The Effect of EFT on Couples Dealing with Trauma

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-Crystal Nelson
Abstract

This literature review examines the effects of Emotion Focused Therapy (EFT) on couples dealing with trauma. The research focused on marital relationships and the application of EFT on couples who met criteria for experiencing marital distress. A majority of the research focused predominately on five main categories of variables: PTSD, significant experiences of trauma in couples, EFT on certain populations, processes of EFT and attachment. The studies mainly support the claim that there is a significant difference in relationship satisfaction between distressed couples who received EFT than those whom have not. Overall, the research found that EFT demonstrates efficacy in creating safety, security and comfort in intimate relationships. As such, EFT is shown to address patients’ and partners’ experience of trauma as well as interactions in the relationship (Rolland, 1994).
The Effects of Emotion Focused Therapy on Couples Dealing With Trauma

Experiences of trauma and the diagnosis of posttraumatic stress disorder (PTSD) is now one of the most heated topics in the fields of psychology and couples therapy due to Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). Research further reveals that there is a rising percentage of PTSD diagnosis (The VHA Office of Public & Environmental Hazards, 2005) which allows for rising difficulties in intimate relationship leading to separation or divorce. Servicemen do not seek treatment for mental health issues nor couples therapy related to trauma due to a concern over how they will be perceived by their fellow veterans or partners (Hodge et. al., 2004). These are major problems. This lack of follow up combined with the stigma veterans face when seeking assistance not only inhibits the diagnosis and treatment of PTSD in veterans but it leads to increased risks of marital problems. Therefore, a thorough review of the literature and process of clinical assessment on couples dealing with trauma or PTSD and Emotion Focused Therapy (EFT) suggests the need of EFT for populations such as veterans and their partners dealing with trauma or PTSD.

Veterans and Servicemen

Those involved in these conflicts include active duty members of the Army, Marines, Air Force, and Navy along with members of the Reserves and National Guard (Government Accountability Office [GAO], 2004). The training soldiers receive in preparation for war, does not address the continuing scope of what they will face in combat nor about their integration back into the family. OIF and OEF servicemen and veterans are obtaining an unacceptable level of health care and disability services across the continuum of care from the VA Medical Care System. When a soldier returns home, they participate in a short debriefing process but are then left to deal with the readjusting to civilian life or family life on their own.
The experiences of trauma or the symptoms of PTSD and the challenges that go along with them in psychosocial functioning makes it important for researchers to find effective treatments for reducing or solving the problems that go along with the symptoms. It is important to understand the symptoms of trauma. PTSD is a psychiatric disorder that can occur following a traumatic experience or witnessing a life-threatening event such as military combat, natural disaster, terrorist incidents, serious accidents, or violent personal assaults like rape (NCPTSD, 2005). Thirty percent of those who experience PTSD will go on to develop a more chronic form of the disorder that will last throughout their lifetime.

In 1980, PTSD was added to the Diagnostic and Statistical Manual of Mental Disorders third edition (DSM–III) (NCPTSD, 2005). This was met with a lot of controversy; it is the only psychiatric problem whose symptoms are said to originate from external events and not from an internal cause (Matsakis, 1996a). According to the current DSM-IV, in order to be diagnosed with PTSD a person must first meet the “Stressor Criterion” meaning they have “been exposed to a traumatic event involving an actual threat of death or injury, during which you respond with panic, horror, and feelings of helplessness” (Matsakis, 1996a, p.16). After the event, the person must experience symptoms in three categories, or “clusters”, including intrusive recollections, avoiding or numbing symptoms, and hyper-arousal (NCPTSD, 2005).

PTSD can be acute or delayed onset, with acute occurring within 6 months of a traumatic event. Delayed onset PTSD can occur any time after 6 months and throughout a person’s life (Matsakis, 1996a). It may last for a short period of time, or it may become chronic, lasting for months or years. Chronic PTSD usually cycles between periods with high levels of symptoms followed by a decrease or remission period; however, some persons may experience symptoms that are consistently severe for long periods of time (NCPTSD, 2005). Along with the DSM-IV
evaluation for PTSD, the Clinician Administered PTSD Scale (CAPS), the Structured Clinical Interview for DSM (SCID), the Anxiety Disorders Interview Schedule – Revised (ADIS), the PTSD- Interview, the Structured Interview for PTSD (SI-PTSD) and the PTSD Symptom Scale Interview (PSS-I), are also used to assess if a person is experiencing PTSD.

In 2000, The DSM-IV was revised in defining the criteria for PTSD. The new revision states that he or she has to experience, observe, or be confronted with a perceived traumatic event threatening serious injury, physical integrity of self or others, and/or death. He or she must experience triggers with extreme fear, helplessness or horror. He or she must also re-experience the emotional, physiological, and psychological effects of the traumatic event in particular ways. At least one of the following symptoms are usually experienced: recurrent recollections of the trauma, intrusive images, thoughts or perceptions of the traumatic event, nightmares, delusions hallucinations, episodic dissociative flashbacks, and severe psychological and/or physiological distress. He or she would persistently avoid situations, triggers, thoughts, feelings, and/or individuals similar to the trauma. He or she blocks out certain aspects of the traumatic event and loses interest in participating in daily activities. He or she will feel detached from others, display emotional detachment and a low range of affect, have insomnia and loose concentration, irritable, and display extreme anger. He or she must have been struggling with such symptoms for a minimum of one month, with this disturbance causing significant impairment in his or her activities of daily living (American Psychiatric Association, 2000).

An Adlerian theorist (Strauch, 2001) states that what is important is the perception of the trauma. It is noted that we are creative individuals and have varied responses to one event. Resembling studies relate the level of trauma exposure to the amount of posttraumatic distress. PTSD specialists (Barker & Hawes, 1999), who provide individual treatment, contrasted two
types of trauma: Big-T trauma that happens as one perceives a threat to the life of oneself or another person. And Small-T trauma is made up of small negative events in a typical day. Small-T trauma occurs in early childhood that would contribute to negative lifestyle beliefs.

Overview of the Effects of PTSD on Couples

When a person suffers from PTSD it has been shown that 88% of men and 79% of women and even their partners will experience other psychiatric and/or physical problems (NCPTSD, 2005). Psychiatric problems include depression, disassociation, anxiety disorders, phobias, conduct disorders, and panic disorders often occur along with PTSD. Those suffering from PTSD also report a large number of physical symptoms including chronic pain with no medical basis, stress related conditions including chronic fatigue and fibromyalgia, stomach pain and digestive problems, eating disorders, asthma, headaches, muscle cramps, low back pain, cardiovascular problems, and sleep disorders (PTSD Alliance, 2005). PTSD is associated with possible neurobiological and physiological changes, such as “altered brain wave activity, decreased volume of the hippo campus, and abnormal activation of the brain” (NCPTSD, 2005). These symptoms can affect the body’s fear response and person’s memory ability. Along with these internal changes, people who experienced trauma or PTSD also have difficulty in interpersonal relationships, employment problems, and increased involvement with the criminal justice system (NCPTSD, 2005). Despite the limitations of what the VA has been providing for individuals dealing with trauma, this study will briefly focus on couples dealing with trauma.

Overview of the effect of PTSD on Couples

The effect of PTSD on couples can be devastating. Experiencing trauma can interfere with trust, emotional closeness, communication, appropriate levels of assertiveness, and effective problem solving. There is also a loss of interest in social and sexual activities, excessive anger,
emotional distance, and numbness makes it difficult to maintain closeness in relationships (NCPTSD, 2005).

