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ORIGINAL PAPER

Homecoming as Safe Haven or the New Front: Attachment and Detachment in Military Couples

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Abstract Traumatized military couples represent a new population for the application of attachment theory constructs. An innovative clinical social work practice model, grounded in a synthesis of social and psychological theories, aims to assist these couple and families who are navigating very difficult transitions. Since social support is known to be a central protective factor in mediating the long-term adverse effects of combat trauma, this therapeutic focus addresses two compelling problem areas: the disruption of secure attachments and affect dysregulation. The effects of deployment stressors on soldiers, their intimate partners, and their families are discussed in depth. Clinical illustrations highlight the utility of a phase-oriented culturally responsive couple therapy practice approach that has clear clinical implications for military couples.

Keywords Attachment · Combat trauma · Military couples

Introduction

This paper addresses the impact of deployment stress on the relationships between warriors[1] and their partners during and following a tour of duty. Military couples face unique stressors that are associated with the culture of the military as well as the agonies of combat experienced in the midst of an active war zone. Unfortunately, the USA is facing a deluge of returning soldiers and marines from the war zones in Iraq and Afghanistan. As of November 2006, approximately 1.4 million troops have been deployed to these areas followed by a steady increase, or surge, in troops in recent months. More than 3,000 American soldiers and Marines have died to date, while at least 700,000 Iraqis have died due to violence (*MHAT*, 2006). War is horrific and devastating for everyone involved. Although a range of protective factors, in particular family and other social supports, mediate the harmful effects of combat exposure, many soldiers and their partners suffer with acute stress responses as well as more severe mental health problems. In a recent study of 2,863 returning soldiers conducted by Hoge, Terhakopian, Castro, Messer, and Engel (2007), combat exposure was directly linked with subsequent PTSD, depression, and other anxiety disorders. Those who were injured suffered three times the risk of PTSD as compared with the non-injured, regardless of the severity of the injury.

Since most of the current psychotherapy models for returning soldiers and their families are based in cognitive-behavioral models (Armstrong, Best, & Domenici, 2006; Riggs, 2000), little attention is paid to how deployment stressors shake the foundations of intimate partnerships and other family relationships. Given this gap in the world of clinical practice with traumatized military couples, I would like to demonstrate the relevance of attachment theory constructs in working clinically with these couples who are coping with the legacies of combat exposure. Numerous

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[1] The terms soldiers, Marines, reservists, and National Guard troops are used in popular discourse to refer to a person who is affiliated with a specific branch of military service. However, most contemporary research and clinical literature relating to military families refers to those persons who are deployed in active military assignments as warriors or warfighters. I will use these terms regularly throughout the paper.

attachment-related questions arise in relation to the after-effects of combat trauma on an intimate partnership. How does deployment stress affect the security of attachment for soldiers and their partners? Do combat stressors disrupt or dismantle a sense of trust? For those soldiers who enter into combat with a pre-existing vulnerability toward insecure attachment, what are the effects on the stability of their relationships? Are there effects on each partner's capacity for careseeking, caregiving, and exploration? Mentalization? Affect regulation? Furthermore, what role do race, ethnicity, gender, and sexual identity play in sustaining intimate partnerships during the post-deployment period? Following a brief review of contemporary literature, this paper will examine these questions and provide a clinical illustration incorporating an attachment-based framework in working with a military couple. Although this phase-oriented couple therapy model draws from a synthesis of theory models, this paper focuses specifically on the role of attachment theory.

Attachment Theory and Research

Secure Base and Working Models of Attachment

Rather than provide a detailed review of the exhaustive literature on early attachment as proposed by Bowlby (1969/1982, 1973, 1980) and Ainsworth (1989), I will highlight their central notion of "a secure base" of attachment. These two founders of attachment theory proposed that the child's internalization of a relationship with an attachment figure creates a secure base of support and comfort in times of distress and facilitates the child's exploration of the wider world. Recent theorists have suggested this relational process can be conceptualized as a "circle of security" (Marvin, Cooper, Hoffman, & Powell, 2002), in which a child moves from secure base to exploration and then back to a safe haven following a rupture. Contemporary theory and research recognize the interconnections between attachment (i.e., careseeking or proximity seeking), caregiving (i.e., offering a safe haven), and exploration for adults as well (Feeney & Collins, 2004; George & Solomon, 1999). Similar to children, an adult's attachment system is activated in times of stress or novelty, and adults turn to their attachment figures to alleviate this distress and regulate their affect (Hazan, Gur-Yaish, & Campa, 2004). Typically, a partner or close friend serves as the preferred attachment figure for adults.

Bowlby and Ainsworth further proposed that young children internalize early attachment processes as "internal working models" of attachment, which serve as relational templates with continuity throughout the lifespan (Hesse, 1999; Fonagy, 2001). Ultimately, adults navigate their relational worlds influenced by either secure or insecure internal working models developed in their early years. Based on research about adult attachments, secure adult relationships are characterized by the capacity to relate to others in a mutual reciprocal manner, to provide coherent narratives about relationships, and to sustain continuity of connections (Basham & Miehls, 2004; Hesse, 1999). Fisher and Crandall (1997) suggest that couples who are securely attached "shift freely between the dependent and depended-upon positions…with an open expression of the need for comfort and contact, as well as an open reception of that contact" (p. 216). In other words, the attachment systems of secure adult partners can be appropriately activated and deactivated in a flexible manner, depending on the emotional needs of the individuals at any given time.

In contrast, insecurely attached adults may be dismissing, preoccupied, or unresolved/disorganized in their states of mind about attachment (Hesse, 1999), leading them to lack the bidirectionality, flexibility, or mutuality common among secure partners (Fisher & Crandell, 2001). Rather than categorizing individuals into one particular attachment pattern, current thinking suggests that people may experience several of these different features at different time periods. In fact, recent research suggests that adult couples may create ways of relating that are specific to the relationship and perhaps different from the individual's global model of attachment or state of mind about early childhood attachment relationships (Creasey & Ladd, 2005).

