earlier by Sneath and Rheem, O’Brien (2012a) reviews the roots of cognitive-behavioral couples therapy (CBCT) and share how this can be effective when working with couples, particularly when using enhanced CBCT. This approach could be “considered a merging with emotionally focused couples therapy (EFCT) and Gottman’s methodology” (O’Brien, 2012b, p. 39). The enhanced version includes the following changes:

1.Focus on the core themes, instead of a microanalysis of behavioral events;

2.inclusion of what each partner brings to the relationship, such as their personality;

3.understanding of external stressors that might impact on the couple’s functioning;

4.understanding how crucial emotion is to the couple relationship and is as valid as the cognitive and behavioral aspects to consider; and

5.expanding the therapeutic goal from reducing negative interactions to include enhancing positive interactions.

A therapist in San Diego, who starts from a CBT perspective finds that adding narrative techniques can also be effective, as many couples and service members gain insight from reflecting on who they are and their unique stories that brought them to where they are in life. Fenell and Fenell (2003) suggested the use of rational emotive behavior therapy (REBT) when working with individual service members, as clients can recognize the activating event that may be creating the problem, acknowledge their self-defeating beliefs about that event, recognize the consequences of those beliefs, and, finally, learn how to dispute the self-defeating beliefs while observing the effects of replacing the beliefs with more rational ones. Some of the more common thinking mistakes are black-and-white thinking, “yes, but” thinking, mind reading, telling the future, emotional reasoning, labeling, “should” statements, overgeneralizing, and catastrophizing. Watching for these irrational beliefs can be helpful in assessing whether the use of REBT would be an effective intervention strategy.

***PTSD and CBT***

Friedman (n.d.) and Foa et al. (1999) pointed out that while many therapeutic approaches are available for working with clients diagnosed with PTSD, the most effective interventions have been anxiety management, cognitive therapy, and exposure therapy, whereas play therapy is often useful with children who have been exposed to trauma. Results have been good when combining CBT, exposure therapy, and cognitive restructuring, especially with female victims of childhood or adult sexual trauma (Friedman, n.d.). Anxiety management includes relaxation training, breathing, positive thinking and self-talk, assertiveness training, and thought stopping. Exposure therapy can be done with imaginative exposure or exposure in reality.

Medication (Friedman, 2006), particularly selective serotonin reuptake inhibitors, were the first medications to receive FDA approval for PTSD and are still being used to reduce anxiety, depression, and insomnia. Antidepressant drugs have contributed to improvement in some trials, and other classes of drugs have shown promise. Medication is often useful for symptom relief, which makes it possible to participate in psychotherapy. “While pharmacotherapy cannot be considered a cure for operational stress injuries, the benefits of medications are often substantial, and they should always be considered in a management program” (Figley & Nash, 2007, p. 6). Medications are usually recommended (a) if the symptoms are severe or have lasted for an extended period of time; (b) if there are other psychiatric problems; (c) if there are thoughts of suicide; (d) if a lot of stress exists; (e) if a client has a hard time functioning; and (f) if psychotherapy alone is not making an impact on the symptoms (Foa et al., 1999).

Friedman (n.d.) and Foa et al. (1999) also reported success with eye movement desensitization and reprocessing (EMDR). One of the therapists I interviewed also mentioned that EMDR has been successful in working with trauma clients. EMDR, particularly in combination with CBT, has been effective in accessing and processing the trauma. A study from the United Kingdom (Wesson & Gould, 2009) found positive results when using EMDR in theater, or as soon as possible after a substantial trauma. The authors point out that there are some difficulties with early intervention and that intervention “at the front line is an exciting and controversial development” (Wesson & Gould, 2009, p. 96), research has shown that “prolonged exposure therapy within two weeks of the trauma is an effective treatment … and that intervening early with exposure-based therapies may lead to better outcomes when compared to cognitive restructuring” (Wesson & Gould, 2009, p. 92).

Often, especially for mildly to moderately affected clients, group therapy is considered, where the discussion of memories, symptoms, and functional deficits can be brought out in the open with others who obviously can relate on an emotional and experiential level. A therapist in Arizona has been very successful with group work with war veterans, particularly for those older veterans who were reexperiencing symptoms of trauma. In a group setting, through sharing the trauma in a cohesive and empathic setting, clients can achieve understanding and resolution, as well as move toward feeling more confident and trusting.

A fact sheet on *The Treatment of PTSD* (NCPTSD, n.d.b) outlines the following common components of treatment from a cognitive-behavioral approach:

1.Evaluation and development of a treatment plan that meets the needs of the survivor should be started after the survivor has been safely removed from the crisis situation. If the client is still exposed to trauma, is severely depressed or suicidal, is experiencing extreme panic or disorganized thinking, or is in need of drug or alcohol detoxification, addressing these crisis problems is important as part of the first phase of treatment.

2.Educate trauma survivors and their families about how and why PTSD develops and how it affects survivors and their loved ones.

3.Help the survivor examine and resolve strong feelings such as anger, shame, or guilt during the first phase of treatment while teaching them ways to cope with the memories, reminders, reactions, and feelings without becoming overwhelmed or emotionally numb. Realize and understand that trauma memories can become manageable but usually do not entirely disappear as a result of therapy.

4.Exposure to the event with the use of imagery will allow the survivor to reexperience the event in a safe and controlled environment.