One major symptom of trauma or PTSD is dissociation, whereby the sufferer tends to cut off emotionally from those who are the very ones who can help them process what they have been through (Hodge et al., 2004). Soldiers may push away their spouses, causing more stress and strain on the relationship. Many of the effects of untreated trauma and PTSD could be remedied through EFT where the problem(s) can safely be acknowledged. Often those returning from combat zones feel on guard, worried, irritable, paranoid, and are startled easily, causing them to avoid social situations and are unable to relax (NCPTSD, 2005). This can cause partners to feel tense, pressured, and controlled. Sexual desire is often greatly diminished, and nightmares make even sleeping in the same bed difficult (PTSD Alliance, 2005). Flashbacks and memories can make living with someone who experienced trauma highly stressful as it is hard to know when flashbacks will occur and what effects they will have. Trauma makes it difficult to maintain a healthy relationship, especially when the couple is not receiving couples therapy because of the stigma that goes with the diagnosis process.

**Effects on Spouse**

Trauma directly affects spouses. In 2002, Calhoun, P, Beckham, J. and Bosworth, H. published a controlled study that focused on distress in partners of veterans with PTSD. In a sample of seventy-one partners of Vietnam War combat veterans, partners of patients with PTSD experienced more caregiver burden and poorer psychological adjustment over partners of veterans without PTSD. The severity of PTSD and higher levels of domestic violence were also found to be associated with increased caregiver burden. Following studies like this, researchers
acknowledged that they needed to reduce caregiver burden and help partners cope more effectively with the demands of living with individuals who have PTSD.

Riggs, D., Byrne, C., Weathers, F., and Litz, B. (1998) provides evidence of why marital counseling needs to be implemented in the VA Care System. There is evidence that the male soldier’s trauma and post-traumatic stress symptoms are transferred to their female partners. The couples experienced adverse psychological and functional adjustment problems. The study illustrated that there is an emotional toll on couples dealing with trauma. Around seventy percent of the couples with PTSD showed clinically significant levels of relationship distress compared to thirty percent of the non-PTSD couples. The intimate relationships with PTSD reported a wider variety of problems including more problems in their relationship, diminished intimacy and more steps towards separation and divorce in comparison to non-PTSD couples. Additionally, these spouses faced the challenges of trauma along with depression (repressed anger at their spouse and themselves are mixed with guilt). These vicious cycles were also strongly correlated with the degree of PTSD symptoms like emotional numbing. The results of this study show the severity of trauma on intimate relationship and on each individual’s ability to cope with the effects of the trauma. Therefore, EFT couples therapy is identified as an important and necessary part of treatment.

Overview of Literature Review

This literature review examines 17 empirical research articles from 1985 to 2006 regarding the effect of EFT on couples dealing with trauma. Thus far in this review, 2 articles focused on trauma in couples (Calhoun et al., 2002; Riggs et al., 1998). Most of the articles focused on EFT, 6 studies focused on principles of EFT, 2 studies on EFT for parents with
chronically ill children. One study was on EFT on adult survivor of child abuse and 4 studies focused on change in EFT. And 2 studies focused on therapeutic alliance

**Overview of EFT**

Emotionally Focused Couple Therapy (EFT) was established in the early 1980’s (Johnson & Greenberg, 1985; Greenberg & Johnson 1986) from a humanistic point of view in response for a demand for more clearly validated and structured couples interventions. Emotion Focused Couple Therapy focuses on the essential importance and significance of emotion and emotion communication in the organization of patterns of interaction and key defining experiences in close relationships. EFT focuses on emotion as a powerful agent for change (it is not just a part of marital distress).

What should be noted is that Emotion-Focused Therapy (EFT) for couples provides therapeutic opportunities for partners to experience and express feelings about problems and develop intimacy. EFT focuses on reshaping a distressed couples structured, repetitive interaction patterns and the emotional responses that evoke these patterns and works on developing a secure emotional bond. EFT is a combination of experiential and family systems psychotherapy with a focus on understanding marital distress and examining individual differences (Johnson, 1996). Reviewing several study outcomes, Emotion-focused therapy is now the most empirically validated approach.

The goal of EFT is to reprocess experiences and reorganize interactions to create a secure bond between partners- a sense of strong connectedness. The focus is always on safety, trust, contact with one another and on any obstacles that may impair connectedness and attachment. The goal is for couples to talk and connect during vulnerable and distressed moments. Emotionally charged moments are the focus; not personality flaws or unconscious
intrapsychic conflicts. EFT clinicians also see relationships as a bond rather than a rational bargain so they work to build more of a secure bond so that issues become more clear and less burdensome because they are not intoxicated by attachment conflicts and insecurities (Johnsons, 2004).

As described in Greenberg and Johnson (1988), EFT focuses on accessing, expression, and acceptance of affective experience in partners. There are nine steps of EFT. Briefly, the nine steps are (1) create a safe and secure base while investigating conflicts and facilitating care between partners (2) identify negative patterns of interaction (3) uncover feelings and unmet needs during interactions (4) reframe the problem(s) externally (5) identify disowned needs and aspects of self (6) encourage acceptance by each partner of the other partner’s experience (7) restructure new interactions (8) establish new solutions and (9) consolidate new positions.

The best-specified and empirically validated form of marital therapy is EFT (Alexander, Holtzworth-Munroe, & Jameson, 1994). According to Johnson & Greenberg (1994), EFT helps partners to surface their emotional responses to each other and through that process, change their interaction patterns to improve their emotional responses for more secure attachment. Overall, the research found that EFT was effective in reducing individual symptoms of PTSD and distress in marital relationships. In addition, studies comparing different types of couples therapy outcomes with EFT found that EFT would be a strong complimentary.

**Efficacy of EFT on Couples**

Recently, the role of emotion in marital distress and couple therapy has become much more accepted (Gottman, 1994). The key role of emotional regulation and engagement in marital happiness and distress (Johnson & Bradbury, 1999 and the emotional nature of human attachment (Bowlby, 1988, 1991; Johnson, 2003) has become more elaborated.
The first randomized trial of the effectiveness of EFT conducted in the United States tested couples in a training clinic. Denton, W., Burleson, B., Clark, T., Rodriquez, C. and Hobbs, B. (2000) studied the effectiveness of EFT on forty married couples placed in eight week session of EFT and compared them to another group of couples who were put on an eight-week long waiting list. The study included novice couples therapists and was the first outcome study where EFT was unconnected to its originators of the EFT model. After the 8 weeks, participants in the immediate treatment group had significantly higher scores of martial satisfaction than those who were waiting list (WL) participants. As the means in significant effects for treatment status imply, $f(1,49, p<.02, r^2 = .27)$, participants completing eight sessions of EFT were significantly experiencing more marital satisfaction at posttest than the WL group.

EFT was empirically validated so there were suggestions for further research to unveil how change occurs. Greenberg L., Ford, C., Alden, L and Johnson, S. (1993) focused on three previous studies to examine clinically significant change in EFT. Studies of change in the sessions of EFT demonstrated couple’s conflict interactions were higher at the beginning than at the end, that conflict events (“peak” sessions) changed or affected affiliation (“poor” sessions) from the beginning to the end of treatment ($\chi^2[3,N= 932]= 44.13,p<.05$) and when the therapist encouraged intimate self-disclosure, there was greater affiliation.

