Application Paper

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**Introduction**

In today’s American, the “typical” suburban, middle-class family is not the only one that exists. There are many different types of families which are made up of different types of individuals. One type of family that is set apart by one of its members being especially unique is that of the military family. These families have one or more members – usually parents – who are either reservists or active-duty members in one of the armed forces.

According to the current research and literature that is available, many military families are well-adjusted, with healthy boundaries and roles established. However, some families experience the stress of adjusting to their service member returning home from deployments periodically. For those families that struggle, Structural Family Therapy and Emotionally Focused Therapy could be applied effectively to help treat some of the symptoms that create conflict and stress.

This application paper will discuss the current literature and research that is available on the topic of how military families are affected by their service member’s transition to and home from deployment. Next, the paper will discuss ways in which the Structural Family Therapy model can be applied to help ease the stresses that military families undergo. Finally, the Emotionally Focused Therapy model will be applied in the same way.

**Literature Review**

 The consensus of the current literature that is available on the subject is clear: life for families with a military service member is often – if not always – extremely challenging. According to Park (2011), “when one person joins [the military], the whole family serves” (p. 65). Whether the service member is a reservist or on active-duty, the family as a whole is affected in nearly every aspect by factors such as the uncertainty of the time and nature of deployment, and Posttraumatic Stress Disorder (PTSD) that the service member may exhibit after returning home.

According to Park (2011):

Since the start of the Global War on Terror, military children and families have faced multiple tests associated with unprecedented lengthy and multiple deployments, shorter stays at home between deployments, and greater risks of death, injury, and psychological problems among service members. (p. 65)

The effects of being stressed about the well-being of the service members often create additional and more severe emotional, mental, and psychological problems, and this should come as no surprise.

 Two of the most common psychological issues experienced by military families are ambiguous absence and ambiguous presence. Ambiguous absence is felt when “a person is perceived by his or her family members as being physically absent but psychologically present” (Faber, Willterton, Clymer, MacDermid & Weiss, p. 223). Conversely, as one might assume, ambiguous presence “occurs when a family member is perceived as being physically present [upon return from deployment] but psychologically absent, as a result of trauma from past experiences as well as of the distress from immediate resumption of previous roles and responsibilities” (Faber, Willterton, Clymer, MacDermid & Weiss, p. 223). These two issues are usually evident when adjustment to deployment and/or reunion of the service member does not go entirely smoothly. These two effects are the root of a number of other struggles.

 The family’s experience of ambiguous presence that is usually caused by PTSD may manifest itself in the form of intimate partner violence (IPV) that occurs between a service member and his or her spouse/intimate partner. According to Finley, Baker, Pugh & Peterson (2010), “there may be distinct patterns of violence committed by PTSD-diagnosed Veterans within the home, perhaps occurring in relation to recognized symptoms of the disorder, specifically amplified anger, dissociation or flashback, and sleep disturbance” (p. 740). Many times, Veterans will lash out in their sleep towards a loved one due to “dissociative” episodes in which the Veteran may involuntarily attempt to harm their spouse (Finley, Baker, Pugh, & Peterson, 2010). Other times, IPV occurs in anger and is more intentional on the part of the Veteran.

 The experience of ambiguous absence often exhibits itself in the form of role confusion. “Structurally, ambiguous loss can be a problem when it leads to boundary ambiguity, described as ‘a state in which family members are uncertain in their perception about who is in or out of the family and who is performing what roles and tasks within the family system’” (Faber, Willterton, Clymer, MacDermid & Weiss, p. 223). Family attachments and the roles that accompany those attachments are an important factor to consider when thinking about how resilient military families are when faced with deployments and other major transitions. According to Riggs & Riggs (2011), “from a systemic perspective, stressful experiences affect the whole family and the impact on all members and relationships is mediated by key family processes” (p. 675).

 A prevalent issue that military families have to deal with that has already been briefly discussed is Posttraumatic Stress Disorder. In an obvious sense, the Veteran who is returning home from deployment will most likely experience some degree of PTSD. According to Alici et al. (2010), “The National Vietnam Veterans Readjustment Study reported that male veterans have a lifetime PTSD prevalence of 30.9% and that half of these experienced chronic PTSD” (p. 508). PTSD is a common occurrence, particularly in Veterans who have been in combat zones (Finley, Baker, Pugh, & Peterson, 2010).

However, in addition to the service member themselves experiencing PTSD, according to Nelson & Wright (1996), “recently, clinicians have begun to identify PTSD-like symptoms in [their] female partners” (p. 455). This is believed to be caused by the depth to which the female partners of PTSD-affected Veterans attempt to sympathize and cope with the symptoms brought on by PTSD. “Because of the degree of stress associated with each of these issues, it is very difficult for these women to be effective or consistent in their coping strategies” (Nelson & Write, 1996, p. 458). The evidence that PTSD is not uncommon in the female partners of Veterans only points to the fact that families are deeply affected by the challenges that military life brings.

These various challenges and obstacles that many military families face are not without consequence. In fact, there has been an “apparent increase in marital and family difficulties during the last decade” (Riggs & Riggs, 2011, p. 675). However, there are programs that seek to help Veterans and their families adjust to deployment and readjust to reunion as smoothly as possible. Family therapy is one of those programs. The rest of this application paper will be spent exploring ways that Structural Family Therapy and Emotionally Focused Therapy can be applied to some of the specific issues that military families encounter, in hopes that the stress that said families experience will be lessened.

