



Attachment and the Creation of a Safe Haven

Use of emotion focused therapy
in treating military couples
impacted by the trauma of war

Michael D. Howard, EdD

Kathryn Rheem, MS

Military couples face enormous stressors and challenges. During wartime, these couples face added dangers and the constant fear that the military service member might return injured, or worse yet, might not come home at all. In most military couples, it is the husband who is serving in combat. Often, however, it is the wife serving in a combat environment. This is particularly true of reserve units and specialized support branches such as medical, dental, and legal. In addition to either the husband or wife serving in combat, many couples are dual-military, where both are serving on active duty and as a result, can both deploy to a combat zone—even at the same time. Unusual relational dynamics can result from these various issues; issues that not only impact the couple, but also raise concerns regarding home management and parenting.

“Combat trauma involves a unique brand of horror that involves exposure to terrifying, violent events, along with a mixture of fear, anxiety, or despair, as well as pride, excitement, loyalty, and patriotism” (Basham, 2008, p. 87). Combat trauma, although categorized as a Type I trauma (single discreet catastrophic event), is more likely to resemble Type II trauma, which involves “chronic and repetitive life threatening events that render a victim powerless” (2008).

Combat-related trauma can be particularly detrimental to marital and other intimate relationships (Nelson Goff, Crow, Reisbig, & Hamilton, 2007; Dirkzwager, Bramen, Ader, & van der Ploeg, 2005; Ruger, Wilson, & Waddoups, 2002). Marital instability is present at higher rates in combat veterans (Kessler, 2000). Veterans with post traumatic stress disorder (PTSD) and their spouses report significantly higher rates of impaired relationship functioning than those without PTSD (Riggs, Byrne, Weathers, & Litz, 1998). World War II former POWs with PTSD reported almost three times as much marital distress as those without PTSD (31% as compared to 11%) (Cook, Riggs, Thompson, Coyne, & Sheikh, 2004). Vietnam veterans and partners reported clinically significant levels of relationship distress (70% as compared to 30%) (Riggs, Byrne, Weathers, & Litz, 1998).

Impact of Attachment

“Emotional attachment is probably the primary protection against feelings of helplessness and meaninglessness (McFarlane & van der Kolk, 1996, p. 24)” (as cited in Johnson, 2002, p. 36). It is easier to cope with traumatic experiences when one has a secure attachment, or a felt security with a loved one. According to Johnson, “the attachment system is evolution’s

way of maximizing survival in a dangerous world, a world in which a person cannot survive alone” (p. 36). The famous attachment theorist and researcher, John Bowlby (1969), defined secure attachment as “providing a safe haven and a secure base from which to explore and learn about the world” (as cited in Johnson, 2002, p. 36). When speaking about the need for secure attachment, Johnson states:

Secure attachment creates resilience in the face of terror and helplessness and a natural arena for healing. Isolation and a lack of secure attachment, on the other hand, add to our vulnerability, exacerbate traumatic events, and are actually wounding in themselves. It is also hard to develop an integrated, confident sense of self without secure connections to significant others.

When a military couple is caught in the echoes of battle, the emotional isolation and lack of secure connection make it much more difficult, if not impossible, for an individual or couple to effectively deal with a traumatic experience. Secure emotional connections with significant

others can significantly minimize the impact of traumatic experiences and facilitate healing in the aftermath of these events.

Case Illustration

The following fictional case is based on real-life situations. Robert and Cindy have been married for 10 years and have three children together. Robert has been a U.S. Marine for 12 years and Cindy is a nurse at a local hospital. Robert recently returned from his third seven-month combat deployment to Iraq. While in Iraq, Robert was involved in numerous firefights with enemy forces. He came close to being shot on several occasions and saw some of his closest friends injured and/or killed. He described feeling helpless and powerless in helping “his brothers,” who he described as “the only people he could completely trust.” He became increasingly angry over time—angry at the war, at the enemy they were fighting, and at himself for not being able to save the lives of those he relied upon and felt closest to. It became increasingly difficult to sleep and eat. His mind was always reliving the traumatic events and he became consumed with the desire to kill enemy insurgents in an effort to avenge the death of his friends.

Robert returned home still angry and bitter. Cindy knew from personal experience and talking with other spouses that Robert’s return would be stressful and complicated. She knew they would both need time to adjust to each other and their life together. She just didn’t realize how difficult it would be. Robert was having a lot of trouble sleeping, averaging only two or three hours of sleep per night. He would often wake up in a pool of sweat, shouting, screaming, or crying in what appeared to Cindy to be a state of intense panic. When she tried to talk to him, he would tell her to just get away from him, that she wasn’t a Marine, and because she had never been in combat she could never understand what he was going through. They both felt extremely alone and were unable to turn to each other for the emotional support they needed and longed for. They did not have a secure attachment and resulting safe haven that couples need. Cindy described feeling very afraid and felt that she had to

walk on egg shells around Robert. This tension was quickly felt by the children who did not understand why Robert was always angry and why their parents were fighting all the time.