[**Solution-Focused Brief Therapy (SFBT)**](https://jigsaw.vitalsource.com/books/9781134494927/epub/OEBPS/004_9780203761984_contents.html#ch9.2)

Solution-focused brief therapy (SFBT) is also one of the most used therapies for many counselors working with military families, and it is particularly useful when working in the school setting. Sklare (2005) gave results of research done by a number of authors that show that as many as 78 percent of children 12 years old and younger and 89 percent of children between the ages of 13 and 18 made progress toward their goals in counseling after seven to nine months of using SFBT. He stated that this “model of counseling … can have tremendous impact in school settings” (Sklare, 2005, p. 4), and it certainly has been found to be effective with adults as well. The value of SFBT is that the “emphasis is on ‘solution’ rather than on [the]’problem’” (Tews-Kozlowski, 2012, p. 53), which demands that the client, couple, or family remain active in the present, as well as emphasizing the future instead of dwelling “more extensively on the ‘what’ and ‘when’ of the presenting situation” (Tews-Kozlowski, 2012, p. 53). The basic assumptions (Sklare, 2005) of SFBT are as follows:

1.If we concentrate on successes, changes can take place, so the focus should be on what is right and working rather than on what is wrong and troublesome.

2.Every problem has identifiable exceptions that can be transformed into solutions, so it is important for counselors to listen for hints as to when, where, and how exceptions occur to help clients develop solutions.

3.Small changes have a ripple effect, and as clients begin to adjust to a minor change, the chain reaction expands into major changes.

4.All clients have what it takes to resolve their difficulties, so focusing on the clients’ expertise and strengths rather than on deficits is important.

5.The clients’ goals are seen as positive, pointing toward what the clients want to do, rather than as negative or reflecting on the absence of something.

In addition to these assumptions, a few additional concepts important for the therapists to practice are (a) avoiding problem analysis; (b) being efficient with interventions; (c) focusing on the present and future; and (d) focusing on actions rather than on insights (Sklare, 2005). By removing the need for in-depth exploration of the antecedents of the clients’ problems and taking the investigation of the causes and origins of problems out of the process, therapists can dramatically shorten the time needed for counseling. Tews-Kozlowski (2012) share three rules from the Northwest Brief Therapy Training Center in Washington state: “(a) If it isn’t broken, don’t fix it; (b) If it works, do more of it; and (c) If it’s not working, do something different” (p. 54). Simply because the focus is on solutions, counseling becomes brief, and actions become of primary importance. Both of these reasons are why this model works well both in schools and with military families who may have a very limited number of counseling sessions available and also have a need to make changes quickly, as the changes in their lives occur so frequently.

I had many occasions to work from a SFBT perspective as a school counselor with parents who were concerned about troubling behavior of their children. Although we were not in a therapeutic setting where we could do long-term counseling, the parents and children were very open to focusing on possible solutions and short-term interventions. Often these simply included finding more time for the family to spend together or learning either new parenting skills or new communication skills so the students felt more acknowledged and cared for. Another point that helps clients and families understand issues and concerns they are having is that often the problem they are faced with was, indeed, a possible “solution” to a different problem someone in the family was facing and was attempting to resolve. As both parents and their children made small changes, they realized these changes had a major impact on their relationship.

The characteristics of a solution-focused approach make it “an ideal counseling approach with diverse populations” (Sklare, 2005, p. 8), as the sessions focus on the clients’ experiences within their own frames of reference. In addition, solution-focused counseling “uses the clients’ terms and phrases rather than the counselor’s, recognizes that clients are the best experts on themselves, and focuses on strengths rather than weaknesses” (Sklare, 2005, p. 8). This is particularly important when working within the military culture because therapists must help military families find solutions that work within the military context.

Solution-focused therapies by their nature emphasize the resilience and strength … in the process of finding a path through the current difficulties. The emphasis of the approach combines an awareness of changing the way the couple defines their current difficulties and the way each individual can contribute to the overall movement through the problem or solution to the problem.

(Tews-Kozlowski, 2012, p. 53)

Sherman et al. (2005) stated that brief psychotherapy that focuses on the emotional conflicts caused by traumatic events can be very healing. By retelling the traumatic event to a calm, empathic, compassionate, and nonjudgmental therapist, the survivor achieves a greater sense of self-esteem and can develop ways of thinking about, coping with, and dealing more successfully with intense emotions. A husband and wife were seen in counseling after he returned from combat, because he had completely withdrawn from his wife. His perspective was that he did not want to alarm her with the images in his mind, and her perspective was that he had stopped caring for her because he didn’t want to be with her. Again, another example of how someone’s “solution” was causing an additional problem, as he believed that he was doing her a favor by not alarming her with the images he was having. As he told his stories in counseling, she could see how difficult it was for him to be with her but not tell her about what was going on in his mind. The therapist asked them to schedule two hours a week in a safe, comfortable place for him to share his stories and helped her learn the best way of responding to the stories. In a short time they could see the value of his sharing, and the connection between the two was reaffirmed. This was probably not someone who would be diagnosed with full-blown PTSD, but someone who needed the compassion and understanding of a caring person and a short intervention to help the couple get back on track.