**Structural Family Therapy**

Structural Family Therapy was developed and lead primarily by Charles Fishman and Salvador Minuchin. This model assumes that the issues within a family are probably due to problems in the structure of the family (Green, 2003). Proponents of this model believe that, by changing the structure of a family, the experience that each client has can also be changed. The main goal of therapy is to create structural change; to clarify, realign, and mark boundaries (Nelson, p. 1). Depending on the rigidness or openness of the structural boundaries, Structural Therapy may seek to change the fluidity and flexibility of those boundaries.

One of the most important parts of the intervention process in Structural Therapy is that the therapist joins with each of the clients and accommodates to each family member. The therapeutic alliance is extremely important in this model of therapy, because it is vital that the therapist has the trust of the clients in order to create real change. After the alliance is formed, the therapist may have the family members enact and reenact issues that are already occurring within the system and subsequently direct family members to act in ways that are more appropriate given the healthier boundaries (Green, 2003, p. 119).

The therapist, after evaluating how he or she should intervene, may then choose to incorporate spatial manipulation into the session, where the therapist literally rearranges specific family members in the room in an attempt to change the structural organization of the family (Green, 2003, p. 121-122). The therapist may also act as a model and a teacher and help join parents and children in their appropriate subsystems. They may assign tasks to affect the presenting problem and the structural problem for the family to complete at home (Green, 2003, p. 123). The therapist may even instruct family members to exaggerate symptoms of depression, anger, or conflict in order to show the individuals that their symptoms were “in vain,” so-to-speak and totally fixable.

As stated above, roles and attachments play a vital role in the resilience and well-being of military families. Riggs & Riggs (2011) argue that “attachment relationships contribute to intra- and inter-personal processes underlying risk and resilience throughout the life span” (p. 675). Avoidant and anxious attachments between spouses and family members can cause reintegration into civilian society to be incredibly difficult for the Veteran and his or her loved ones.

A Structural Family Therapist may attempt to address these weak attachments by having the Veteran and his or her spouse enact an ongoing conflict that they had been having. For example, the therapist may observe that a Veteran husband and wife begin quarreling during a session. The wife is frustrated because her husband does not express his emotions in the moments he is experiencing them, but rather bottles them up and then “explodes” every couple of days in fits of anger or frustration. The structural therapist would observe the husband shutting down as the wife expresses her own feelings, and the therapist would then direct the husband to communicate more clearly about what he is feeling in that moment. The therapist would be able to recognize that the boundary between the spouses was one characterized by conflict. By utilizing enactment and acting as the expert and director in the room, the therapist would be working towards creating a clearer boundary in the husband and wife’s relationship.

**Emotionally Focused Therapy**

Susan Johnson and Les Greenburg were the primary proponents of Emotionally Focused Therapy. Emotionally Focused therapists believe that “emotion is a target and agent of change (Nelson, p. 23). This model is not interested in things like genograms (family history) or pathologizing. On the contrary, this model sees the present emotions and occurrences as the biggest factor when it comes to change. Some of the main goals of Emotionally Focused Therapy are to get to the root of emotional tendencies and create healthier ways of expressing primary emotions. Emotionally Focused Therapy seeks to uncover the primary emotions behind the more commonly expressed secondary emotions. According to Nelson, this model seeks to “foster the creation of a secure bond between partners through the creation of new interactional events that redefine the relationship” (p. 23).

An Emotionally Focused therapist’s biggest tool in the therapy room is to ask questions that provoke the clients’ self-reflection. The therapist seeks to truly empathize with each client, and should willingly self-disclose when appropriate. Enactments, reframing, heightening and expanding on emotional experiences and softening harsh comments are all ways that the therapist may choose to intervene (Nelson, p. 24). The therapist comes into the therapy room with the assumption that, although they are the expert on the actual process of therapy, the clients are the experts on their own lives. Sometimes the therapist is simply a collaborator, while other times the therapist takes on a heavier leadership role within a therapy session.

Proponents of Emotionally Focused Therapy believe that “change happens as couples have a new corrective emotional experience with one another” (Nelson, p. 24). In the case of a military family, the therapist would empathize deeply with the emotions of the Veteran (or spouse) suffering from PTSD. Here is a specific example of an intervention a therapist might use. The wife of a combat Veteran seems to be suffering from some clear symptoms of Posttraumatic Stress Disorder because of the things that her husband has shared with her about his time in the war zone. The therapist sees her expressing anger and distancing herself from her husband and recognizes that the primary emotion behind those reactions is fear. The therapist asks questions such as, “What causes you to react towards your husband so rashly?”

As the wife began to uncover and reveal more about the primary emotions she was experiencing, the therapist would be sure to validate and reflect on those emotions, and ask the husband to share his honest and full reactions. If any of his or her reactions were harsh or blunt, the therapist would soften and reframe those emotions to reflect the primary ones that were under the surface. If either spouse continued to withdraw or become defensive, it would be the role of the therapist to direct that spouse back to the discussion and help clarify what was really going on.

The end goal would be that the spouses would be able to more easily and clearly express their emotions to each other in a way that is healthy and sensitive to the other spouse. Positive cycles would be enacted, and negative cycles would, although still potentially present, be controlled (Nelson, p. 24).

**Conclusion**

 Military families are among the types of families that experience the most raw and painful conflict. Posttraumatic Stress Disorder certainly takes its toll on many areas of family life, particularly in active-member military families. The issues these families experience are deeply rooted in the psychological injuries that many Veterans sustain as they engage in combat and serve overseas.

According to Park (2011), “although aspects of military life can be difficult for families, positive family functioning boosts a service member’s morale, retention, and ability to carry out missions” (p. 65). Clearly, the health of military families is vital to the success of the service members. Structural Therapy and Emotionally Focused Therapy can be applied in practical ways that can help mend some of the broken and rigid bonds between family members following subsequent deployments and reunions with Veterans.

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