The first study focused on EFT on distressed couples seeking treatment from session one to session eight (Johnson, S. & Greenberg, L., 1985a; Johnson, S. & Greenberg, L., 1985b). The study was previously recorded sessions of couple’s therapy. This study’s focus was to find if couples were showing different forms of change from the beginning to the end of treatment. The study also focused on reciprocal hostility from the beginning to end of treatment. The results compared Session 2 of the control group and Session 7 of the experimental group. There were
significant findings found in hostile behaviors (t = 1.88, p < .05), in autonomous affiliative behaviors (t = 1.77 p < .05), in affiliative other-focused behaviors (t = 2.03, p < .05) and in affiliative self focused behaviors (t= 1.88, p < .05). Significant differences were also shown in the expected direction of treatment process: on hostile sequences (t= 2.85, p < .05), hostile complementary sequences (t= 2.85, p < .05) and hostile reciprocal sequences (t = 2.15, p < .05).

The second study examined how conflict events (“peak” sessions) in session changed or effected affiliation (“poor” sessions) (Alden, L., 1989). Results showed more affiliative interactions among couples at the end of treatment than at the beginning. The degree of affiliation between peak and poor sessions in the four quadrants suggested significantly differences in peak and poor sessions (χ2 [3,N= 932]= 44.13,p<.05. As predicted, there were significant affiliative scores in the control segment (t = .54). The results from the second study suggests that taking a self-focus, turning inward to one’s experience for information, about one responses to situations and accepting the other in a friendly manner is crucial for resolving conflict (versus focusing and blaming others).

The third study examined the role of intimate self-disclosure in couple therapy (Ford, 1989). The study found that couples in EFT responded affiliatively when a therapist facilitated intimate self-disclosure in each partner. After self-disclosure, the percentage of affiliative codes was 90% compared to the control’s 45%. These differences strongly support the notion that radical changes happen when the listener responds to the partner after the other partner intimately self-discloses in therapeutic setting.

Further studies were performed to compare differences in approaches for couples therapy. One study compared couples receiving two marital therapy interventions: Systemic Therapy (IST) and an Emotion Focused approach (EFT) (Goldman, A. & Greenberg, L., 1992). Couples
who responded to a newspaper article and were randomly assigned to either of the two treatment groups (EFT or IST). The study included a control group (CG) who were tested after a ten-week period and then were provided with martial therapy.

Those from both IST and EFT groups were found to be superior to the control in facilitating conflict resolution, alleviating marital distress, goal attainment and reducing complaints by the final session. From the end of therapy to a 4-month follow-up, IST couples showed greater gains of marital satisfaction and goal attainment.

There were other recent studies that presented the findings of couples therapy and compared scores between CTMD, CTMD+C and random psychotherapy scores of behavioral marital therapy (from Shadish et al., 2000 & 2005). Wright, J., Sabourn, S., Mondor, J., McDuff, P. and Memodhoussen, S. (2006) examined fifty published couples therapy outcome trials including thirty-four couple therapy outcomes studies for marital distress (CTMD) and sixteen couple therapy outcomes studies for comorbid relational and mental disorders (CTMD+C) up to September 2004 via PsychINFO. The studies were performed to examine several therapeutic approaches such as behavioral or cognitive behavioral, emotionally focused, insight-oriented and systemic. The outcome of this study showed that clinical representations of couples therapy outcome studies are only fair. The studies that obtained mean clinical representativeness scores higher that 5.0 on the midpoint of a 0-10 scale was 17.6% for CTMD and 50% for MTMD+C studies. Therefore, MTMD+C studies scored superior to CTMD studies on many clinically significant dimensions. The mean total score for clinical representation reached 4.68 (SD=1.45, Md=4.90) for CTMD+C and 3.96 (SD=1.73, Md= 3.66) for CTMD studies.

Although many of the articles reported on the effectiveness of EFT on trauma involving married adults, recent studies have focused on populations involving parents and chronically ill
children. Gordon Walker, J., Johnson, S., Manion, I., Cloutier, P. (1996) showed the effectiveness of EFT on parents with chronically ill children. Thirteen couples with chronically ill children received EFT to evaluate significant differences in marital satisfaction. This study demonstrated the effectiveness of EFT on the parent’s depression and the “burden” experienced with illness in these families. P. Cloutier, I. Manion, J. Walker, and S. Johnson, (2002) showed the long term benefits of EFT. This study presented a two-year follow-up of a randomized control trial that assessed the effectiveness of EFT in couples with a chronically ill child. Thirteen couples with chronically ill children who received previous treatment were assessed. The results showed that marital satisfaction was maintained and was even enhanced in certain couples. More specifically, 76% (10 couples) improved or recovered at post-treatment and 61.5% (8 couples) had improved or recovered 2 years post-treatment.

After there were studies performed on parents with chronically ill children, there is more of a focus on ways EFT alleviates trauma in adult survivor of childhood trauma (Paivio and Nieuwenhuis, 2001). The study examined the effectiveness of EFT with 32 adult survivors (EFT-AS) of childhood abuse. The objective of this study was (1) to evaluate the effectiveness of EFT-AS and (2) to obtain the emotional process that affects change. The EFT-AS psychotherapy had its foundations in emotion theory and experiential theory. The criteria for being a client with childhood abuse included clients who experienced emotional, physical and sexual abuse. The 20 week long study provided a quasi-experimental design in which participants who met a certain criteria for EFT-AS showed significant improvements comparable to the immediate therapy group. EFT-AS consisted of six tasks: (1) create a safe and objective therapeutic relationship by responding empathetically to the client’s abuse, (2) open up to the emotions resulting from the abusive experience (3) resolve issues with the perpetrators (4) role play an imaginary
confrontation with the perpetrator (5) edit or reframe views of self, others and of the abusive event(s) (6) another imaginary confrontation to have a sense of reconciliation over the abusive situation. EFT-AS proved to make statistically and clinically significant improvements in client’s disturbance such as symptoms of PTSD, abuse-related problems, self-affiliation and interpersonal problems.

The clients who participated in EFT-AS achieved significant improvements in multiple areas of disturbance or distress. The clients who received EFT-AS after being on a waiting list showed small gains while waiting for treatment but after receiving EFT-AS treatment, they showed significant improvements equal to that of the first immediate group who received EFT-AS.

In several studies on EFT outcomes, clients acted as their own controls but in one clinical trial the focus was on predictors of success in EFT (Johnson, S., & Talitman, E., 1997). Researchers studied the client variables that are predictors of success for significant marital satisfaction outcomes. Couples were recruited from a newspaper advertisement that wished to improve their relationship. Thirty-six couples were admitted. The mean pretreatment level of marital satisfaction was 88 on the DS (range 68-97, SD= 7.9); therefore the couples fell into the criteria of being moderately distressed. In the study, therapists and clients were accessing and reprocessing each partner’s emotions during experiences. In detail, each partner’s perspective and needs were addressed during interactions so that a shift is made to increase the accessibility and responsiveness of each partner. In terms of the percentage of couples who recovered, (scoring on the non-distressed range) the study found that there were rate of 70-73% recovery from relationship distress in 8-12 sessions (Johnson & Greenberg, 1985; Johnson & Talitman, 1997).
To date it has been proven that EFT is effective, but there were issues raised with how therapeutic alliance forms and impacts the process of change and therapy outcomes. Several studies considered this empirically (Greenberg & Johnson, 1988; Knobloch-Fedders, L., Pinsof, W., and Mann, B., 2004). In Knobloch-Fedders (2004), the study examined the outcome of several clinical variables like marital distress, individual symptomatology and family-of-origin experiences to predict therapeutic alliance in integrated psychotherapy. They found (a) marital distress predicted a strong therapeutic alliance with men at session 1 and for women at session 8, (b) family-of-origin dysfunction predicted therapeutic alliance for men at session 1 and for women at session 8. Two variables such as women’s trust in their partner’s care and therapeutic alliance were strongly correlated with successful outcomes in EFT. These variables were more dominate than a variable such as an initial distress level. There were eighty participants who had finished at least eight sessions of marital therapy were compared with eighty eight others who were tested at session one but ended before session eight. Participants who completed at least eight sessions rated their alliance with their therapist significantly higher on the CTS-R Total scale (X=3.86, SD=.41). While those who ended before session eight scored (X= 3.71, SD=.43) t(146)=2.20, p=.029 (Knoblach-Fedders, 2004).

