

United We Stand: Emotionally Focused Therapy for Couples in the Treatment of Posttraumatic Stress Disorder

Paul S. Greenman¹ and Susan M. Johnson²

¹University of Québec in Outaouais

²University of Ottawa

We present emotionally focused therapy (EFT) for couples as a viable treatment option for posttraumatic stress disorder (PTSD). We outline the empirical evidence of a link between interpersonal relationships and posttraumatic stress, with an emphasis on social support as a buffer for the development of PTSD symptoms. This leads into a discussion of the usefulness of attachment theory in the conceptualization and treatment of PTSD, followed by a description of the EFT approach and its empirical evidence. We present a clinical case with excerpts from EFT couple therapy sessions in which one partner was diagnosed with PTSD. The article concludes with clinical recommendations for helping people confront and overcome the pain and the fear that PTSD provokes. © 2012 Wiley Periodicals, Inc. *J. Clin. Psychol. In Session* 68:561–569, 2012.

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Researchers and clinicians have acknowledged the interpersonal components involved in the etiology, manifestation, and treatment of posttraumatic stress disorder (PTSD) ever since the late 19th century. For example, Pierre Janet concluded in the 1890s that there was a link between the condition commonly referred to at the time as *hysteria* (i.e., intense, often intolerable emotional responses after the experience of traumatic events, with subsequent reactions of numbing and dissociation) and episodes of sexual abuse within the family (Herman, 1992). Similarly, Freud noted famously in 1896 that “at the bottom of every case of hysteria there are one or more occurrences of premature sexual experience (Freud 1896/1962, p. 203),” often perpetrated by people close to the young women whom he treated. Later, clinicians treating male soldiers serving in the First World War noted reactions of interpersonal disconnection and emotional numbing among them that strongly resembled the symptoms of hysteria that Freud and his contemporaries had observed in women (Herman, 1992).

These observations laid the foundation for the inclusion of strong interpersonal or relational components into many psychological treatments for symptoms of posttraumatic stress, resulting in improved outcomes for people suffering from PTSD (Billette, Guay, & Marchand, 2008). In her groundbreaking work on PTSD, Herman (1992) concluded that “traumatized people feel utterly abandoned, utterly alone, cast out of the human and divine systems of care and protection that sustain life” (p. 52), and that any psychological intervention for trauma must involve the establishment of safe emotional connections to significant others. It is against this backdrop that we will make the case for couple therapy, specifically emotionally focused therapy (EFT) for couples, in the treatment of PTSD.

This article is divided into several sections. First, we will outline the relational elements implicated in the genesis of and protection against PTSD, with an emphasis on the power of human relationships to either exacerbate or attenuate the effect of the disorder on affect regulation. We will highlight the harm that PTSD can do to the very interpersonal connections that are necessary for healing, using attachment theory to explain the clinical phenomena and to suggest avenues for treatment. Next, we will present the rationale for and empirical evidence

Please address correspondence to: Dr. Paul Greenman, Department of Psychoeducation and Psychology, University of Québec in Outaouais, 283, Alexandre-Taché Blvd., Gatineau, QC J8X 3X7 Canada. E-mail: paul.greenman@uqo.ca

of EFT for couples as a viable treatment for PTSD, which will set the stage for the presentation of a clinical case. We conclude with clinical recommendations.

PTSD and Relationships

PTSD is essentially a disorder of affect regulation: Individuals with PTSD have difficulty controlling their impulses and their extreme fear reactions, which can diminish their ability to enter into and maintain close relationships with others (Herman, 1992).

Affect Regulation

Close relationships appear to play a causal role in the development of PTSD symptoms, particularly acts of physical or sexual abuse perpetrated by caregivers during childhood (Herman, 1992). By the same token, symptoms of PTSD can have detrimental effects on the quality and stability of people's relationships. Although they need the comfort that comes with emotionally close interpersonal relationships just as everyone else does, traumatized individuals' struggles with affective numbing and dissociation, on the one hand, coupled with hyperarousal, anger, and distrust, on the other, make it difficult for them to get close and stay close to other people. This is problematic because social isolation has been shown to exacerbate symptoms of PTSD (Brewin, Andrews, & Valentine, 2000).

Social Support and Attachment

Close connections to significant others can play a significant part both in protecting individuals from posttraumatic stress reactions and in helping those who do become afflicted to recover. A large body of research supports this notion. For instance, in a study of over 300 undergraduate students in Canada, perceived social support was a primary determinant of psychological adjustment among those who reported having been maltreated as children (Runtz & Schallow, 1997). Those who perceived the emotional availability and responsiveness of significant others were less likely to exhibit signs of psychological dysfunction. Conversely, a meta-analysis of 77 studies of adults exposed to trauma revealed that lack of social support was one of the strongest risk factors for the development of PTSD (Brewin et al., 2000). The results of more recent studies and literature reviews (e.g., Guay et al., 2011) corroborate the notion that the presence of perceived social support acts as a buffer against PTSD, whereas a dearth of social support makes it more likely that PTSD will manifest itself in people who survive traumatic events.