Obviously there is not enough material presented here for a therapist to begin using SFBT without more training; however, “key concepts from the approach are easily integrated into other formats that may be utilized” (Tews-Kozlowski, 2012, p. 68) by almost any mental health practitioner. The work of Berg and Steiner (2003), deShazer (1985), Sklare (2005), Tews-Kozlowski (2012) and others should be used to learn more about the approach and gain skills necessary to work from a SFBT perspective, either with couples, in family counseling or in a school setting as “this approach empowers and allows clients to discover coping strategies, it is time limited, emphasizes strength and capacity, and fits well within the military lifestyle” (Tews-Kozlowski, 2012, p. 68).

[**Family Systems Therapy**](https://jigsaw.vitalsource.com/books/9781134494927/epub/OEBPS/004_9780203761984_contents.html#ch9.3)

Wakefield (2007) wrote, “The responsibility of the profession is to address things systemically and recognize the family and community dynamics of military service” (p. 23). She believes that it is not unpatriotic to acknowledge and “understand the depth of trauma to soldiers, their children and their loved ones. It’s neglectful not to” (Wakefield, 2007, p. 23). Many therapists interviewed for this book mentioned that having a systems approach was effective, and they referred to work by Jay Framo and John Gottman when working with couples and families. Having parents do their family-of-origin work from a systems perspective incorporates some of the cognitive-behavioral approaches with understanding the influence of their childhood, as well as their reasons for joining and their commitment to the military. However, because of the emphasis in the military on personal accountability, a systemic family-based approach may meet with initial resistance (Fenell & Fenell, 2003). “The counselor should be prepared for this response and begin to introduce the systemic paradigm that identifies dysfunctional relationship patterns as the focus of the problem rather than dysfunctional individuals” (p. 11).

In an excellent publication outlining numerous ways to use a systems approach with military families, editors Everson and Figley (2011) have brought together experts in the field to share the concepts, highlights, strategies and successes of this approach when practitioners find themselves working with military families. “The application of family systems theory and practice to families within the military system … has been identified as crucial to improving our understanding of military family functioning in the social and behavioral sciences literature” (Everson & Camp, 2011, p. 4). The authors point out that just because a practitioner might have more than one member of a family in the counseling session does not mean they are working from a systems perspective; they believe “that the orientation to this particular set of assumptions is the key difference between ‘treating families’ and merely seeing them for therapy as a collective of individuals” (Everson & Camp, 2011, p. 4).

Ridenour (1984) wrote that when mental health professionals first see families in the military setting, the families are often in conflict with the military or with each other over a matter related to the demands of military life. “Couples in the service may use the military as the third party in their dealing with one another. Therapists dealing with these families in such times of upheaval must not allow themselves to become allied with such maneuvers” (Ridenour, 1984, p. 5). Alfred Adler was probably the first systems theorist, even though he didn’t use those words. Most theorists and practitioners who come from a systemic, developmental, and strength-based approach usually have some grounding in Adlerian psychology, so “it is not surprising to find the Adlerian model very much compatible with most currently popular systems-based models of marriage and family therapy” (Nicoll, 1989, p. 5). The Adlerian model focuses on the healthy development of the family, including parent education programs. The work by McKay and Maybell (2004), discussed in [Chapter 5](https://jigsaw.vitalsource.com/books/9781134494927/epub/OEBPS/013_9780203761984_chapter5.html), which helps parents learn new parenting styles and understand the democratic world children live in is an important source of information when working from a systemic base with military families.

The assumptions of the systems orientation (Nicoll, 1989) are based on seven major principles, including (a) circular causality, in which behavior is understood to be circular in nature instead of existing in a linear, unidirectional manner; (b) nonsummativity, in which the family is viewed as a whole that is greater than the sum of its parts, which was Adler’s reason for calling his theory individual, or indivisible, psychology; (c) equi-finality, which is the idea that the meaning one attaches to events is far more important than the event itself, or seeing the world from a phenomenological approach; (d) communication, which is seen as the foundation of all behavior, and all behavior is understood in terms of its purposive and interpersonal context, or social interest; and (e) family and marital rules, which are a series of repetitious patterns based on explicit and implicit assumptions, or what Adlerians might also call a cognitive framework that creates each person’s lifestyle. Two additional principles from a basic systems model are homeostasis, or the ways in which the family maintains stability within the system, and morphogenesis, which are the mechanisms that enable changes to occur when needed within the system (Nicoll, 1989).

Everson and Camp (2011) point out that knowing and understanding family structure concepts, such as boundaries, family roles and rules, triangles, birth order and ecosystems, are all essential to understand when working with families. In addition they focus on the family processes that include emotional regression, differentiation and separation, multigenerational influences, paradoxical situations, family secrets, family rituals, and sibling relationships. The explanation and detailed strategies used in these processes is beyond the scope of this book, but understanding the importance of the above concepts and processes should be a part of the training of anyone working from a family systems perspective.