Attachment theory has been applied to adult love relationships and has been researched in EFT for change process. A comprehensive review is beyond the scope of this literature review, however, The EFT model suggests that the cause of marital distress is in experiences of negative emotions about self or others and the rigid, negative interactions. The foundations from this negative affects are associated with a “wired in” evolutionary survival system. Attachment theory states that seeking and staying in an irreplaceable relationship is a primary goal of human beings that provides people with a safe haven in a chaotic world (Bowlby, 1988). An empirical
study examined attachment styles for adult love (Hazen, C., & Shaver, P., 1987). One questionnaire and another replication questionnaire showed results that (a) the three attachment styles are roughly the same in infancy and adulthood (b) the three kinds of adults experienced romantic love differently (c) attachment style is associated clinically with views of self and social relationships. Analyses were based from the first questionnaire: 620 of over 1,2000 replies in one week after publication were used for the questionnaire and one hundred eight undergraduates (38 men and 70 women) who were enrolled in a course entitled Understanding Human Conflict completed the second questionnaire. Significant findings in the two questionnaires were (a) there were 56% secure (vs. 56% of newspaper respondents); 23% avoidant (vs. 25%); and 20 % anxious/ambivalent (vs. 19%) (b) “It is easy to fall in love” was endorsed by 32% of anxious/ambivalent, 15% of the secure and none of the avoidant subjects and item 7 (“It’s rare to find someone” was endorsed by 80% of the avoidant, 55% of the secure and 41% of the anxious/ambivalent subjects (c) in the differences of the mental models attachment styles: secure objects thought they were easy to know and that others had good intentions. The anxious/ambivalent subjects reported more self-doubts, being misunderstood and found others less willing and able to commit to a relationship. The avoidant subjects fell between the extremes set by the secure and anxious/ambivalent subject. These implications suggest that romantic love is an attachment process designed by evolution to develop and maintain attachment between two adult sexual partners. This is precisely the approach of EFT tries to accomplish!

Methodological Considerations

The methodology section is important in describing definitions, sampling, procedures and design. Research methodologies are essential for producing research with meaningful and valid
results. This section is designed to examine the accuracy of the studies that were performed in the research of treated PTSD on Marital therapy outcomes. This section examines measurement tools, discusses design and shows how data may be skewed by misrepresentation. For the record, all EFT studies have included treatment integrity checks and have very low attrition rates.

Though many of the articles defined marital distress as the criteria of their study, research differed in how investigators identified and measured participants who met criteria for experiencing marital distress. Dyadic Adjustment Scale (DAS) forms were widely used in the studies that measures levels of satisfaction, cohesion, affection and consensus in the marital relationship. In the original study of the DAS, scores that were below 97 represented one standard deviation below the mean of married participants who experienced marital satisfaction (Spanier, 1979). Several of the studies used the DAS as a pretest (Denton et al., 2000, with couples in an EFT training clinic; Greenberg et al., 1993, with a study focusing on change in distressed couples; Goldman, A. & Greenberg, L., 1992, with couples receiving both IST or EFT; Johnson, S., & Talitman, E., 1997 used therapist ratings of DAS factors and focused on predictors of success for distressed couples; Cloutier, P. et al., 2002, with couples who had chronically ill children).

In contrast to using the DAS, Riggs et al. (1998) used the DAS differently to assess global marital satisfaction. The study used a joint score of the husband and wife as well as husband and wife reports. In all cases, global marital satisfaction was considered over marital adjustment so less than 98 for both couple average and individual were defined as a DAS score for distress (Heyman et al., 1994). Furthermore, S. Paivio and J. Nieuwenhuis (2001) used The Inventory of Interpersonal Problems to average sources of interpersonal distress and the Resolution Scale to assess levels of resolution of past issues.
Several articles defined the diagnosis of PTSD as meeting the criteria in the DSM-IV but research differed in how investigators identified and scored participants who would meet the criteria to be diagnosed with PTSD or have experienced enough trauma. In Riggs et al. (1998) used the PTSD Checklist Military Version that corresponds to the DSM-IV diagnostic criteria. In, Calhoun et al., (2002) PTSD symptom severity was assessed with the Mississippi Scale for Combat-Related PTSD. S. Paivio and J. Nieuwenhuis (2001) used dependent measures such as the Impact of Event Scale that measures trauma-related avoidance and the Symptom Checklist-90-Revised (SCL) that measures general symptom distress. The study also used predictor measures such as the Childhood Trauma Questionnaire (CTQ) that measured child abuse and neglect and the PTSD Symptom Severity Interview that is an interview to evaluate DSM-IV criteria for PTSD. S. Paivio and J. Nieuwenhuis (2001) used dependent measures such as the Impact of Event Scale that measures trauma-related avoidance, the Symptom Checklist-90-Revised (SCL) which measures general symptom distress.

Hostility was assessed with Cook-Medley Hostility Scale that is the short version of the original Cook-Medley Hostility Scale (Calhoun, 2004). Calhoun (2004) used a violence scale of the Conflict Tactics Scale which includes behaviors of throwing something, at someone, punching, grabbing, shoving, slapping, kicking, biting, hitting, beating up or threatening with a gun or knife. While Greenberg et al. (1993) used the Structural Analysis of Social Behavior to study whether interactions were friendly or hostile on self or other focus grids.

Caregiver burden was assessed during the partner phase that was the Burden Interview (BI) that examined both objective and subjective burden that would be associated with functional/behavioral impairments and home care situations (areas of concern were in health, finances, social life and interpersonal relationships (Calhoun, 2004).
There were differences in studies with couple populations where procedures were needed for identifying and measuring intimacy. In Greenberg et al., (1993), used the Self-Disclosure Coding System was used to identify intimate self-disclosures. SDCS not only measured intimate self-disclosure but also appropriate affect. Two studies used the Miller Social Intimacy Scale (MSIS) to measure the levels of intimacy currently experienced in marriage (Johnson & Talitman, 1997; Cloutier, P. et al., 2002). Denton et al., (2000) In the methodological process, the personal assessment of Intimacy in Relationship (PAIR) assessed emotional, social, sexual, intellectual and recreational intimacy. Post-therapy testing was held one week after the last session for participants to repeat instruments that they completed at the baseline session which was the Positive Feelings Questionnaire, the Personal Assessment of Intimacy in Relationships scale and the Role Category Questionnaire to measure cognitive complexity. Ford (1989) Finally, the third study used measures from Self-Disclosure Coding System (SDCS) and Structural Analysis of Social Behavioral (SASB). The SDCS was used for measuring intimacy and intimate self-disclosure while SASB was used for measuring differentiations between affiliation and interdependence.