Attachment theory (Bowlby, 1969) provides an explanation for these findings and a foundation for EFT with couples. In a nutshell, attachment theory stipulates that humans have innate needs for proximity to and comfort from other human beings. They develop emotional bonds with primary caregivers during childhood, which provide a template for future relationships. During times of stress or threat, whether one is a 2-year-old child or a middle-aged, married man, an inborn tendency to seek support and comfort from attachment figures becomes activated. This proximity seeking represents an attempt to regulate the negative affective states such as fear or sadness that stressful situations provoke.

According to attachment theory, those individuals whose primary caregivers respond consistently and effectively to their emotional distress signals will come to perceive the world as a place in which comfort in a time of need is not far away and perceive themselves as worthy of love and support. These are the *internal working models* to which Bowlby (1969) referred. Positive models help attenuate the effects of danger and stress. It is no wonder, then, that some researchers have found that the inclusion of a spouse in individual treatment with victims of sexual assault suffering from PTSD appeared to reduce patients' posttraumatic symptoms (Billette et al., 2008).

Attachment theory also suggests that individuals whose caregivers respond inconsistently to their cries for help or who actively abuse them will come to perceive the world as a dangerous place. They tend to attempt to either numb the negative emotions they feel in times of distress or seek comfort and reassurance excessively, but to no avail (Mikulincer, Shaver, & Horesh, 2006).

The solitude that they experience on a regular basis becomes even more salient in the face of trauma and can exacerbate its effects (Mikulincer et al. 2006).

It therefore makes sense that those who perceive the emotional availability of significant others would be protected from the negative effects of psychological trauma; they recognize and actively seek support when they need it, with the conviction that they will get it. It also becomes clear that perceived lack of emotional support would make a bad situation worse for traumatized individuals. They feel that they are, after all, alone in a perilous world. Perceptions of isolation and abandonment tend to characterize their experiences both inside and outside of their relationships with romantic partners.

EFT for Couples and PTSD

Clinicians have taken note of the empirical findings related to social support and attachment theory and have integrated them into an array of psychotherapies designed to alleviate psychological distress, including PTSD. EFT (Johnson, 2002) for couples is one of these that has been extensively studied. EFT therapists construe the creation of loving, supportive bonds between romantic partners as essential components of the healing process in the wake of trauma.

EFT is an experiential, systemic therapy. EFT practitioners conceptualize chronic difficulties in couples as the result of unmet attachment needs that give rise to behaviors such as emotional stonewalling and criticism that have been found to pervade troubled couples' interactions. From an EFT perspective, these rigid behaviors mask underlying attachment longings for closeness and comfort, and they reinforce negative interaction patterns between partners.

EFT consists of three stages: de-escalation of the couple's negative cycle (Stage I), restructuring of problematic interactions (Stage II), and consolidation/integration (Stage III; Johnson, 2004). EFT practitioners follow a set of nine prescribed steps (four in Stage I, three in Stage II, and two in Stage III). The overarching goal of the treatment is to help couples become more aware of their negative interaction patterns and overcome them by establishing a secure emotional connection. EFT therapists achieve this by encouraging partners to recognize and react appropriately to each other's needs for emotional connection, the expression of which they foster during Stage II. The goal of EFT is to shape interactional cycles characterized by the emotional accessibility and congruent responsiveness that constitutes effective dependency. Each partner becomes a safety cue for the other. Contact mitigates the encoding of threat and increases the ability to cope with stress. For this reason, the moments of guided communication, or *enactments*, in EFT focus specifically on expressions of vulnerability and longing, rather than on the generation of solutions to specific problems. Couples address particular problems in detail only in Stage III, once the relationship has become a secure base for them to explore solutions. The EFT therapist does not propose solutions but rather acts as a process consultant, reflecting to partners how their way of interacting with each other fosters or hinders the experience of safety and closeness in the relationship.

There is substantial empirical support for EFT for couple distress. For example, a meta-analysis of EFT outcome research (Johnson, Hunsley, Greenberg, & Schindler, 1999) revealed a mean effect size (d) of 1.3 compared with no treatment, an effect that is quite large in psychotherapy research. Johnson (2004) reports that 70%-73% of couples who receive EFT recover from their relationship distress, and that 86-90% of distressed couples who participate in EFT exhibit significant increases in relationship satisfaction. The effects of EFT appear to be stable over time (Halchuk, Makinen, & Johnson, 2010), and as such, it is considered to be an evidence-based treatment for couple distress (Snyder, Castellani, & Whisman, 2006).