In general, persistent self-reliance among adults is thought to characterize a dismissing attachment pattern where an individual may be aloof or distant, reluctant to become close, and disparaging of intimacy. When both partners in the couple relationship share a dismissive pattern, they tend to keep their attachment systems deactivated and remain in the "exploration" position on the "circle of security." They collude in their denial of any dependency needs in the self or the other, and they avoid conflict or ruptures in a placid, smoothly functioning relationship (Fisher & Crandell, 2001). In contrast, an adult with a preoccupied state of mind regarding attachment is constantly seeking comfort, is vulnerable and needy, and may appear clingy. A shared preoccupied attachment pattern maintains a couple's attachment system in a hyper-activated mode, remaining fixed in the "seeking safe haven" position on the "circle of security." Both partners seek validation of their worthiness, but mutually feel deprived, never satisfied in terms of the comfort they receive for their heightened affect arousal. This attachment pattern may manifest in an obsessional need for ongoing reciprocation or "keeping score."

Most troublesome, an adult who has unresolved childhood abuse and trauma and/or loss and grief is considered to have an unresolved/disorganized state of mind regarding

attachments, leading to a chaotic pattern of relating. An adult with unresolved attachment is considered to have a secondary attachment pattern (i.e., secure, dismissing, or preoccupied), since the disorganization triggered by unresolved trauma may be intermittent (Cassidy & Mohr, 2001; Hesse, 1999). These adults create partnerships with no ordered pattern of relating. They may be fearful and defensive or behave in rigid and inflexible ways, setting the stage for battles around dominance and control that erupt in attachment rage. Partners with unresolved/disorganized attachment often vacillate between approach and avoidance, are charged by emotional volatility, and may erupt with physical violence. Fonagy (1999) has proposed that male perpetrators of violence against women may have disorganized attachment systems.

Finally, it should be noted that adult partnerships may be created by persons with discordant models of attachment, leading, for example, to a dismissing/preoccupied couple attachment or an insecure/secure couple attachment (Fisher & Crandell, 2001). These discordant couple systems may be at more risk for frustration than couples with similar attachment patterns. Indeed, dismissing/preoccupied couples frequently present for treatment because one partner has heightened dissatisfaction and volatility in the face of the other's dismissive and disparaging stance toward neediness. Couples where one partner is secure and the other is preoccupied, dismissing, or unresolved also face challenges. However, recent research suggests that one partner's security may serve to mitigate the conflicts that arise, raising the possibility that these couples can create a relationship-specific secure attachment, despite the other partner's general insecurity (Creasey & Ladd, 2005). Inevitably, couples that have the most challenging relationships are those where at least one or both partners have unresolved/disorganized attachments. Relational dynamics in these couples are particularly complex when at least one partner also has PTSD due to military trauma, which may be exacerbated by childhood trauma.

Trauma, Infant Development, and Right Brain Dysfunction

To provide a developmental context to the disorganized attachment pattern, I will turn to the contemporary groundbreaking research on the effects of early relational trauma on infant development, as well as subsequent development in adolescence and adult life. In his impressive body of work summarizing recent brain research, Schore (1998, 2000, 2003) discusses how an infant's capacity to shift between dual states of interactions with others and solitude depends on a secure attachment, which facilitates right brain development. Such a relationship promotes efficient affect regulation and fosters adaptive infant mental health. In contrast, traumatic attachment experiences disrupt the brain and contribute to the emergence of a disorganized/disoriented attachment pattern in the child that influences affect regulation and right brain dysfunction. Early trauma alters the development of the infant's right brain, the hemisphere that is responsible for processing socioemotional information, attachment functions, and bodily states. Since the right prefrontal cortex is critical in processing affect and self-functions, any intense and unregulated stress induces heightened negative affect, chaotic biochemical reactions, and a developmentally immature right brain.

Needless to say, there are serious long-term effects of early trauma that bear scrutiny. When this frontal network of the right brain is compromised as a result of early relational trauma, a "type D" disorganized attachment pattern often emerges (Cassidy & Mohr, 2001; Main & Solomon, 1986). Not only have these disorganized attachments been associated with a later onset of PTSD syndrome, they are also associated with hostile, aggressive behavior (Lyons-Ruth & Jacobvitz, 1993; Schore, 1998, 2000). Numerous studies suggest an important relationship between childhood abuse and adult psychopathology (Bremner, Southwick, Johnson, Yehuda, & Charney 1993). However, there are several papers with contradictory findings that explore the relationship between combat-related PTSD and childhood abuse.

A study by Black et al. (2004) found that the greatest risk of post-war anxiety disorders among veterans from the first Gulf War resulted from the presence of pre-existing anxiety disorders of any kind, but not PTSD per se. A comprehensive meta-analysis of risk factors for posttraumatic stress disorder conducted by Brewin, Andrews, and Valentine (2000) revealed that factors such as psychiatric history, reported child abuse, and family psychiatric history had more uniform predictive effects of post-combat mental health problems. Yet, statistically, the effect sizes for all risk factors were modest. Several factors operating during or after the traumatic deployment-related events—such as trauma severity, length of exposure, and absence of social support—had somewhat stronger effects as compared with pre-trauma factors. Although risk factors for heightened PTSD often include pre-existing psychiatric disorders, an interesting recent study conducted by Yehuda, Flory, Southwick, and Charney (2006) revealed that those soldiers who had successfully resolved trauma-related symptoms, attachment, and relationship issues related to their childhood experiences navigated better in acute combat situations without suffering negative mental health outcomes. In recent war zones in Iraq and Afghanistan, many soldiers have discovered that a pre-existing psychiatric diagnosis of a personality disorder has often prevented

them from accessing services. More specifically, many wounded troops who experience acute symptoms of PTSD, for example, have been denied assistance and disability benefits upon return to the USA with the explanation that they may have suffered a pre-existing personality disorder. This controversial disability assessment procedure flies in the face of studies that suggest that pre-military factors are less significant predictors of PTSD. Instead, the primary predictors for combat related PTSD are exposure to war-related combat stressors. The intensity of stressors and the length of time subjected to combat related stressors are directly associated with negative mental health outcomes (Institute of Medicine, 2006).