Family systems theory and therapy as a “conceptual system and therapeutic methodology has a great deal to contribute in enabling helping professionals, especially mental health professionals, to understand and intervene more effectively in treating military personnel and their families” (Ridenour, 1984, p. 3). A therapist shared a story of working with a military officer and his daughter. The dad was furious with the acting-out behavior of his daughter and declared in the first session, “If she doesn’t stop screwing around with older men, she’ll end up…. ” One can readily imagine the rest of the sentence. Through the course of family counseling, it became clear that the acting-out behavior was the daughter’s way of reaching her goal of getting her father’s attention, and the repetitive patterns of his finding fault was his way of trying to force her to change and follow the family rules. Although this interactive communication pattern was driving them farther apart, it wasn’t until the therapist took the time to teach the dad how to use “I” messages and he could see the negative consequences of his actions that he was willing to change. He had, of course, assumed that it was the daughter who would have to change. When he was asked to share his fears and concerns for his daughter in a new way, the large gruff military dad was able to say, “When you date older men, like the guy you saw last week, who is 27, I feel sad, lonely, afraid…. Like you are going to leave me like your mother did.” What a difference for this 16-year-old to hear the fears of her father rather than the condemnation of her actions. What became clear to him was that he was attempting to treat his daughter in ways that might be appropriate when he was addressing his command but were inappropriate when speaking to his daughter.

As early as 1984 Keith and Whitaker pointed out that one of the discouraging ways military men reduce family tension is by leaving the family circle, and the military father can, all too easily and even in therapy, become a scapegoat, so it is frequently the mother who expresses the symptoms for the family. As the bond of the military takes precedence over the bonds of the family, it is essential to work with the whole system to eliminate some of these inherent tendencies. They stated, “The gulf that develops between the military man and his children is one of the most hopeless troubles in family therapy” (Keith & Whitaker, 1984, p. 151). Early in therapy the rank structure must be clarified and an agreement made that in the family both parents have equal rank. The manner in which the military member is handled early is often critical, and if the service member feels ignored, little work can be accomplished.

Often using metaphors of the military is valuable, and Carl Whitaker, as he was so well-known for, gave examples of using metaphors, such as asking a parentified child, “Did your mother court martial your father when he was gone and then promote [you] to General?” (Keith & Whitaker, 1984, p. 161). The authors also cautioned,

[w]ith rigid families the amount of intimacy possible correlates with what the most paranoid member can tolerate. The military is the paranoid edge of the culture … [and] the paranoid component is difficult to disrupt because … it is validated by his profession.

(Keith & Whitaker, 1984, p. 150)

Family therapy can, however, help the military service member discriminate between the military reality outside the home and the family reality inside the home.

Many of the factors that Donaldson-Pressman and Pressman (1994) looked for in their work with families may also be important to watch for when working with highly traditional military families, including the following:

1.Watch for indirect communication in the family, in which the expression of feelings and concerns may be denied or not expressed in a timely or appropriate manner.

2.Watch for triangularization that often happens when the military parent is out of the picture and the other parent tends to confide in the children about inappropriate or more adult issues, building a coalition that will be either in the way or resented when the military parent returns.

3.Pay attention to parent inaccessibility, which is often part of the structure of the military family but may also include emotional inaccessibility, as the parent who is left to run the household may be inaccessible because of the stress level or duties that are being required.

4.Watch for unclear boundaries between the subsystems, where the children may feel entitled to certain privileges when the military parent is gone but not when he or she returns; the children are parentified by the responsibilities they are expected to carry out, or the children have no right to privacy, as the parents feel it is their right to intrude into the children’s private space, possessions, or thoughts to maintain a certain family image.

5.Watch for children who believe that love and affection are like moving targets because their relationship with their at-home parent totally changes when the military parent returns.

6.Watch for children who seem to have few ego boundaries, perhaps resulting from a belief that they do not have the right to express their feelings or ask for their needs to be met.

7.Watch for children who are hypervigilant and appear to be good at mind reading, as they feel a need to always be prepared for disaster or be ready to meet someone else’s needs, only to discover that it almost never works.

***Family Assessment***

An important aspect of working with families is the understanding that often the crises that bring families to counseling are somehow related to marker events or transitional periods within a family’s normal life cycle. Often these transitional periods, when combined with the normal events or transitions of military life, can lead to what looks and feels like crisis. It is important for the therapist to focus the attention of the family “upon itself and its part in the unfolding drama and to facilitate [the family’s] developing strategies for easing these passages and making them worthwhile individuation growth experiences” (Ridenour, 1984, p. 5). Some questions Ridenour suggested that we ask include:

1.Where is the family in terms of its own stages of development?

2.Where is each member in his or her own individuation?

3.Where is the family in terms of its relationship with the military?

4.What style has it developed to deal with periodic separation and reunion phenomenon?

5.Is there any impact on the family caused by its particular branch of the military?

6.Does the changing role of women have any effect on the family’s current situation, such as spouse employment concerns?

7.Is the family’s current crisis being influenced by the service member’s rank?

8.What is the family’s concept of how the military sees that family?

Ridenour also suggested that we pay attention to factors that may have an impact on the crisis, including cultural, ethnic, or racial backgrounds; the presence of adopted or foster children (and I would add stepchildren); the issue of spouse or child abuse; the presence of alcoholism or drug use; and any significant physical or mental illness or financial difficulties. Of course any assessment would also include any potential for harm, including investigating risk factors that may be associated with violence and considering individual traits and variables related to violence (Elbogen & Sullivan, 2013).

Springle and Wilmer (2011) challenge practitioners, particularly civilian mental health professionals who may not have personal experience in the military, to learn about the military history of our nation as well as the present and relatively recent military conflicts. In addition they urge practitioners to understand something about DoD and the VA health care system and to ask every client whether he or she, or any close family members, are a current or veteran service member; they also believe in the need for all professionals to be culturally competent. In addition, they suggest that a few additional questions are added to any practitioner’s assessment, including:

1.Why did the service member join the military, what service, and why?