As the anger and tension continued, Robert became increasingly isolated and Cindy and the children avoided him as much as possible. Robert’s drinking also increased dramatically as he sought to escape or numb-out. Cindy was feeling extremely alone and isolated from her husband. She remarked to a male co-worker that Robert was not the same man she had married and that she didn’t feel that she was in love with him any longer. An emotional and eventually sexual relationship developed between Cindy and the co-worker. Cindy stated that she feels understood by this man, and that he makes her feel important and loved. With Robert, she says she feels invisible.

Johnson, Makinen, and Milliken (2001) describe attachment injuries as a situation in which one partner experiences a sense of betrayal or violation resulting from the other partner failing to offer care and comfort in the face of distress. In the case illustration, a series of escalations or threats to attachment security occur. For example, when Robert returns from combat, Cindy reaches for him in an attempt to draw closer to him, only to be pushed away and to have her efforts discarded. Cindy experiences this rejection as betrayal. Further betrayal and attachment stressors occur when Robert begins drinking excessively, spending time getting drunk instead of spending time with Cindy and the kids. This makes Cindy feel unappreciated, unloved, and unimportant. Similarly, Cindy finds comfort in the arms of a co-worker, a man who is reaching out to her physically and emotionally during a time of greatest need. Although it feels good now, it will ultimately have devastating effects upon her marriage.

For Robert, the adaptations he made for deployment now leave him feeling confused and disoriented at home. Without the same sense of purpose and his comrades close, he reports feeling a bit lost and misunderstood. He knows

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he’s different, but he is still making sense of how different he is and how this impacts his wife and family.

Treatment

Well-designed couples therapy has the potential to help service members cope more effectively with trauma-related distress, to assist partners to understand and empathize with confusing behavior, and to strengthen intimate relationships (Sherman, Zanotti, & Jones, 2005, p. 626). The interactional dynamics between the service member and his or her family are complex at best.

The inclusion of family members in treatment increases the likelihood of creating positive, enduring change. Without helping the veteran address his individual trauma-related issues and simultaneously altering the family’s expectations of and ways of interacting with him, families will continue to engage in familiar, dysfunctional patterns (Sherman et al., 2005, p. 627)."

Johnson (2002) adds, “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 cited in Sherman et al., 2005, p. 627).

In treating a couple such as Cindy and Robert, it would be critical to build the necessary level of rapport with each partner—an alliance that is built upon mutual trust, respect, and acceptance. This is especially important considering the stigma associated with receiving mental health assistance in the military. Hoge, Castro, Messer, McGurk, Cotting, and Koffman (2004) discovered that less than half of service members returning from combat in need of mental health care actually asked for it, and a much

smaller number actually received it. Because of stigma, service members are less likely to seek help, and if they do, they may prefer to go outside the military system, even if they have to pay for it themselves.

Regardless of where the service member goes for help, it is crucial that the therapist has knowledge of the military organization and its unique culture. He or she should not try to fake an understanding of what military service, particularly combat, is like. Service members and veterans will spot this immediately, and any trust that has been developed will be permanently destroyed. When unsure, therapists should take a one-down position and allow the service member to educate them on the specific issue or concept. This is even true when counseling individuals from different branches of service. Each branch has its own unique way of doing things, and in many ways, is a subculture of its own.


Emotion-focused therapy (EFT), as developed by Johnson (2004), can be extremely effective in treating military couples impacted by war and the trauma of combat. This model consists of nine steps contained within the following three stages: (a) de-escalation of negative cycles of interaction; (b) changing interactional positions; and (c) consolidation and integration. The premise of the model is that couples get stuck in dysfunctional patterns of interaction as a result of attachment styles that develop beginning in childhood and are built upon in subsequent years, as well as specific events that stress or injure the attachment security of the couple relationship.

EFT synthesizes experiential and systemic approaches, combining the intrapersonal and the interpersonal. The EFT therapist

helps partners to reprocess their emotional experience and uses emotional expression to create a shift in their interactional positions. The EFT therapist also directs and choreographs new interactions, which evoke new emotional responses in the partners (Johnson, 2004, p. 16).

An EFT therapist working with Robert and Cindy would try to identify the dance or attachment cycle in which the couple is likely stuck. This cycle typically consists of one partner taking on a more critical, blaming, or aggressive pursuer role, while the other partner takes on a more defensive withdrawer role. As the cycle begins to unfold through the manifestation of overt behavior, the therapist can identify primary and secondary emotions, as well as the unmet attachment needs of each partner.