Mentalization

Another construct of importance to the focus of this paper is "mentalization," a concept originally created by Fonagy, Gergely, Jurist & Target (2002) to refer to self-reflection and the regulation of affect. In mentalization, there is an awareness of the affect and "the capacity to fathom the meaning(s) of one's own affect states" (p. 96). In application to couples, such awareness and reflective functioning occurs when an individual partner in the couple actually experiences and attaches meaning to the affect (Basham & Miehls, 2004). Another feature of mentalization, which resembles empathy, involves the ability to discern and anticipate the meaning of another person's affect and behaviors. These capacities are similar to the hallmarks of a secure-autonomous attachment, which include the capacity for metacognitive functioning and the ability to narrate one's story in a coherent manner. These capacities are validated and explicated thoroughly in research literature on the Adult Attachment Interview (Hesse, 1999; Main, Kaplan, & Cassidy, 1985).

Attachment Theory and Couple Therapy

Attachment theory has provided the core foundation for several contemporary theorists who write about and practice couple therapy (Clulow, 2001; Eagle, 2003; Fisher & Crandell, 1997, 2001; Johnson, 2002; Johnson & Whiffen, 2003). Johnson, Makinen, and Millikin (2001) talk about "attachment injuries" (p. 145), where one partner experiences a sense of violation and betrayal, while the other partner fails to offer comfort and caring in the face of distress. Johnson's (2002) approach aims to repair an attachment injury by moving through a series of steps in couple therapy. First, the couple talks about their respective experiences of the injury and each partner begins to grieve the injury. The clinician facilitates the expression of disavowed or suppressed feelings to foster the development of empathy and connection. Solomon (2003) also promotes the expression of unresolved feelings early on in the couple therapy with the goal of enhancing understanding and empathy.

Although these goals are worthwhile in many couple therapy frameworks, an underlying critique for both Johnson and Solomon is the absence of selection criteria for participation in this affectively charged work. These models suggest that all couples can benefit from expression of affect that leads to enhanced empathy. They presume a certain capacity for reflective thinking and insight, which is often lacking for many couples, particularly when partners have insecure or unresolved/disorganized attachment styles. Instead, many couples need to focus on self-care, stabilization, and safety first, within a phase-oriented model (Basham & Miehls, 2004). Major problems with affect regulation need to be addressed first, at the beginning of the therapeutic work, before a couple is ready to access and express their feelings effectively. The processes of attunement and repair/regulation are central features of healing as well, yet frequently emerge at different times within the therapeutic interactions. Traumatized couples may experience damage and exacerbation of problems if affect-laden traumatic memories are uncovered prematurely. Consistent with the phase-oriented couple therapy model for survivors of childhood trauma explicated in my co-authored text (Basham & Miehls, 2004), preparatory stabilization work is necessary for those couples who need to establish consistency with their affect regulation and self-care.

In summary, the theoretical constructs drawn from attachment theory that are most useful in couple therapy practice with traumatized military couples are: (1) affect regulation; (2) careseeking/caregiving/exploration built on a secure base of attachment; (3) mentalization; and (4) internal working models of attachment. To sharpen the focus, I will direct my attention to these particular attachment-related themes in the discussion of combat trauma and the effects on soldiers and their partners, as well as in the assessment and treatment with these couples. Clinical examples are included to illustrate these themes. First, I will introduce the phenomenological experience for a soldier in combat and the effects on their partnerships.

Combat Trauma as Attachment Rupture

Combat Trauma

Traumatic experiences as defined by Figley (1998) point to a state of discomfort, extreme stress, and memories of a catastrophic event, while Herman (1992) stresses the

rupture to connections and a profound sense of powerlessness. A familiar understanding of traumatic events emerges from the *DSM-IV-TR* (American Psychiatric Association, 2001) where an individual must have experienced (1) a threat to life, as well as (2) feelings of powerlessness. Combat trauma involves a unique brand of horror that involves exposure to terrifying violent events along with a mixture of fear, anxiety, and despair, as well as pride, excitement, loyalty, and patriotism. Combat trauma is often considered a Type I traumatic event (i.e., a single discrete catastrophic event) according to the typology outlined by Terr (1999). Unlike the impact of a car accident or a natural disaster, combat trauma comes closer to Type II trauma, which involves chronic and repetitive life threatening events that render a victim powerless (e.g., children who survived persistent physical, sexual, and emotional abuses in terrorizing families, Terr, 1999). With the lengthy nature of recent deployments in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) in Iraq and Afghanistan, respectively, intense combat exposure occurs continually over longer and longer time periods. If soldiers experience betrayal from their commanding officers or the military establishment in general, these experiences translate into relational trauma, which disrupts attachments while also harming relationships.

Finally, many troops from targeted racial or ethnic or sexual identities are subject to racial or cultural trauma (Allen, 1998), viewed as the chronic, pernicious, bigoted threats that undermine psychological and physical safety. Although the military promotes a “Don’t Ask-Don’t Tell” policy around sexual identity, gay warriors are also subjected to overt and covert discrimination in the battlefield and upon return home to the community. The oppressive effects of maintaining secrecy alienate these soldiers from their necessary family and social supports. Clearly the persistent, toxic effects of repetitive traumatic events disrupt a soldier’s sense of safety and security, posing formidable challenges for them to hold onto their attachment capacities. With the increased number of women and parents deployed to both war zones, we see additional stressors and burdens placed on these families in managing the disruptions to attachments between partners and between parents and children. Multiple separations, threats of intense danger, and military sexual assault further burden these families.