There were a couple studies focusing on success of EFT through therapeutic alliance. S. Johnson and E. Talitman (1997) used measures from The Couples Therapy Alliance Scale which examines bonds between therapist and client, agreement as to therapeutic goals and perceived relevance of therapeutic tasks. These dimensions are scored in relation to self, other and the relationship. A. Goldman and L. Greenberg (1992) used four independent measures from the Couple Therapy Alliance Scale, Target Complaints, Goal Attainment Scaling and The Conflict Resolution Scale. The measure design was used with the control, IST and EFT group. The measures were also used during three different periods of the treatment (pretest, posttest and
follow up). Each group was also given a measure to compare demographic data and therapeutic alliance in the multivariate analysis of variance (MANOVA) and the CTAS measured alliance between therapists and couples.

In comparison, Knoblach-Fedders et al. (2004) used measures such as COMPASS treatment Assessment System that is used to assess patient characteristics and responses to therapy. Subscales questioned in areas such as: Current Well-Being, Current Symptoms and Current Life Functioning. Other measures were Marital Satisfaction Inventory, Family Assessment Device and Couple Therapeutic Alliance Scale that is completed by each partner answering questions related to therapy tasks, goals and bonds.

A very interesting procedure of measurement was in J. Wright, S. Sabourn, J. Mondor, P. McDuff, and S. Mamodhoussen, (2006) which used the PsychINFO electronic database to review couple therapy outcome research literature and rated on a rating scale of Shadish et al. (2000). PsychINFO was used to search specific keywords to meet three criteria. The three criteria were (1) clear description of the treatment for couples (i.e. behavioral, emotionally focused, cognitive behavioral, etc.) (2) applied intervention model (3) the study used a methodology based on pre-post assessments with measures and report of data. The study also used coding to categorize therapeutic approaches, clinical orientation (CTMD or CTMD+C), designs and study results. The clinical representativeness criteria were based on a rating scale developed by Shadish et al (2000) for psychotherapy outcome studies. The scale measured the clinical representativeness of several dimensions of outcome studies such as patient problems, treatment setting, therapist experience, pre-therapy training, etc. Total scores on this rating scale are from 0 (no clinically representative) to 10 (clinically representative).

*Future Research*
All the studies reviewed previously support the fact that EFT is effective in treating both individual symptoms of PTSD and marital distress. All of the studies were favorable of EFT being an effective therapeutic approach to reducing symptoms of PTSD and marital distress; however, these studies provided many limitations. First, and foremost, future studies could include more research in regards to marital satisfaction among OIF and OEF servicemen and the causal or correlating factors of the military environment. At this point there is no empirical data that claims the effects of couple therapy on OIF and OEF veterans.

Given the complexity of trauma that OIF and OEF servicemen experience, future research is necessary to determine whether the relationship or individual problems should be addressed first. In other words, there is a complexity of traumas that a veteran may experience a combination of TBI, lost limbs and PTSD. There needs to be future research on dealing with these individual problems before addressing multiple complexities of interactions with the spouse (Riggs et al., 1998).

There also could be future replications of studies focusing on the change process of EFT. Goldman & Greenberg (1992) found several factors to consider for future research: to perform replications focusing on what principles lead to change and processes of change. The study concluded with suggestions for future research on the combination of experiential and systemic effects martial functioning; the mixed approach was hypothesized to be extremely effective for solving marital problems and improve marital functioning. Finally, IST and EFT interventions were researched under a limitation of a four- month follow- ups. Therefore, future research and replication studies were suggested to find if there are differences between EFT and IST over longer periods of time.
Ultimately, there needs to be more studies validating EFT processes and outcomes. Greenberg et al. (1993) suggests that further studies need to be performed on the process of expressing needs and feelings so that couples can change negative interactions to increase their accessibility and responsiveness. There were also suggestions to validate principles of EFT with other couple populations.

The literature stresses the need to be especially alert during assessment to issues of addiction and angry abusive behavior and to expect crises and “emotional storms” during treatment. McCann and Pearlman (1990) make the point that to work with the emotional turmoil of the survivor’s world, the therapists must have a map. In the text, future research was suggested to be on how the EFT map enables the therapist to help the survivor and his or her partner create healing relationships- a “safe haven” in a dangerous world. In addition, Paivo et al (2001) suggested that there be future research examining the emotional process of client change.

There were many studies on clinical trials of EFT where subject were acting as their own controls. However, S. Paivio and J. Nieuwenhuis (2001) suggested that limitations were on a first-come-first-served basis of subjects. The future research suggested took account that there were not extensively controlled factors in outcomes of their study (which focused on EFT on adult survivors of child abuse).

Saver et al. (1987) provided findings that love and loneliness are an emotional process that serves biological functions. For that reason, future research was suggested for examining the concepts of attitude and physiological arousal. It was also suggested that research be performed on caretaker and infant attachment.

Such issues could be examined to greatly affect an individual’s and couple’s ability to process and get relational support to process traumatic information and treat symptoms.
Therefore, especially with OEF & OIF continuing, it is critical that these issues be a strong consideration for future research and treatment at all V.A. Hospitals.

**Clinical Implications**

There is a rich variety of evidence on trauma and PTSD showing clinically significant disruptions in the individual’s intimate relationships and families. Riggs et al. (1998) showed results that this population needs to be addressed clinically. The results also suggest that relationships in which one member suffers from PTSD might benefit from interventions like EFT that improve communication and problem solving skills. The importance of these relationship difficulties is highlighted for empirical studies on EFT effectiveness because potential contributions of intimate partners add to the process of coping with chronic stress or psychological symptoms. Intimate partners usually serve as a primary source of social support and positive intimate relationships were proven to serve as a buffer when one is confronted with significant stress (Barrett & Mizes, 1988; Beiser et al., 1989; Davidson et al., 1991; Flannery, 1990; Solomon et al., 1990).

Research showed that EFT is effective in reducing trauma or PTSD and is effective in reducing marital distress. A. Goldman and L. Greenberg (1992) found that 67% of all treatment couples in their study who finished therapy rated in the non-distressed range on one or more measures of marital functioning. There were 33% of couples in the moderate range but they showed marked improvement and gains in marital functioning later on in the process of therapy. This data shows that both forms of marital therapy were significantly successful. And the study proved that EFT provided therapeutic opportunities for partners to express and experience intimacy as well as emotions.
Greenberg et al. (1993) provided results from exam three to indicate that intimate disclosures result in greater affiliative behavior in the process of treatment and that intimate experiences together leads to change in interaction. The results also suggested that change in EFT is correlated with the expression of feelings and underlying needs. This frees couples to change their negative interactions and respond more to one another’s needs.

Some finding suggested that treatment outcomes might be improved through therapeutic alliance. Knoblach-Fedders (2004) findings suggested that couples’ immediate perceptions of their therapists formed in the beginning of session 1 are strongly correlated to their decision to either stay in or drop out of treatment. Clinically, this finding suggests that alliance building may be one of the most important therapeutic tasks of the first conjoint session.

Treatment outcomes might be improved through therapeutic alliances; however, there have been others who suggested that this variable is not important. In Goldman, A. & Greenberg, L. (1992) in the multivariate analysis of variance (MANOVA) and the CTAS measured alliance between therapists and couples. The variables implied that there were no significant differences between any group treatments. The outcomes of this study suggested that benefits of therapy derived from the teamwork of several trained professionals. A type of “think tank” was found to make a greater impact long-term. The presence of a team is an integral part of treatment and through IST, it was proven that a wide variety of social psychological influences might play a huge part in the impact of marital therapy in general.

Johnson et al (1996) examined predictor of success in EFT. This study suggested EFT is most effective with older males, less expressive males and withdrawn males. The results also implied attachment and emotional engagements are key tasks: females’ trust and faith in their partner predicted satisfaction in follow up. The results of the study also indicated that practicing
EFT on Couples Dealing with Trauma

EFT therapists must focus on building strong alliances. In detail, an alliance needs to be perceived by clients.