2.If he/she served in combat, how many tours and to what location and when?

3.What is/was the MOS (military occupational specialty) or the job one trained for?

4.Is there satisfaction with training and preparation?

5.Is there satisfaction with leadership and equipment?

6.How do the service member’s family and friends feel about the military and about the separation from the military (if appropriate)?

Many of these questions relate to the idea that sometimes family members come to counseling questioning the military or their experience in the military and because of the service member’s allegiance to the service may not be shared as early in the process as would be helpful. Often service members’ satisfaction with their training, the leadership, and the conflicts they were involved with, has a lot to do with their responses during counseling. “If successful, one might experience growth. But if things did not go well, and especially if people died or were seriously injured, the results can be disastrous for one’s sense of self” (Springle & Wilmer, 2011, p. 251).

Other forms of family assessment are the use of a genogram, family structural analysis or ecomapping and family-of-origin self studies (Everson & Camp, 2011). Families may discover that patterns they experienced and attributed to living in the military culture may, in fact, have been present in earlier generations and not a factor of military living at all. Obviously the ability to shift the blame away from the military structure may help in resolving issues that may be more family-of-origin or generational issues. In addition, the use of the Isolation Matrix (O’Beirne, 1983), discussed in [Chapter 3](https://jigsaw.vitalsource.com/books/9781134494927/epub/OEBPS/011_9780203761984_part2.html#ch3), can assist counselors in assessing families regarding the impact of isolation on their life and how they might begin to involve these external systems to contribute to their well-being.

***Addressing PTSD in Family Therapy***

The National Center for PTSD Web site ([www.ptsd.va.gov](http://www.ptsd.va.gov/)) is an exceptionally valuable resource for understanding, assessing, and treating PTSD. “Trauma survivors with PTSD often experience problems in their intimate and family relationships or close friends. PTSD involves symptoms that interfere with trust, emotional closeness, communication, responsible assertiveness, and effective problem solving” (NCPTSD, n.d.a). Survivors often experience a loss of interest in social or sexual activities, feeling an emotional distance from others, as well as a sense of emotional numbness. Tick shares that Erik Erikson, throughout his life, wrote about the damage done to young men and their newly formed “sound identity, formulated during adolescence and culminating at the ages at which we typically send young people off to war” (Tick, 2005, p. 104). Tick quotes a 1963 publication by Erikson who wrote:

[T]hey knew who they were; they had a personal identity. But it is as if, subjectively, their lives no longer hung together—and never would again. There was a central disturbance of … ego identity … the ability to experience oneself as something that has continuity and sameness, and to act accordingly.

(Tick, 2005, p. 105)

The partners, friends, or family members of these young service members often feel hurt, alienated, or discouraged because the survivor has not overcome the effects of the trauma, and they eventually become angry or distant. “Two of the major war-time-related stressors for military families include post-traumatic stress disorder (PTSD) experienced by some service members exposed to combat, and secondary traumatic stress that often develops within family members of those who suffer from PTSD” (Herzog & Everson, 2011, p. 192). There is usually a feeling of being irritable, on guard, easily startled, worried, or anxious, which will naturally lead the survivors to be unable to relax, socialize, or be intimate. These are generally related to what we now refer to as secondary traumatic stress, even though technically the diagnosis would come only if the individual was also exposed to another post-traumatic stressor (Herzog & Everson, 2011).

Significant others begin to feel pressured, tense, and controlled. Difficulty falling or staying asleep and having severe nightmares may prevent both the survivor and his or her partner from sleeping restfully. The trauma memories, trauma reminders, or flashbacks and the ways in which the survivor attempts to avoid such memories or reminders can make living with a survivor “feel like living in a war zone or like living with the constant threat of vague but terrible danger” (NCPTSD, n.d.a). Living with an individual who has PTSD does not automatically cause PTSD, but as noted above, can produce vicarious or secondary traumatization. Because the trauma memories, the attempts at avoiding the trauma reminders, and the struggles with fear and anger greatly interfere with a survivor’s ability to concentrate, listen carefully, or make cooperative decisions, problems often go unresolved for long periods of time. Survivors of childhood sexual and physical abuse and survivors of rape, domestic violence, combat, terrorism, genocide, torture, kidnapping, and being a prisoner of war often report a lasting sense of terror, vulnerability, and betrayal when they begin to feel close or start to trust.

Becoming emotionally or sexually intimate may bring back a feeling of letting down their guard, which can be perceived as dangerous. Sometimes survivors avoid closeness by expressing criticism toward or dissatisfaction with loved ones and friends, leading to intimate relationships that actually have episodes of verbal or physical violence. In addition, alcohol and drugs are often used in an attempt to cope with PTSD and obviously can destroy intimacy and friendships. In other cases, survivors may be overly dependent on or overprotective of their partners, family members, friends, or support persons (NCPTSD, n.d.a).