Nature of Combat

What are the combat zones like for warriors who are currently serving in Iraq? Rather than facing consecutive, isolated, devastating life threatening events, soldiers report the absence of any safe space “outside the wire” when they leave camp to go out on patrols into the local communities. For that matter, “inside the wire” lacks safety as well, based on an increasing rate of incidents of military sexual assault, primarily from men against women (Suris, Lind, Kashner, Borman, & Petty, 2004). More male soldiers have reported being sexually victimized during the current wartime conflicts as well. Living areas are threatened with the continual possibility of sniper fire aimed at their sleeping areas and communal dining spaces. Unlike the warfare in WWII and the Korean War, where periods of boredom were interrupted by violent intermittent episodes of combat on the front lines, these war zones involve continuous exposure to lack of safety. Combat exposure is one of the greatest stressors a person can experience in life. Soldiers report continuous encounters with roadside IEDs (improvised explosive devices), suicide bombers, sniper fire, and an indistinguishable insurgency. Veterans describe dealing with exploding vehicles and body parts thrown about, blanketed in shrapnel, as everyday events. Unrelenting, continuous horrors of attacking or being attacked, killing or witnessing killing or mutilations, and seeing dead bodies and human remains occur all the time as soldiers patrol the communities.

Inevitably, when a warrior returns home, he or she returns as a changed individual. He may have suffered profound disillusionment with the senselessness and immorality of some combat-related actions and the political decisions affecting the war. However, they also have gained a whole new set of skills and strengths that alter the way they relate to other people and the world in general. These skills helped them survive in a combat zone, but do not necessarily serve them well in coping with day-to-day stressors of life back home. Soldiers learn to control fears and suppress emotions, to master the art of deception while cunningly devising ways to survive, and to parse information while restricting communication. As they gain physical strength, endurance, and quickness to respond to dangerous situations, they also develop the capacity to respond immediately and instantly with violent lethal force. They maintain a vigilant watchful stance at all times, preparing to respond to danger and recognize that the fixed rules of hierarchy can be broken when they pose a threat to safety.

Finally, warfighters develop a new pattern of relating to the world through the lens of the “victim-victimizer-bystander” triangle (Herman, 1992; Staub, 1989). When a soldier fights and kills others, he or she may identify as a victimizer, a victim, and/or a bystander. Some people question why this process of identification would occur when killing, capture, and intimidation have been sanctioned societally as part of battlemind training and a wartime code of ethics. Even so, paradoxically, the internalization of these new disturbing combat experiences can

disrupt earlier relationship templates that provide safety and security. Whether a soldier enters combat with a preexisting secure or insecure internal model of attachment, the horrors of war can readily alter those existing attachment patterns. Following homecoming, a returning soldier may readily experience disrupted attachments with family members, colleagues, and friends. In fact, they may experience their partners and other family members as victims, victimizers, and bystanders, a phenomenon that leads to polarized beliefs and conflicts over power and control. This pattern is vitally important in understanding the complexity of traumatized couples and families as their working models of attachment shift and change.

Shattering of "Thumos"

When facing horrific traumatic events and/or ethical dilemmas about the rightness or wrongness of wartime actions, demoralization and apathy may settle in. A gradual erosion of self-regard occurs in response to these ethical conflicts (Shaw, 2007). Shay (2002), a dedicated psychiatrist who has worked with Veterans in Boston for many years, writes eloquently about the phenomenology of warfighters, tracing the experiences back to early Greek history. He refers to a process of dismantling character which involves the destruction of "Thumos," a Homeric term that describes the energy related to spirited honor—a sustaining life force for psychological well being (p. 156). Trust in other people is virtually shattered, and attachments to other people are altered and often disrupted. Attachments transform from secure connections into tenuous insecure connections managed through ambivalence or avoidance. At an extreme, as noted earlier, relationships can become very chaotic and disorganized in response to this assault upon the basic relational patterns. Many soldiers wrestle with shame over their actions and survivor guilt in response to the loss of their "buddies." Although many veterans move past the horrors of their traumatic memories, their greatest challenge is to feel a sense of purpose for their wartime sacrifice and a sense of social vindication. Without these healing experiences, a veteran often remains despairing and ashamed. Another response to this injury is irritability and grandiose entitlement. Small slights may be experienced as major offenses resulting in rage responses. From the perspective of a clinician, empathizing with a client who expresses sadness, fear, and vulnerability in response to this psychological injury is far easier than empathizing with a veteran who sports a protective narcissistic armor that periodically erupts with intense rage. Nonetheless, regardless of the particular response expressed, the traumatized veteran may be wrestling with a profound wounding to a very basic core self.

Traumatic Rage Response

The obvious question arises as to why returning soldiers are so filled with rage. Clearly, soldiers have many reasons to feel anger and frustration related to surviving combat, but traumatic rage has a different origin that calls for a neurobiological explanation (van der Kolk, 2003). The biology of traumatic stress directly relates to the sustaining or rupturing of attachments and the consequent effects on affect regulation. As mentioned in an earlier section of the paper, early trauma and early attachment relationships shape the right brain of the developing child, which influences affect arousal and regulation.

However, we cannot presume that all soldiers with preexisting childhood histories enter a combat zone with complex PTSD-related patterns of insecure or unresolved/disorganized attachments. The Yehuda et al. (2006) paper reveals that the resolution of the legacies of childhood trauma during adult life may lead to improved affect regulation and more enhanced security of attachment. In this regard, it is crucial to remember that there is a wide range of active duty troops, including reservists and National Guard, who serve in the current war zones. They represent diversity in age, race, ethnicity, socio-economic status, sexual identity, as well as family background and pre-existing histories of childhood trauma. Although many of the reservists and National Guard members may possess the protective factors of more stable income and older age, they may lack crucial protective factors of intensive battlemind training, an espirit de corps, and strong leadership (*MHAT IV*, 2006). As a result, they may face heightened risk for negative mental health outcomes post-deployment, regardless of how resilient they were prior to deployment. Soldiers entering combat with preexisting secure attachments regularly experience traumatic stress responses that can be potentially damaging to physical and mental health. As the intensity of exposure and the length of time of trauma exposure vary, the subsequent mental outcomes will differ as well. The following clinical vignette illustrates how an ordinary event activates (or triggers) a traumatic stress response, accompanied by a "rage storm" with one of my treatment couples.