Short-term EFT therapy is suggested to impact couples dealing with trauma and individual symptoms. In S. Paivio and J. Nieuwenhuis’ (2001) study, they found that EFT-AS achieved significant improvements in several disturbances (the average pre-post effect for EFT-AS for seven areas were 1.53 standard deviations).

Results from the study support that EFT-AS is effective in short-term treatment for the effects of different types of child abuse. EFT-AS is also supported as being a promising treatment for extremely important clinical problems.

In Denton et al.’s study (2000), participant’s posttest marital satisfaction scores were correlated with several individual differences in gender, age, income, length of marriage education, etc., It is important to note that marital satisfaction was correlated with participants’ levels of marital education. (r = -.01) and cognitive complexity (r = -.12). This suggested that participants with low levels of education and low levels of cognitive complexity may have gained the most from involvement in EFT. The path model indicates the regardless of their level of marital satisfaction at the point they entered the study (pretest), clients whose marital satisfaction increased the most over the course of the therapy were those most satisfied with therapeutic program.

Cloutier, P. et al. (2002) was the first study to examine the long-term effectiveness of EFT treatment for couples coping with chronically ill children. This study affirmed that treatment effects significantly maintained over a 2- year span. Several couples experienced a greater degree of marital satisfaction after the last session. In detail, 76.9% improved by post treatment and 61.5% either recovered or improved by the two year follow up. Given the
promising results of this study, it is crucial that maritally distressed couples with chronically ill children be referred for intervention as soon as possible. In Johnson et al. (1999), it summarized that the effect size of EFT outcome research for marital adjustment from four clinical trials of EFT calculated at 1.3. The follow up results suggest that treatment effect remain stable or improve over time.

The fact that 38% of control couples separated shows the importance of providing EFT or any marital therapy for this population. Separation may pay a higher toll on this population; making family life even more challenging to deal with.

Wright et al. (2006) presented that overall, the clinical representativeness of couple therapy outcomes studied fair. This conclusion rests on the mean total scores of clinical representativeness for marital distress (CTMD) and comorbid/mental disorders (CTMD+C). CTMD+C was superior to CTMD studies on principles of clinical relevance.

Wright et al. (2006) empirically validated that EFT’s focus on attachment makes creating secure attachments extremely relevant for couples facing trauma. This study showed data that attachment behaviors are salient to intimate relationships. This is strongly significant for couples dealing with trauma to develop and maintain strong attachment to face adversity and highly stressful situations.

Intervention

Recognizing the specialized care needs of soldier’s and family members who are coping with symptoms of PTSD, the VA must establish four Polytrauma Debriefing and Rehabilitation Centers (PDRC) to provide services such as Adlerian based individual therapy as well as a combination of Prepare & Enrich and EFT for marital, and family counseling interventions. The mission of the PDRC is to provide comprehensive debriefing and rehabilitation services to
individuals with mental health conditions from severe trauma and provide therapeutic support to their families. Intensive Prepare & Enrich (P & E), Adlerian and EFT will be essential to coordinate the components of the week long intervention, established and proposed in this integrative paper as well as continuing care for soldiers and their families after they return home to their community. The goals of this intervention will be to (1) circumvent the stigma veterans and their spouses feel when seeking treatment for PTSD in order to prevent future marital problems through Adlerian Couples Therapy, EFT and Prepare & Enrich (2) assess veterans who have spent time in combat zones and spouses who are at an increased risk for developing PTSD and secondary PTSS through Prepare & Enrich. The target population of this intervention will be men and women, between the ages of 18 – 40 who have returned from a deployment from OEF & OIF in which they witnessed direct combat. The spouses of these persons will also be involved in the intervention. It will continue over a two -year period post deployment and capitalize on the free medical care offered to veterans during this time. The intervention will consist of two phases; a lengthened debriefing and mandatory meetings with EFT, Adlerian and Prepare & Enrich trained therapists and social workers once every six months for two years. The goal of this plan is to assist the military in providing thorough EFT and Adlerian Therapy for the basic mental health needs of its soldiers and their family members, therefore promoting social justice. The ‘macho’ attitude that is praised by officers while in battle becomes a barrier when seeking treatment for mental health problems. Many, if not most, of these service members and veterans will be combat-injured and experience trauma in support of Operation Iraqi Freedom and/or Operation Enduring Freedom. The U.S. government can no longer stand by and allow those who have served our country in battle fall through the cracks due to mental health problems caused by their service.
The Veterans Health Administration [2005-017] (2005) would have to commit to provide specialized care for soldiers and their families dealing with multiple traumas at four VHA Polytrauma Centers, located at (1) James A. Haley Veterans Hospital- Tampa, FL (2) V.A. Medical Center- Minneapolis, MN (3) Veterans Affairs Palo Alto Health Care System- Palo Alto, CA (4) Hunter McGuire Veterans Affairs Medical Center- Richmond, VA. The new PolyTrauma Centers will include PDRC to provide coordinated mental-health care and marriage therapy services to active duty service members, veterans, and family members who have experienced or are caring for severe injuries and multiple traumas.

The four PolyTrauma Debriefing and Rehabilitation Centers (PDRC) will provide a retreat setting for VA social work case management services nationwide. The marital and family therapy as well as the social work case management program will provide a combination of EFT, Adlerian therapy, Prepare & Enrich Couple programs, and professional guidance, which helps military servicemen, couples, and family members rediscover the best in themselves and support each other in their relationships.

The VA established the system of social work case management with the goal of assisting active duty military and veterans and their families in progressing along the continuum of care (Appendix B, page 55) toward achieving and maintaining optimal marital relationship outcomes. Appendix B provides an overview of the different assessments that may be needed to diagnose individuals with PTSD. It, then, illustrates that the therapists and social work case manager provides continuing advocacy for the couple and ongoing marital therapy. This helpful and rehabilitating intervention program with the combination of therapists, social work case management, Prepare & Enrich support groups, seminars and resources that will give the couples the essential tools for change as they return to civilian life.
This VHA program will be enhanced through LMFT’s to provide different types of therapy to address the psychosocial needs of the soldier through the EFT/Adlerian model, advocate for the soldier and spouse and, provide supportive services for the whole family, and address marital issues and the living situation through Prepare & Enrich.

A therapist conducts a complete Prepare & Enrich assessment. There is a complete review of the test results; the couple goes through the workbook for skill building and goal reaching support later in the week (i.e. vocational and academic). After speaking with several soldiers returning from combat around the world, they stated that they receive a minimal debriefing lasting approximately 4 days, and return home to their spouses. In contrast, this intervention includes active involvement of the therapists, spouses of the soldiers, and veterans -- which is crucial to the successful treatment of PTSD and healing of any form of marital distress.

Debriefing and follow-up social work case management requires that the soldier and family will attend a paid, mandatory debriefing to obtain comprehensive services and close monitoring through case management (See Appendix B). The debriefing would last 7 days, but would include half-day programs, and therapeutic sessions. An advantage to having half days, would be that the soldiers are integrated slowly back into the civilian life.

The therapists will debrief by accessing the psychosocial, marital, and case management needs of OIF/OEF servicemen and their spouses to help the case managers identify VA and non-VA resources to meet those needs while in their community. The debriefing would access encounters of traumatic events, therapy and resources to help the family cope together.

The therapists will provide clinical services, such as EFT and Adlerian couples counseling. The social worker case manager also contacts the soldier or spouse throughout the
week to answer any questions they may have and assist them with the transition back to their communities.