In the first weeks or months after a traumatic event, survivors often feel an unexpected sense of anger, detachment, or anxiety in their intimate, family, and friend relationships. Although most are able to resume their prior level of intimacy and involvement in relationships, it has been found that up to 10 percent will develop PTSD with lasting problems in their relationships. Often it is only through therapy in a safe and caring environment that people with PTSD can learn to create and maintain successful intimate relationships, by establishing a personal support network to help them cope and rebuild relationships. By learning how to share feelings honestly and openly with an attitude of respect and compassion, by continually strengthening cooperative problem-solving and communication skills, and by including playfulness, spontaneity, relaxation, and mutual enjoyment in their relationships, clients can return to their former level of productivity.

The NCPTSD fact sheet titled *PTSD and Relationships* (n.d.a) points out that intimate, family, and friend relationships are extremely beneficial to the survivors of PTSD, as these provide (a) companionship and a sense of belonging that can act as an antidote to isolation; (b) a growing level of self-esteem that can help overcome depression and guilt; (c) opportunities to make positive contributions to others that can reduce feelings of failure or alienation; and (d) practical and emotional support when coping with life stressors. Survivors of PTSD find a number of different professional treatments helpful for dealing with relationship issues, including individual and group psychotherapy, anger and stress management, assertiveness training, couples communication classes, family education classes, and family therapy.

Families have long been known to be affected by the physical and emotional stress of war, and for services to be effective, they must be “built on a solid understanding of twenty-first-century warfare, warrior culture, and stress injury science” (Figley & Nash, 2007, p. 2). Including the partner in working with PTSD survivors is essential to treatment, as this is the only framework available to conceptualize both the relationship issues and the potential treatment plans (Sherman et al., 2005). Couples therapy can be either a powerful adjunct or the primary treatment modality.

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 PTSD…. Common sense and clinical intuition tell us that families are dramatically affected and are instrumental in the veterans’ recovery.

(Sherman et al., 2005, p. 626)

Well-designed couples therapy has the potential to help veterans cope more effectively with trauma-related distress, to assist partners in understanding and empathizing the confusing behavior, and to strengthen intimate relationships. Given the large number of service members who have been deployed to Iraq and Afghanistan and are now dealing with PTSD, additional and immediate attention to effective treatment modalities is critical (Sherman et al., 2005).

Research has clearly documented the adverse effects of PTSD on intimate relationships. Combat veterans experience a high rate of marital instability, and veterans with PTSD and their spouses describe their marital problems in more severe terms than do veterans without PTSD. Furthermore, 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. Female partners of patients with PTSD are often unhappy and quite distressed with their relationships and report lower overall satisfaction, more caregiver burden, and poorer psychological adjustment. “Over three quarters of partners … rate getting couples or family therapy as very important in coping with the stress of PTSD in the family” (Sherman et al., 2005, p. 627). Figley and Nash (2007) shared the results of a study that concludes “a husband’s impairment and a wife’s sense of burden predicted both of the latter’s emotional distress and the overall marital adjustment” (p. 5).

Sherman et al. (2005) pointed out that two findings in research highlight the need to intervene to help partners manage their stress level and experience greater relationship satisfaction. The first is that high levels of expressed emotion in the family have been shown to impede improvement in PTSD clients, and the second is that family members who are hurt by the veteran’s behavior are often reticent to provide the necessary support during treatment and recovery. High levels of support have been associated with decreased intensity of PTSD symptoms, and increased social withdrawal has been associated with PTSD intensity. “In addition to withdrawing support, some partners become critical and hurtful; the survivors’ interactions with unsupportive partners is associated with worsened mental health outcomes for the survivors” (Sherman et al., 2005, p. 627).

It is clear that inclusion of family members in treatment increases the likelihood of creating positive, enduring change. If this does not happen, “the soldier brings the battle home, but the battle lives on within the couple’s relationship and threatens their bond” (Sneath & Rheem, 2011, p. 127). Without helping service members address the individual’s trauma-related issues and simultaneously altering the family’s expectation of and ways of interacting with him or her, 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 as well as dealing with family problems that arise as a result of PTSD. The family experience of PTSD can become one-sided if the family expends considerable energy helping the veteran; although this may be functional at the time of the diagnosis, it could reinforce the role of the service member as the client and ignore the partner’s or family’s needs.

Couples therapy strives to move beyond the conceptualization of an identified patient and balance the needs of both partners by assisting both to recognize and empathize with each other’s needs and a healthier balance in the relationship. A challenge for therapists is to help couples move beyond the veterans’ diagnosis as an explanation or a rationalization for the confusing and uncomfortable behavior. There are numerous versions of systemic couples work that can be used, including work by Gottman (O’Brien, 2012) and emotionally focused couples therapy (EFT) (Sneath & Rheem, 2011; Rheem et al., 2012). However, one concept to consider is that if PTSD victims begin to identify themselves with the diagnosis, and partners also adopt this disability-based view, the unwanted behavior is often tolerated and excused, and the chance for making positive relationship changes is reduced dramatically (Sherman et al., 2005). Therapy can help couples move toward a new paradigm in which the service member is viewed as having challenges related to wartime experiences that need to be addressed, but the service member is not the problem. These challenges are similar to those faced when working with any couple in which one of the partners brings a chronic condition to the relationship, such as diabetes, heart disease, a bipolar diagnosis, or chronic depression. As a conference presenter who had bipolar disorder once stated, “We are not our disorder; how often do we identify someone with a broken leg as their medical condition, so why should we define a person with a mental disorder by that disorder?”