Clinical Vignette of Traumatic Stress Response: John and Jean

John, age 54, is a veteran of both the Vietnam War, where he served as a helicopter pilot, and the recent OIF war zone in Iraq, where he led transports of weapons and artillery. John was reared in poverty by second-generation Czech parents who relied upon their faith in Catholicism as a source of strength. As one of eight children enlisted by his

family to work on the family farm, he experienced dismissing and neglectful parenting, in part related to the scarcity of emotional and material resources shared among so many children. His early encounter with physical abuse, emotional undernourishment, and inconsistently available parenting set the stage for an unresolved/disorganized attachment with insecure preoccupation in adulthood. Following his tour of duty in Vietnam, which was characterized by intensive exposure to aerial bombings with napalm, John suffered horrific nightmares of maimed women and children villagers. His trust in relationships was shattered, resulting in global disorganizing disruptions in all of his attachments to significant people. Fortunately, he received helpful treatments for both PTSD and substance abuse. After 20 years of recovery and very sound functioning in his work life, John married his second wife, Jean, 5 years ago. She was unfamiliar with war and military culture; however, she had unresolved physical abuse in her childhood at the hands of her stepfather, leaving her, like John, with an unresolved/disorganized state of mind regarding attachment, combined with preoccupation as well. Now 48-years-old, Jean was similarly reared in rural West Virginia by second-generation Irish American parents who encouraged her to pursue education as a path out of poverty. Each partner had been married once before and shared four adult children between them, all who were living independently in different regions of the country. Both John and Jean were estranged from all of the children.

After John's eight-month tour of duty in Iraq, John and Jean sought couple therapy inspired by Jean's distress over John's re-activated PTSD symptoms of hyperarousal, nightmares, and flashbacks. John got angry a lot of the time, while Jean retreated into quiet depression. The "victim-victimizer-bystander" pattern was complete. Although John had felt increasingly more secure with his attachment to Jean prior to deployment to Iraq, the challenges of combat disrupted all sense of safety, rendering him more distrustful, estranged, fearful, and disorganized in his attachment toward his wife. Although Jean had also benefited from some reparative nurturing in her marriage to John prior to his deployment, the shock of war thrust her back into a state of tentative, ambivalent attachment toward her traumatized husband.

One day, when they were driving to the grocery store, John spotted a teenager in the distance hanging over the railing of a bridge traversing the highway. As John drove toward the overpass, he started to tremble and perspire profusely, veering the car across several lanes of traffic to get into the shoulder lane. Accelerating quickly to 90 mph, he yelled for Jean to duck under the seat and pushed her beneath the dashboard. After they sped under the bridge, John kept racing along for another several miles in a high-speed chase with his own internal demons. Finally, Jean screamed for him to stop. She was shaken and terrified. Apparently, the visual image on the bridge triggered a frightening traumatic memory from a year earlier when John watched his truck blow up right in front of him as he was preparing to lead a convoy to Baghdad.

What was happening to John physiologically to explain his disrupted perceptions and affect arousal? Clearly a traumatic stress response was stimulated. Both the sympathetic and parasympathetic systems were activated simultaneously. As the thalamus received stimuli from the outside world with the sounds, vision, and smells of the moment, the amygdala (the alarm system of the brain) fired while activity in the cerebral cortex was compromised. Then, the speech region, called the Broca area, shut down so there was little access to a rational monitor. Instead, adrenalin and noradrenaline are released simultaneously (Basham & Miehls, 2004) and as a result, John felt the innervating effects of a heightened pulse, flushing, racing heart, and the enervating effects of numbness. The release of opiates further contributed to a dulling and numbing effect. When these traumatic stress responses occur over and over, a soldier's resilience weakens. Once the amygdala receives the emergency signal to fire, the usual cognitive system cannot process information adequately, nor can it gain a sense of perspective. Instead, the emergency alarm activates physiological responses and feelings that dominate the person's functioning. Triggers can lead to full-blown re-traumatization, which in John's case resulted in the eruption of an impulsive, rageful fight-flight response. This is not solely an individual response, since John's flashback terrified Jean as well, further weakening an already tenuous trust in their relationship. Their interactions could be viewed as an enactment of their couple dynamics, but recognizing the neurobiological underpinnings of the flashback adds to the complexity of the understanding. The flashback clearly conveys the powerful effects of a traumatic stress response in dysregulating John's affect, which in turn disrupted the attachment between John and Jean, and undermined both partners' capacities for careseeking, caregiving, and exploration. All of their energies were focused on survival.

Mental Health Responses at Homecoming

As the previous clinical vignette illustrates, returning soldiers frequently experience mental health responses at homecoming. Both in the field and upon return home, usually within the first month or so, it is not uncommon for soldiers to report concerns related to an acute stress response characterized by nightmares, irritability, and mood instability. These symptoms are related, in part, to the effects of the traumatic stress response. Many warriors

return home without adverse mental health after-effects, fortified by their own constitutional resilience and bolstered by family and other social supports. However, recent studies have reported a direct association between deployment and the emergence of PTSD and co-varying conditions of depression, suicidality, substance abuse, and other anxiety disorders (Hoge et al., 2007). In addition, many veterans face physical disability related to lost limbs and traumatic brain injury, leaving partners and other family members to struggle with ongoing caregiving.

Responses of Partners and Families

The responses of family members to the homecoming of their loved ones vary a great deal. This is true for both dual trauma couples (where both partners have trauma histories) and single trauma couples (where one partner has a trauma history and the other partner experiences secondary trauma). Many soldiers and their partners experience pride and a shared sense of accomplishment. Yet, other soldiers return with heightened anxiety, panic attacks, and rage eruptions, which set the stage for secondary trauma among partners and other family members (Figley, 1989; Riggs, 2000). Secondary trauma was originally understood as a typical response for caregivers and first-responders based on their exposure to traumatized persons (Dirkzwager, Bramsen, Ader, & van der Ploeg, 2005; Figley, 1995). Similar processes of secondary trauma also affect family members as they interact with their traumatized relative. They may actually develop PTSD-like symptoms of hyperarousal, avoidance, and numbing, which ultimately interact synergistically with the PTSD symptoms of the veteran. Regrettably, combat exposure is strongly associated with subsequent marital conflict and a heightened incidence of intimate partner violence (Marshall, Panuzio, & Taft, 2005; Riggs, Byrne, Weathers, & Litz, 1998; Tully, 2001).