The social work case managers provide a debriefing to (1) integrate the couple into therapy sessions (2) provide a family program. The Centers will provide a full-range of care for all soldiers diagnosed with PTSD and their families and/or any psychosocial problems.

During the debriefing, a morning child care camp would be provided so both spouses would be able to participate fully in the program without distractions. Afternoons and evenings would be reserved for the family to spend time together and become reacquainted. The goal of this plan is to provide the families with a structured reunification process, free from the stresses of home, and combined with the necessary education and techniques to facilitate a successful transition from combat to home life.

The second phase of this intervention will be mandatory meetings with a therapist and/or social work case manager once every six months for the first two years after deployment. Social work case management services will start on Day 5 while discharging the couple from the PDRC and continue with annual meetings offered every 6 months for 2 years to create and maintain healthy marriages and family relationships through social work advocacy. With EFT and Adlerian Couples Counseling, couples will clarify relationship issues and choices related to supporting the individual with PTSD, learn to manage conflicts while dealing with the symptoms of PTSD; learn and practice communication skills while approaching a spouse with PTSD; learn essential relationship skills and resources to cope with PTSD; learn to model healthy relationships; be aware of issues on the traumatized spouse as they return home; renew trust; practice individual responsibilities; and increase intimacy for optimal marital relationship outcomes.
Conclusion

In conclusion, a review of the empirical research on the effect of EFT on couples dealing with trauma suggested chronic illness due to trauma or PTSD affects individuals and their partners. Therefore, this review as been a particularly fruitful avenue to explore EFT interventions for this population. There is now reason to believe that EFT interventions develop more secure attachments and marital bonds. And EFT interventions facilitate intimacy with trauma survivors and their partners on many levels; it can help individuals process the traumatic experience more effectively and to re-establish a sense of safety, security, comfort and connection with others. It is worth noting that in a study of burn patients (Perry et al., 1992), it was not so much the injury or facial disfigurement that predicted the development of PTSD but the amount of perceived social support available to the victims. Positive attachment can also help to restore self-efficacy. As attachment theorists assert, “nothing fosters the confidence to utilize our own capabilities to the full more than the knowledge that when we are in a fix we are not alone” (Clulow, 1991).

Furthermore, after recognizing the specialized care needs of soldier’s and partners who are dealing with PTSD, the VA must establish Polytrauma Debriefing and Rehabilitation Centers (PDRC) to provide services such as individual interventions and EFT. Appendix A and B (pages 40 through 44) gives a structured overview of how the PDRC would provide comprehensive debriefing and rehabilitation services for individuals and their partners to recover together. Intensive clinical and social work case management services would also be essential to coordinate the components of the week long intervention as well as continuing care for soldiers and their families after they return home to their community. The goals of this intervention will be to (1) circumvent the stigma veterans and partners feel when seeking treatment for trauma in
order to prevent future marital problems (2) assess veterans who have spent time in combat zones and spouses who are at an increased risk for developing PTSD and secondary PTSS. The target population of this intervention will be men and women, between the ages of 18 – 40 who have returned from OIF and OEF deployment and experienced trauma or direct combat. EFT will continue over a two year period post deployment and capitalize on the free medical care offered to veterans during this time. The intervention will consist of two phases; a lengthened debriefing and mandatory sessions with a EFT therapist or specialized social work case manager once every six months for two years. The goal of this plan is facilitate the military in providing more thoroughly for the basic mental health needs of its soldiers and their family members.

The Veterans Administration [2005-017] (2005) should commit to provide specialized care for soldiers and their families at Polytrauma Centers, located at (1) James A. Haley Veterans Hospital- Tampa, FL (2) V.A. Medical Center- Minneapolis, MN (3) Veterans Affairs Palo Alto Health Care System- Palo Alto, CA (4) Hunter McGuire Veterans Affairs Medical Center- Richmond, VA.

This literature review does not claim to have a sole causal relationship to treating trauma. It does hope to promote more research on a much needed topic. The needs of future research to determine the influences, or determinants of EFT that could assist in a higher public acceptance of couples therapy treating both individual symptoms and couple issues and also a scientific breakthrough for veterans and their families who are dealing with PTSD. These are just a few of the implications of what more conclusive data could do or promote for all. A love relationship involves hard work; it is a responsibility we all must face. Individuals working in the helping professions will forever be in a process of building their knowledge and skills for assisting others to not only survive individual, but to transcend many of life’s challenges and despair such as
symptoms of PTSD (Sweeney & Witmer, 1991), as well as the many challenges of being in a love relationships. In Social Interest, providing an encouraging climate and context for growth, wellness and satisfaction becomes a process likely to extend over the inspired family’s entire life span.

*Integrating Adlerian Perspective with EFT*

From an Adlerian standpoint, when looking at a discouraged couple and the lack of wanting to be involved in an intimate relationship it is of utmost importance as a therapist to give courage, help in a non-biased atmosphere through an acknowledgment process that people diagnosed with PTSD are of equal social status, as capable to have social interest, and able to succeed in the three life tasks (Schramski & Giovondo, 1993). As a therapist bringing the courage and worth back to the individual and couple can facilitate social interest and may help to raise satisfaction in the life tasks. And in the interest of security, survival and fulfillment that the couple needs together, in EFT the therapist can guide the couple in reorganizing this as well by focusing and orienting the couple towards each other’s needs and social cues. For example, when the veteran is feeling anxious, he or she can more likely seek out his or her partner for comfort and reassurance (Johnson, 2004).

Adlerian therapists can also help through the use of lifestyle information. When dealing with the couple there should be additional questions that are asked for a thorough lifestyle assessment. These questions could be when they remember their traumatic experience, when they realized they were emotionally cutting their spouse off or how they felt after a flashback, and if they ever knew anyone in that they respected who was diagnosed with PTSD (Fisher, 1993). These questions can be used alone or in a couple setting when providing EFT. For example, the therapist identify hot interactions and, then, ask particular questions to pinpoint
complimentary or hostile emotional responses (Johnson, 2004). In a couple setting Fisher, 1993 states, “Inspection of these life-style issues frequently provides the therapist with an understanding of the unhealthy dynamics of couples who are encountering conjugal strife” (p. 442).

When gathering lifestyle information some of the mistaken beliefs may become apparent and show where there are areas of inferiority. “Adlerian counselors can focus on mistaken beliefs about needing to conform or sacrifice personal needs in order to belong and gain significance” (Kottman, Lingg, & Tisdell, p. 120, 1995). If there is indeed a lack of feelings of belonging or significance Adlerian therapists can help reframe the mistaken beliefs.

As an Adlerian, there can be concrete ways to counsel couples dealing with trauma. An important message that Adler conveyed was of social equality. Adlerian policy makers and therapists need to identify and open up resources for servicemen to reach their goals in the 5 tasks of life. Chernin and Holden (1995) state:

We encourage Adlerians to keep in mind that acceptance of and respect for normal phenomena that contributes to the achievement of one of Adler’s highest goals, social equality, whereby we are all free to love, work, and live in a way that contributes to the common good (p. 99).

If the therapist is to bring respect to the client and family’s sense of social equality, then the therapeutic relationship will strengthen trust and there can be maximum goal alignment in both the couple’s lives.

_Private Logic_

Adlerians believe that feeling inferior makes us vulnerable and oriented towards ourselves rather than the community. Adlerians believe that humans use private logic to excuse
and justify their behavior which places them ahead of others. For example, a veteran could possibly come back home and may think “I can do what I want,” or “I don’t have to follow the rules of the family because I did not have to do this when I was at war.”