Sherman et al. (2005) noted that an experienced therapist’s attention might be focused more on symptom management than on helping couples communicate their wishes for how to cope with specific phenomena, such as flashbacks. Focusing solely on managing symptoms superficially tends to reinforce a pathology perspective and fails to address the couple dynamics. On the other hand, a sole focus on the couple’s struggles would also be one-sided. Therapy must always start with an assessment as noted in an earlier section and determination that neither partner is abusing substances, that remaining in the relationship is physically safe, and that working together will promote acceptance by helping the partner learn to tolerate and respect relational differences rather than attempt to eliminate what seems like unsolvable problems.

The following short overview of the three domains of PTSD treatment and suggested interventions from a systemic perspective are based on the work of Sherman et al. (2005) and could be used from any systemic approach.

*Interventions for Reexperiencing the Symptoms*

Tick (2005) tells us that “for the survivor’s soul to heal, he or she must revisit the experience of war in a way that tells the truth and frees the heart from bondage to the past” (p. 198). Interventions for the first domain of reexperiencing the symptoms include the following:

1.Assist PTSD survivors in educating their partners about what it is like to reexperience the symptoms, framing the veterans as the experts, and supporting them in sharing their symptoms.

2.Help the survivors teach their partners how to be supportive by articulating their needs, and, if necessary, educate the partners about grounding techniques to help the couple stay in the present. If violence is possible, partners need to develop an escape plan and a means of securing assistance.

2.Teach couples a debriefing process to help deescalate difficult situations and promote learning by helping them master a structured dialogue to facilitate awkward discussions and promote interpersonal learning and closeness.

4.Help couples cope with upsetting reminders of the trauma that trigger symptoms by teaching them how to predict difficult times and plan in advance how to cope.

*Interventions for Avoidance Symptoms*

The second domain of PTSD are the avoidance symptoms, which often lead to social isolation, with the partner feeling embarrassed by the veteran’s absence from social events or a desire for early or rapid departure from socializing events. The couple then often becomes isolated, leading to emotional distance rather than emotional intimacy. Couples often have problems expressing caring, self-disclosure, and emotional expressiveness and problems with sexual disinterest, leading couples to describe themselves as cohabiting. This lack of connectedness can often lead to infidelity as a means of seeking connections but still avoiding true intimacy. If, through their military experience, they gained a strong sense of identity with the military, they may even be overcome with depression because of how meaningless civilian life seems.

Positive intervention and treatment for this domain include the following:

1.Engage the couple in assessing its readiness and commitment to the difficult work involved in strengthening its emotional bond.

2.Empower the couple to risk trust and openness with each other, use cognitive interventions that may help the PTSD survivor realize that the military approach of keeping others at bay may not be useful or necessary, and help the partner avoid personalizing the distancing behavior.

3.Empower the couple to negotiate the degree of the trauma that is shared, as it is critical that the survivor has control over how often, when, and how to share these experiences, and help the partner respect these choices. Sometimes the partner may need assistance in coping with the veteran’s decision to share more with his fellow veterans than with her. It is also crucial to help survivors explain what meaning the trauma holds and then process what meaning it may have for the couple.

4.Encourage the pursuit of enjoyable activities, both individually and together, so that, at least initially, there is a high chance of success, and help the couple to cope with solitude to create and use its own support networks. Help veterans be aware of the consequences of isolative behavior, and help their partners overcome feelings of guilt for enjoying themselves when the veterans choose to stay home.

*Interventions for Increased Arousal*

The third domain of PTSD includes increased arousal symptoms, including sleep disturbance and consequent fatigue that will exacerbate social withdrawal, hypervigilance, and startle responses. This constant low-grade irritability adds to tension and stress in intimate relationships, eroding positive feelings and often resulting in partners becoming critical or emotionally disengaged. Studies (Sherman et al., 2005) have shown that the risk of violence is elevated, with as many as 42 percent of men who are PTSD survivors engaging in physical aggression against partners, more than 90 percent becoming verbally aggressive, and virtually 100 percent reporting the use of psychological aggression.

***Interventions might include the following*:**

1.Assist the couple in giving each other feedback about their needs and setting limits on their emotional involvement. Understand that the hyperarousal phenomenon, known as flooding, where the veteran is emotionally overwhelmed and physiologically aroused, will render the vet less effective in communicating. Veterans say they are often unable to remain emotionally present at these times, so couples need to implement nonjudgmental means of setting limits by letting each other know when their personal boundaries are being invaded.

2.Assess the possibility of domestic violence, and if that possibility exists, referrals to appropriate additional services are essential. Couples therapy is usually contraindicated in the presence of domestic violence, but therapists specially trained in treating domestic violence may assist couples with lower levels of aggression by teaching nonviolent means of conflict resolution.

3.Assist couples in coping effectively with irritability and the expression of anger by exploring the triggers and learning effective ways of coping. Help survivors identify times when they may displace anger onto their partners, and assist the partners in providing feedback about the behavior, which opens avenues of communication and builds skills.

4.Teach conflict disengagement strategies or time-out processes to prevent escalation and create emotional safety.

5.Educate couples about anxiety management strategies and other healthy lifestyle changes, such as the need for exercise, healthy nutrition, sleep, and hygiene, that are necessary to maintain any changes they attempt to make.