Traumatized couples, whether they are single or dual trauma couples, often report difficulties with adjusting to the many shifts in family roles and the balancing of power in decision making. Typically the partner who has remained at home has assumed primary responsibility for all parenting and management of the household. Learning to cooperate and share in problem solving is difficult under ordinary circumstances, but with the added pressure of trauma-related symptoms, all of these family responsibilities become even more burdensome. A recent study of parenting satisfaction suggested that the numbing/detachment cluster of PTSD symptoms described in the *DSM IV-TR* is very problematic for families, since both parents and children feel estranged from each other (Samper, Taft, King, & King, 2004). In another study, Rosenheck and Fontana (1998) write about the disturbing transgenerational effects of trauma on children whose parents have unresolved PTSD. In these families, we see the insidious effects of affect dysregulation on the parents and children, disrupted attachments, and erratic parenting, which fuel disorganized attachments and increased behavioral problems in children.

Warriors and their partners often experience multiple separations and reunions as very stressful (Henderson, 2006). For example, the repeated deployments of National Guard and Reserve troops in OIF and OEF have imposed continuing pressures on these military families who must negotiate not only one, but several tours of duty. In contrast, as the Marine Corps considered the effects of long-term deployments, they restricted the time period of deployment to 8 months. With each separation and reunion, the attachment systems of the partners are activated as they must face saying goodbye along with the whole range of feelings that accompany the farewell. Feelings may range from worry, anxiety, fear, and apprehension to anger, sadness, and despair. During deployment, the warrior and his or her partner may have different emotional experiences, which they may not be able to share effectively via e-mail or cell phone communications. The at-home partner may feel a sense of accomplishment and pride in managing multiple responsibilities, but also may be burdened with anxiety about financial hardships. She or he may also worry about the psychological adjustments of their children while fearing for the safety of the deployed partner. A warrior inevitably feels the whole range of intense emotions described earlier in this paper, which are only exacerbated further by more intense combat exposure and lengthier tours of duty. Reunions often involve very brief two-week respites followed by the warrior's having to leave home again for a second or third tour of duty. Clearly, family members are challenged to make rapid adjustments to many transitions, which can overburden the attachment system.

If we think of attachment theory constructs applied to the warfighter's homecoming process, we can say that, during active deployment, many of these men and women experience something like a "preoccupied" attachment bond with their superiors. In these situations, the soldier's day-to-day life is governed by the directives issued by the commanding officer. Some warriors may experience their commanding officer as an "inconsistent," "intrusive," and "unreliable" adult caregiver. More fortunate warfighters may yearn for the continuing wise and supportive protection from an excellent superior officer, as well as their "buddies." Consequently, these warriors often worry about returning home to their partners and families with potentially de-stabilized and insecure attachments. Shortly after their return home, traumatized soldiers and Marines often express strong desires to return to active deployment, to a

large extent to return to what they experience as a secure and protective attachment. In contrast, following discharge, many veterans have been greeted with inadequate medical, vocational rehabilitation, and mental health services along with pervasive neglect of their needs. These potential caregivers may well be experienced as "dismissing" or indifferent providers.

The adjustment process is primarily affected by the psychological and health status of the returning warrior along with the psychological and financial stability of the at-home partner, their children, and their extended family. Given the increased risk of negative mental health outcomes beyond the first year following homecoming, returning soldiers and their families need reliable community support and immediate and short-term interventions to normalize acute stress responses. They also need to discuss the effects of combat trauma on families and learn about the importance of re-building attachments with their families, workplaces, and communities. This process helps them restore more equanimity in their internal working models of attachment. As couples progress and heal, partners often describe experiences of an increasing sense of inner security and safety along with an increased sense of security within the relationship.

Couple Therapy Practice

In thinking about the most effective ways to respond to returning soldiers and their partners, many clinicians recognize the importance of a relationship-based treatment model, especially in light of the disruptions to attachment caused by exposure to traumatic stressors during deployment. Valuing the centrality of resilience, empowerment, and cultural responsiveness is vital for effective engagement. Most veterans express a wish for their treatment to be customized to them as individuals, rather than following a prescribed, manualized protocol. A one-size-fits-all treatment approach further alienates returning soldiers, reinforces the objectification of people, and perpetuates disengagement. In contrast, a more flexible practice approach allows for a synthesis of social and psychological theory models to guide the assessment and treatment course with a couple. As noted earlier, social vindication of their war efforts is key to a warrior's recovery; therefore, much of the healing for them and their partners should occur in the context of meeting with other veterans and their family members and of re-building a sense of community.

Couple therapy with traumatized military couples can be very challenging, considering the potential effects of secondary trauma and countertransference responses based on enactments of a victim-victimizer-bystander relationship template (Basham & Miehls, 2004). As a result, it is important to avoid becoming an overly zealous rescuer or a detached bystander. Yielding either to a passive, futile victim stance or an aggressive and victimizing condemnation of soldiers remain ongoing risks for the clinician as well. The following clinical vignette of treatment with John and Jean, discussed above, illustrates an approach that is sensitive to the special needs of these couples and is based on an understanding of attachment theory and the effects of trauma.

Clinical Case Vignette: Couple Therapy with John and Jean

In general, I argue for a flexible, multi-modal, phase-oriented couple therapy model that draws upon a synthesis of social and psychological models, including attachment theory (Basham & Miehls, 2004). A phase-oriented model directly challenges the constrictions of stage models that rely upon a linear, essentialist path. As couples achieve progress in different arenas with a particular phase of the work, a rupture or crisis can readily lead them to shift back to previously familiar ways of relating, and this requires a re-visiting of earlier challenges. Such movement and fluidity characterizes the entire stage-oriented therapeutic process. Although this model is grounded in a wide range of theory models, for purposes of this paper, my primary focus is on the role of attachment processes in couple therapy with couples navigating the aftermath of combat trauma.

Phase I focuses on safety, stabilization, and self-care with a couple. As couples enter therapy, each partner may approach the work with long-standing secure or insecure attachment patterns. Combat exposure can often de-stabilize a warrior's working model of attachment, so entry into treatment can be experienced as potentially threatening. As a result, each clinician needs to be keenly mindful of the need to gently establish a developing therapeutic alliance, while also conveying knowledge and authority. As a clinician conveys empathic attunement and provides a flexible yet reliable structured therapy environment, the stage is set to facilitate movement toward a secure attachment bond for the couple.