The integrated approach of EFT and Adlerian therapy will be oriented towards uncovering private logic that supports each individual’s mistaken style of living and socially useless behaviors. Such self-oriented thinking is the basis for many of the couple’s problems in their life, not only to excuse “socially useless” behaviors but also to justify maintaining a generally mistaken life style. Alfred Adler’s own approach that could be used in sessions is “making guesses” with the couple. For example, the therapist might say, “I wonder if, when you say that your wife compared you unfavorable to other husbands in the troop, you were really giving yourself an excuse to not try as hard as you could.” If the individual has a response with a sly smile (meaning “you got me there!”), the therapist can then move on suspecting he or she is on target in having revealed private logic. The purpose of doing this in therapy is not to play “Gotcha!” (that would only feed the individual and couple’s sense of inferiority) but to make “public” to the couple what has been a private reasoning to justify a style of behavior. Private logic will justify socially useless behavior, while EFT and Common Sense will encourage socially useful behavior and healthy attachment (which EFT provides) in the couple relationship and family (Ansbacher, 1964, p.45.)

Social Interest

Even from Alfred Adler’s experience during World War I, he came to believe that community involvement, serving others, kindness and putting others above or equal to one’s own needs are crucial to individual and couples health. He spoke of the ability to see from the other’s point of view, to contribute through work and relationships, to cooperate in solving not only
community problems but relationship problems. The therapist can see Social Interest as a maturity and positive movement in therapy with couples and evidence that the couple has succeeded in the Task of Love. Adler would have viewed social interest in this integrated therapy as the goal of the individual and couple.

He said to the Vienna Medical Association:

> Particularly, it means feeling with the whole, a striving for a form of community which must be thought of as everlasting, as it could be thought of if mankind had reached the goal of perfection. It is community [not specific] or society or political or religious form. The goal best suited for perfection would have to be a goal which signifies the ideal community of all mankind, the ultimate fulfillment of evolution. We conceive this idea...as the ultimate form of mankind in which we imagine all questions of life, all relationship to the external world as solved. It is an ideal, a direction-giving goal. This goal of perfection must contain the goal of ideal community, because everything we find valuable in life, what exists and what will remain, is forever a product of this social feeling. (Ansbacher, 1964, pp. 34-35)

In therapy, Social Interest is the Fictional Final Goal in the integration of EFT and Adlerian counseling in helping the couple enhance their relationship satisfaction. In the couple’s life, the clinician would challenge, facilitate and teach altruism, caring, working together and cooperating toward common goals and other similar activities for the couple to form a strong bond. It is pretty simple to say that the motto of Social Interest will be the Golden Rule within these integrated therapy sessions.
Appendix A:

Treatment Plan for Redeployment Debriefing (Deployment back to duty station)

DAY 1 (0800-1100)

Soldier- Soldiers will get their physicals to check physical status upon arrival.

Spouses- A support group meeting with other wives discussing how the first night home was and concerns they have with their soldiers.

PM- Spouses will both take P&E test individually and then have time together alone.

DAY 2 (0800-1100)

Soldier & Spouse together- Have an EFT therapist give a seminar educating on signs and symptoms that the soldiers may exhibit. Soldier and Spouse also take the Prepare & Enrich test individually.

PM -Spouses will have time together alone.

DAY 3 (0800-1100)

Soldier and Spouse - Provide P&E to help assess strengths, growth areas and general information on how to individually and interpersonally manage possible diagnosis(s).

PM -Spouses will have time together

DAY 4 (0800-1100)

Soldier and Spouses (Emotion Focused Therapy, and Adlerian Couples Therapy Integrated) – Therapy and Counseling on:

- How to appropriate a spouse if a symptom of PTSD appears.
- How to appropriately communicate needs.
• How to appropriately express feelings.
• How to appropriately respond to each other’s needs and personal/couple/family goals.

DAY 5 (0800-1100)

Social work case management with couples only
Appendix B

Therapist and Social Work Case Management Agenda

Basic Outline
Day 3: Assess Functional and Psychosocial Problems/Needs (e.g. P&E)
Day 3: Assess Prevalence of Trauma Exposure. Couple take (P&E)
Day 3: Assessment of Possible diagnosis (e.g PTSD)
Day 4: Therapy for the Couple through Adlerian Couples Therapy and Emotion
Focused Therapy.
Day 5: Provide Supportive Services for the Couple and Family
Day 5: Address Home & Community Environment Issues
Day 5: Steps to Recovery & Coping in Civilian Life

Essentials for Assessing Prevalence of Trauma Exposure

[Orienting statement] “I’m going to be asking you about some difficult or stressful things that sometimes happen to people. Some examples of this are being in some type of serious accident; being in a fire, a hurricane, or an earthquake; being mugged or beaten up or attacked with a weapon; or being intensely sexually harassed or forced to have sex when you didn’t want to. I’ll start by asking you to look over a list of experiences like this and check any that apply to you. Then, if any of them do apply to you, I’ll ask you to briefly describe what happened and how you felt at that time.”

“Some of these experiences may be hard to remember or may bring back uncomfortable memories or feelings. People often find that talking about them can be helpful but it’s up to you to decide how much you want to tell me. As we go along, if you find yourself becoming upset,
let me know and we can slow down and talk about it. Do you have any question before we start (First, 1995, p. 15)?

Essentials for Assessing Traumatic Stress Exposure

[Assessing subjective reactions to trauma exposure (Weiss, 1997)]

a.) At the time of the trauma was occurring, did you believe your life was threatened? Did you think you could be physically injured in this situation?

b.) At the time this occurred, how did you feel emotionally (fearful, horrified, or helpless)?

c.) Were you stunned or in shock so that you didn’t feel anything at all?

d.) Did you disconnect from the situation, like feeling that things weren’t real or you are in a daze?

e.) Can you recall any bodily sensations you may have had at the time?

Essentials for diagnosis of couples dealing with trauma

[DSM-IV strategy for assessing Traumatic Stress Disorder (Davidson, 1997, p. 127)]

(1) Did you witness others being killed, injured or wounded?

(2) Were you wounded or injured?

(3) Were you exposed to bodies that had been dismembered?

(4) About how many times were you exposed to {the traumatic event}?

(5) Where you captured or tortured, or a POW

(6) During the trauma, did the perpetrator threaten to injure you or kill you if you did not comply with his or her wishes? Did you believe there would be any other negative consequences to you if you did not comply with the perpetrator’s intentions (e.g. do what was demanded)?
(7) Was somebody important to you killed or seriously hurt during this situation or another situation?

(8) Did you witness the killing or injured?

(9) Where you injured?

(10) How long have you been away from home?

(10) Do you sleep well at night?

(11) Do you have history of violence in your past?

(12) Have others recognized a difference in you?

(13) What did other people notice about your emotional response?

(14) What were the consequences or outcomes of this event?

(15) Did you receive any help, or talk to anyone, after this event occurred?

*Essentials on Advocacy for the Couple and Marital Therapy*

The therapist will start on Day 1 (with P&E) and end on day 4 (integrating EFT and I). The social work case manager will start on Day 5 and end on Day 5, which will help the couple identify and deal with symptoms of PTSD at their home and community. During Day 5, the social work case manager overviews the history of the couple’s marriage, reviews the progress of the week and offers supportive services for the couple and family. Throughout the 6 month annual sessions, the therapist teaches Steps to Recovery through teaching advanced skills on coping with PTSD through EFT, Adlerian Couples Therapy and Prepare & Enrich: clarifying needs and values of the marriage, assisting in role plays, and assisting with making goals for optimal marital relationship outcomes.
References