The authors (Sherman et al., 2005) summarized their findings by stating:

The extent to which this proposed conceptual framework applies to noncombatant trauma is uncertain [but their belief and findings are that] adjunctive couples therapy can foster interdependent, balanced intimate relationships and can be an important element in the comprehensive treatment of PTSD.

(p. 632)

When a survivor undertakes a healing journey…. [t]raumatic wounds shrink as the soul grows big enough to carry them. The survivor gives his or her experiences meaning by serving as witness and servant of restoration. What was once a wound that dominated life and yet could not be spoken becomes instead—a story.

(Tick, 2005, p. 198)

***Addressing Deployment in Family Therapy***

A considerable amount of information is shared in [Chapter 7](https://jigsaw.vitalsource.com/books/9781134494927/epub/OEBPS/015_9780203761984_part3.html#ch7) regarding the psychological processes that families go through during a deployment, but often the most difficult time in the process is the return of the service members. As Sneath and Rheem (2011) point out “military families going through the emotional cycle of deployment and experiencing the demand of combat tours are stressed at the very deepest levels of the human experience” (p. 150).

When military parents come home, they often want to make up for the time they were gone, sometimes by sacrificing their own needs or the needs of the couple to be with the kids and often going overboard, only to undermine the structure, rules, and rituals set up by the spouse. “Feelings of not belonging anymore are common in soldiers returning from war, even in the absence of more serious problems such as combat stress” (Alaimo, 2006a). Each time the service member leaves and returns, the couple has to make the kinds of adjustments new couples face, and often it is tough on everyone. This is indeed another transition journey the entire family must endure.

Most of the returning wounded are amputees; most of them are under 25; most of them earn less than $30,000 a year; most of them suffer from multiple problems—including post traumatic stress syndrome; most of them jump when they go over railroad tracks (or hear a car backfire or a balloon pop) and most of them find their marriages are a new battleground.

(Houppert, 2005b, p. 194)

For some, the reintegration may be slow and painful (Brothers, 2006). War changes everyone, the warriors and their families. Spouses who have set their hopes on getting back the same person they sent to war the year before have a rude awakening when they find themselves next to a virtual stranger for weeks after their return. And kids who sent their daddy all those loving cards and drawings can be found crying, “Why don’t you go back to Iraq!” when their idea of their dad doesn’t match the angry, depressed, or withdrawn man lying on the couch when they get home from school (Brothers, 2006, p. 5).

Returning home can be fraught with more complications than just readjusting to the family. “One fifth of the soldiers returning from Iraq suffer from major depression, anxiety or trauma” (Brothers, 2006, p. 4). In a survey (Lyons, 2007) conducted to determine the level of involvement of the families of veterans in treatment for PTSD, spouses reported that they had a very active role in the treatment and care, including getting military members to appointments, reminding them about medication, orchestrating family life around the symptoms to minimize relapses, and taking on many of the roles that the veterans can no longer fulfill.

Obviously these additional duties create a great deal of difficulty if the spouse is working outside home, perhaps now in the role of the primary breadwinner, and inside the home as the primary caretaker for children and the veteran. Many of the spouses in the survey expressed an interest in therapy for themselves to improve their relationships or to reduce stress. They added that they did not need more information to understand the problems their returning spouse was going through but that they needed therapy that would focus on their needs and additional social activities to offset the isolation they felt. A therapist in Tucson who works primarily with military wives understands how the trauma of living with military veterans affects the spouses and families. She does family and group counseling with the women, teaching anger management, self-regulation, identification of perceived threat, and resolution of their own PTSD-like symptoms that they were often attempting to resolve through pain medication and other addictions.

Joyce Brothers (2006) believes that counselors are greatly needed to help families adjust following deployment. She believes that giving the returning military member time and letting him or her know that it is not necessary to talk about the experience immediately can be powerful. It then becomes important to teach family members, especially the spouse, how to listen and realize that the recollections may come out over the course of weeks or months. In addition, helping family members realize that things will be different, some jealousy over what has been missed may be present, and they may have to renegotiate family routines. It is also important to help family members understand that returning service members need to spend time with their war buddies and that this lifeline to their peers often makes the difference between coping and a withdrawal into isolation.

It often takes six to eight weeks, a typical period of adjustment, for life to approach anything close to normal and for the individual, couple, or family to realize that if problems persist for more than three months, they more than likely need help. Helping families through the healing journey outlined in [Chapter 8](https://jigsaw.vitalsource.com/books/9781134494927/epub/OEBPS/016_9780203761984_chapter8.html) will be helpful. Rotter and Boveja (1999) recommended that intervention strategies always approach the issues of anticipation, separation, and reunion from a systems orientation; these recommendations include (a) clarifying boundary issues, so spouses can maintain separate identities and privacy is allowed and acceptable; (b) being aware of contextual issues, so that desires and expectations are handled through open and consistent communication; (c) approaching power issues from an egalitarian and mutually supportive point of view where equity, individuality, and happiness are valued more than being right or maintaining control; (d) assisting with affective issues, where a wide range of emotions, including anger, optimism, good-natured teasing, and even a sense of the absurdity of life, is allowed; (e) teaching negotiation skills to provide for the possibility of a win–win solution rather than compromises that may be experienced as a loss by at least one member of the family; and (f) addressing spiritual or value issues to promote discussions of shared beliefs, a kinship with the world, a belief that the family members matter, and an abiding sense of meaning and purpose.