Phases II and III involve reflecting on the influences and meaning of the attachment injuries and traumatic events as they affect day-to-day life. In terms of the couple's attachment, both John and Jean presented with a mutual preoccupation with attachment, intensified by their individual experiences with unresolved trauma (e.g., Jean's childhood physical abuse and John's childhood physical abuse and neglect, as well as his war-related PTSD). Since this couple's presenting issues included John's rage

eruptions and flashbacks, marital conflict, and Jean's depressed state—all signs of affect arousal in need of regulation—the treatment plan first involved a need to assess for physical and psychological safety as well as self-care. A thorough biopsychosocial assessment revealed major strengths for John in having managed his sobriety and PTSD for decades, and a strong sense of loyalty to his family and his fellow soldiers. In spite of Jean's presenting fragility, what emerged was her fierce sense of loyalty and devotion to her children, even though they were estranged from each other. Both partners reported major problems with regulation of their self-care. Jean was unsuccessfully trying to micromanage the insulin dosage for John's Type II diabetes, while John was unsuccessfully trying to manage Jean's mood swings by limiting her phone calls and access to the outside world. They fought every day with vicious verbal exchanges, but they did not engage in physical violence. Six months prior to starting couple therapy, Jean's stepfather died. Since she did not attend the funeral, Jean missed the opportunity to actively grieve, leaving her with intense unresolved mourning, complicated by her ambivalence toward her stepfather.

What unfolded was a couple therapy plan that focused on re-establishing safety and stabilization in an effort to repair the attachment ruptures. Goals focused on promoting sound physical and mental health, nutrition, sleep, and exercise; monitoring of John's relapse prevention; attention to stress reduction plans for both partners, including deep breathing and yoga; and a psychoeducational approach focused on PTSD symptomatology while also expanding family and spiritual supports. Several of these affect regulating interventions utilized cognitive-behavioral techniques grounded in a psychodynamic therapeutic relational framework (Basham, 1999). Since this couple was not yet prepared to start talking about grief and pain surrounding their attachment injuries, an initial therapy goal focused on strengthening affect regulation. Only when John and Jean could begin to regulate their emotions more effectively and experience attunement from me, as their clinician, could they even begin to develop a "secure base in-process." As stabilization progressed, each partner developed greater capacity to attune to the affect and thoughts of the other partner. Eventually, Phase II tasks focus on facilitating more reliable attunement and regulation, as well as re-establishing a more secure attachment bond for the couple to develop enhanced abilities to attune to the affect and thoughts of the other partner.

A sample of the Phase I effort follows; it occurred in the process of the sixth couple therapy session of a total of 30 sessions. One of Jean's presenting complaints had been that John was dominating and controlling. She claimed that he chose her clothes and food for her, saying that he was trying to help her feel less depressed. Yet, she complained, "I end up feeling totally overpowered and consumed by his supposed benevolence. He is no better than my intrusive stepfather, who watched every step I made and beat me." John frequently complained that Jean was unappreciative of his magnanimous efforts and that she "checked out." In this particular session, both partners started to recount an event where John accused Jean of stealing his driver's license when he could not find it in its usual place in a desk drawer. As he re-told the story of his frustration with the missing license, his volume increased, his face reddened, and his fists clenched as he yelled at his wife, "I hate you as much as I hated those #X#^*X#&& (racial epithet toward Iraqis)." Jean tentatively shared her total lack of comprehension of why John was so enraged about his missing license. Actually, he found it ten minutes after his eruption toward Jean. Apparently, he had mistakenly put it in a small basket where bills were kept. In spite of his error, he remained enraged with Jean.

Similarly, in the re-telling of the incident, John once again erupted in rage, which was triggered by an earlier traumatic memory. Apparently, John's belief that Jean had stolen his license stirred a memory of Iraqi insurgents hurling explosives at his truck about 200-feet from where he was standing. They damaged the truck sufficiently so that he was unable to drive it. Fortunately, John's fellow soldiers fought back against the combatants and saved his life. Apparently, John's feeling of powerlessness was triggered by kinesthetic and olfactory stimuli. As he was walking about the house frenetically searching for his license (his metaphoric ticket to mobility), a kinesthetic stimuli triggered his traumatic stress response. There was a strong smell of burned toast, and it reminded him of the stench of burning rubber that had overwhelmed him at the time of the truck explosion. Jean was terrified by what appeared to be John's irrationality, and this triggered her early traumatic memories of being beaten by her rageful stepfather. While John reacted to his traumatic stress response with rage, Jean shut down by retreating into a protective, dissociative shell. In the session, they were alternating between the roles of the victim and the victimizer, reflecting a disorganized attachment pattern of relating.

Balancing the "Rage Storm"

This was not the optimal time to encourage verbal communication between partners. Instead, it was time to remind the couple of their agreement to cease destructive exchanges and focus on their own respective self-balancing of affect. Clearly, intense hyperarousal requires attention to affect regulation. As partners de-escalate from a "rage storm," they benefit from the clinician's attunement as a building block toward their own capacities for attunement.

I asked each partner to turn away from the other and to focus on the deep breathing methods that each partner typically used to interrupt a traumatic stress response. Within a period of five minutes, Jean looked more connected. She was calm and sat quietly. Several minutes more elapsed before John reported that his heart rate was slowing down and his breathing felt more regular. This neural relaxation exercise helped to re-activate John's neo-cortical functioning and to reduce the intensity of Jean's dissociative disengagement. Overall, this couple benefited greatly from a focus on these Phase I therapy tasks of affect-regulation, stabilization, and self-care. As John understood that Jean's memory lapses were actually dissociative states and that his rages triggered her protective distancing, he started to see his role in this relational dynamic. As Jean recognized that John's rage storms were triggered by flashbacks involving stimuli reminiscent of an earlier traumatic experience (i.e., his truck blowing up), she developed more understanding and compassion. As each partner started to identify their feelings and experience their affective states without the extremes of rage eruptions or dissociation, they moved toward stronger affect regulation, both individually and as a couple. As Jean and John developed these enhanced capacities to regulate their affect, they also moved along in their developing abilities to reflect on their emotional states. This emerging process of mentalization set the stage for work on other Phase II and Phase III tasks.