In the given case, Cindy seems to be the pursuer and Robert the withdrawer. This is a complex case because Cindy started out pursuing Robert following his return from Iraq, subsequently became burned-out in the process, and ultimately became what is commonly referred to as a burned-out pursuer. Robert, on the other hand, responds aggressively, but does so within a defensive posture, thus making him a defensive withdrawer. The cycle then looks something like this: Robert comes back from Iraq and is unusually quiet or withdrawn. He attempts to isolate from Cindy and the kids, becomes easily provoked, frustrated, and irritable. He is feeling alone and is experiencing guilt associated with friends that were injured and killed in combat. Cindy attempts to reach out to Robert, to talk to him, and to console him. As he pushes her away, she is left feeling confused, alone, and rejected. Robert becomes increasingly angry, isolates himself even more from the family, and



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begins drinking to emotionally cope and escape. He doesn't feel that Cindy can understand what he is going through, and as a result, feels increasingly lonely. He doesn't feel that anyone except his fellow Marines can understand what he is feeling. He begins to believe that the best thing he can do is return to Iraq. Cindy feels unappreciated, rejected, and unlovable. She questions whether the marriage can work, whether she really wants it to work, and what has happened to her husband. She withdraws into a relationship with a co-worker in an attempt to feel important, cherished, loved, and visible.

The EFT therapist helps each partner attend to and organize their underlying vulnerabilities and feelings that fuel their respective part in the cycle. This helps the withdrawn partner see the pursuer as afraid rather than threatening, and the withdrawn partner as lonely and rejected as opposed to uncaring. When they hear the softer sides of their partner's experience, this sharing pulls for a different, more compassionate response from the partner.

Once the cycle is defined, it becomes the problem as opposed to the spouses themselves being the problem. This dramatically lowers the level of blame within the cycle and gives the couple a common goal from which to begin to connect. An EFT therapist would capture, highlight, and even intensify the emotion experienced by the couple

in order to help each spouse better understand the unmet attachment needs of the other. For example, the therapist might highlight Robert's frustration and irritability so that he can convey the feelings of loneliness and guilt he is experiencing to Cindy. This allows Cindy to see Robert in a different light and to experience his irritability and frustration as something other than not caring about her. Similarly, the therapist would highlight Cindy's attempts to reach out to Robert and her subsequent confusion, loneliness, and rejection. By doing so, the therapist can help Robert experience Cindy in a different way, as a wife who loves him, cares deeply about him, and wants to draw close to him in a loving and supportive way. This is dramatically different than the smothering or controlling manner he currently views her.

As each spouse's attachment-oriented emotion is highlighted, the therapist works with the couple to deescalate the dysfunctional cycle through an acknowledgement and understanding of this cycle, as well as an acceptance of the partner's underlying emotions, needs, fears, and desires. The therapist then creates bonding events through relational enactments and ultimately works to develop a new, more functional way of interacting with one another through a process referred to as withdrawer re-engagement and blamer softening (Johnson, 2004; Johnson, 2002).

Conclusion

The connection and comfort found in a loving marriage is a powerful antidote to combat stress and is a preventative factor in the development of post traumatic stress. Soldiers with positive secure relationships recover from stressful deployments more easily and have less anxiety and depression after potentially traumatic events. Emotional isolation, on the other hand, exacerbates the aftermath of stress and trauma for the soldier and his or her partner. The transition and readjustment of homecoming is also a critical period for the future of family life and health and the future of the marriage. Extensive research now demonstrates that secure emotional connection with a significant other is a powerful source of resilience and impacts physical and mental health.

The goal of EFT is to help the couple become emotionally accessible to one another, to be able to turn to the other, sharing vulnerabilities, and trusting that the other will be there. Through this process, the couple can share their longings for each other, as well as their fears, needs, wants, and desires in a way that provides a safe haven of attachment. Military couples impacted by the trauma of war are in a very delicate place. Deployment and combat activate their attachment needs in ways that are hard to imagine for civilian mental health professionals. As therapists, we have an enormous responsibility to those who defend our freedom. Treating these couples from a systemic perspective only makes sense. By mending the shattered heart and attachment bond, real healing can occur—for the individual, the couple, and the family. ■



Michael D. Howard, EdD, LMFT, LPC, LMHC, LCAS,

earned his doctorate in counseling psychology from Argosy University. He also has earned master's degrees in professional counseling, addiction psychology, and marriage and family therapy. He holds licenses as a marriage and family therapist, mental health counselor, clinical addictions specialist, and professional counselor. Howard is certified as a clinical mental health counselor, master addiction counselor, and sex addiction therapist. He is a Clinical Member of the AAMFT and teaches in both the graduate MFT program at Northcentral University and the undergraduate psychology program at Campbell University. Howard is an active duty Navy Chaplain assigned to Naval Hospital Camp Lejeune in Jacksonville, NC.



Kathryn Rheem, MS, LCMFT,

is a licensed clinical marriage and family therapist, certified EFT therapist and supervisor, and has worked extensively with combat-related trauma and the impacts of high stress on couple relationships. She has worked with military service members and their families at Fort Belvoir, VA, and is currently the director of The Couple & Family Therapy Center, LLC, located in Bethesda, MD, which serves military and civilian couples. Rheem presents EFT internationally and, along with Dr. Sue

Johnson, is a founder and director of Strong Bonds, Strong Couples, LLC, which provides EFT-based weekend retreats for soldiers coming home from Iraq and Afghanistan and their spouses. She is an AAMFT Clinical Member.

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