Phase II of the couple therapy practice model for trauma survivors involves a cognitive reflection on ways to temper the victim-victimizer-bystander pattern in their day-to-day relationships with their children, their friends, and each other. Grieving major losses often occurs within this phase (Fraley & Shaver, 1999). From an attachment theory perspective, Bowlby (1980) anticipated stages of grief, including intermittent protest, despair, detachment, or reorganization following a disrupted attachment. With some skills in place to balance affect, John and Jean were able to talk about their frustrations and worries, as well as some of their hopes in being able to shift this destructive relational pattern. In terms of attachment theory, each partner was experiencing and reflecting upon their affect, thus moving toward enhanced mentalization. What emerged with great intensity was Jean's unresolved grief related to her stepfather's death. As she expressed the mixture of hatred countered by relief and deep regrets, Jean acknowledged that she missed the positive memories of time spent with her stepfather, in spite of his violating physical abuse. As Jean talked, John listened attentively, offering sympathy and concern. Slowly, each partner's capacity for careseeking and caregiving started to strengthen.

John then asked if he could talk about his sadness about the deaths of two of his "buddies" who had been killed in Iraq less than a year before. As John talked about how deeply he missed these friends, he shared a sense of deep shame over his actions both in Iraq and Vietnam when he killed people, not always knowing if they were combatants or civilians. Frozen tears started to fall as he talked about wanting to honor his friends. Suddenly, John started to escalate and rant about how much he hated "the enemy." He wondered why he was so hateful in general, and Jean asked why he sounded as if he hated all Iraqis and all Vietnamese people. She deplored his generalizations, thinking that an entire ethnic community of people should not be vilified for a war where lives were lost all around. As John recognized his retreat from despair back to protest, he understood his anger to be a more comfortable space, as compared with his profound sadness. Slowly he talked about the origins of his racial hatred, sharing how helpless and powerless he felt to protect anyone during the throes of combat. These sessions clearly mined the depths of both John's and Jean's grieving, which had been previously stymied. Although at the onset of these sessions, I sometimes enacted a detached bystander role, I soon gathered my own capacities to stay with the intense affect in the room. Gradually, I became a much more engaged and respectful witness of their shared grieving. Although John's attachment world had been shaken by the horrors of combat, he was able to transform a disorganized attachment bond into a newly restored secure connection with Jean. Although Jean had been wrestling with a fiercely preoccupied attachment style throughout her life, the resonance that she felt from and with John enabled her to build trust and a fledgling experience of security.

As we neared the end of our work together in Phase III of the couple therapy, our tasks were to focus on consolidating new perspectives, attitudes, and behaviors. In attachment theory terms, this is the territory of "exploration." Although there were efforts to try new ways of relating, behaving, and thinking in earlier phases of the work, exploration was always limited by the shifting back and forth of heightened anxiety related to disappointments and fears that undermined a secure base. Phase III tasks also reinforce more reliable attunement and affect regulation, reestablishing a renewed balance of the couple's attachment bond congruent with Bowlby's reorganization phase. As both partners developed greater empathy toward each other with their increased capacities for mentalization, they reported feeling more joy, a sense of connection, and playful sexual exchanges. As each partner resolved their grieving, energies could also be directed into new adventures. Both partners started to talk about ways to re-connect with their children and to become involved in community activities that promoted peaceful means to resolve conflict. In a joint effort to re-establish spiritual connections they had previously abandoned, they decided to experiment with

attending a liberal Episcopal Church that promised their family more hope for change. Both partners reported that their decision-making process in choosing a faith-based community felt like a constructive compromise. Such a period of adventure and experimentation represents a time when surviving is replaced with thriving and re-engagement in the vitality of day-to-day life.

Evaluating the efficacy of this couple therapy approach with John and Jean brings us back to the goals established at the beginning. Both partners aimed to improve their communication, reduce animosity, and disrupt their abusive and alienating relationship pattern. John also wanted to manage his rage storms more effectively, while Jean hoped to feel less depressed. In attachment theory language, this couple aimed to restore a secure attachment where they could seek comfort and attunement, as well as provide a sense of solace to each other. They also sought to improve their understanding of each other and to be able to express strong feelings and thoughts effectively. Clearly, their mentalization processes improved, as did their capacities for exploration. As they grieved their earlier profound losses, both partners were freed to embark on new connections with different friends, as well as to repair ruptured connections from the past, particularly with regard to their children.

Summary

In his compelling book titled *Odysseus in America*, Shay (2002) captures the horrors of psychological injury inflicted by war on the soul and character of soldiers. Rather than relying exclusively on diagnostic classifications needed for treatment planning and financial compensation, he urges health professionals to think about combat-related mental health issues as psychological injuries rather than disorders. Just as we would avoid referring to a veteran who had lost an arm as having an "amputated limb disorder," we should think of returning soldiers as having a psychological injury that disrupts their capacities for attachment and relationship with others and themselves at the very core of their being.

This paper has addressed the trials and challenges facing returning warriors who have witnessed exposure to combat. As we see from the experiences expressed by partners, the world of combat extends beyond the soldier to the entire family through a range of processes of secondary traumatization and cyclic patterns of disrupted attachments. A phase-oriented couple therapy model attuned to the centrality of relationship, along with sensitivity to the culture of the military, can be useful for these couples facing the unknown and unexpected challenges of returning home. As the partners address their respective attachment injuries and other trauma-related issues, they may find new ways of relating, both intrapersonally as well as interpersonally. The secure base of a couple therapy framework, anchored by the careful attunement and affect-regulation from the clinician, may facilitate the emergence of these new capacities. Positive re-connections can only ease the profound pain and losses involved with reentry from a combat zone and hopefully fortify these traumatized military couples on their path toward continuing growth.

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