There is also preliminary evidence of EFT's effectiveness as a treatment for PTSD. There have been four initial outcome studies of EFT's effects on PTSD to date, with promising results. For instance, in one study of 10 highly distressed couples in which one partner was a childhood sexual abuse survivor (CSA) who met diagnostic criteria for PTSD (MacIntosh & Johnson, 2008), half of the CSAs demonstrated clinically significant decreases in PTSD symptoms on the Trauma Symptom Inventory (TSI; Briere, Elliott, Harris, & Cotman, 1995) and all of them demonstrated clinically significant decreases in PTSD symptoms as measured by the Clinician Administered PTSD Scale (CAPS; Blake et al., 1995). This is noteworthy given the fact that in this sample

couples completed only an average of 19 therapy sessions due to methodological constraints, when successful resolution of this type of extreme relational trauma and the relationship problems that it causes normally requires a minimum of 30 couple therapy sessions (Johnson & Courtois, 2009). In another pilot study of EFT for couples for war veterans suffering from PTSD, there were statistically significant decreases in veterans' PTSD symptoms after participation in an average of 30 sessions of EFT (Weissman et al., 2011).

Similarly, Naaman (2008) discovered statistically and clinically significant reductions in symptoms of PTSD among women suffering from breast cancer after a course of EFT for couples, whereas couples in her control condition did not exhibit significant changes. Finally, Dalton and colleagues (2011) detected a notable reduction in the trauma symptoms of women who had been subjected to intrafamilial abuse during childhood and who participated in 20 sessions of EFT for couples. Although this line of research is in its infancy and only two of these studies included control conditions (Dalton et al., 2011; Naaman, 2008), to our knowledge EFT is the only couple therapy that has yielded consistent results to suggest it as a useful treatment for PTSD.

Case Illustration

The following case is part of an ongoing investigation of the effect of EFT for couples on the quality of marital relationships in which one partner has been diagnosed with coronary artery disease (CAD). In the case presented here, the wife of the cardiac patient had a history of PTSD.

Presenting Problem and Client Description

Joyce and Peter are in their early forties. They have been married for 15 years, and they have a 3-year-old daughter. For the past 10 years, Joyce has held a high-level position in the Canadian government. She was a human rights activist before joining the government. Joyce was working for the Red Cross in the early 1990s in Africa, where she witnessed the atrocities committed by the Rwandan government against the Tutsis during the genocide of 1994. She was diagnosed with PTSD 6 months after she came back to Canada. She underwent a course of successful individual psychotherapy over the 2 years that followed her return home, during which Joyce worked through the flashbacks and emotional numbing linked to her experiences in Rwanda and to the sexual abuse perpetrated by her father when she was a young girl.

Joyce met Peter shortly after her homecoming. She explained at the beginning of couple therapy that his compassionate support and calm, reassuring presence during that tumultuous period in her life were key components of her recovery and of her ability to feel alive and safe in the world. She described him as her "lifeline" and became emotional as she talked about how her relationship with him had awakened in her a joy and a zest for life that she had not previously known. Joyce stated that whereas her previous long-term relationship partner had been emotionally and physically abusive, Peter went to great lengths to show his respect for her and to make her feel loved and valued.

The couple married after a brief courtship. Peter advanced in his career as a computer programmer, and the couple settled in a quiet suburban neighborhood. At intake they both described their first years together as happy and contented. Then, 6 months before their initial consultation in couple therapy, Peter was diagnosed with coarctation of the aorta, a congenital heart condition that had been present since birth but only discovered when he started experiencing chest pains and shortness of breath as an adult. The condition required immediate installation of four endovascular stents, which opened his arteries sufficiently to reestablish normal blood flow. However, his physicians warned Peter that lifestyle changes were in order. He was instructed to stop smoking, reduce his alcohol intake, commence a regular exercise regimen, and go on a strict low-fat diet.

Peter said at intake that he had been having difficulty making these adjustments, and that it had become a source of strain on his relationship with Joyce. He said that she often nagged him about his health and that she had become demanding and critical in general. His response to her constant exhortations to take better care of himself, which he experienced as personal

affronts, led him to withdraw from Joyce emotionally and become persistently defensive and wary of her moods. Joyce admitted that she had become increasingly vigilant of Peter's risky health behaviors since the installation of the stents, and that she tended to confront him angrily with his lack of discipline and his shortcomings as a husband and parent, something that she had not done before. Joyce indicated that since the diagnosis of heart disease and installation of the stents, she had lost interest in Peter sexually and that she felt isolated and alone. She also said that her PTSD symptoms were recurring: She began having flashbacks and nightmares of her experiences in Rwanda and of the abuse from her father and her previous boyfriend. She explained that these flashbacks led her to feel constantly shaky, insecure, and on guard. The couple sought treatment to help them overcome the pervasive demand and pursue-defend and withdraw pattern that had come to define their relationship.

Case Formulation

The EFT therapist (first author) conceptualized the couple's difficulties as the direct result of a perceived loss of what had been a secure emotional connection, because of Peter's cardiac illness and his subsequent reactions to it, in conjunction with Joyce's trauma history. He set out during Stage I of therapy to help both partners construe the problem in attachment terms: Joyce suddenly feared losing her "lifeline," which had rekindled dormant experiences of terrifying violation, isolation, and loneliness in the face of danger; whereas Peter was abruptly faced with a life-threatening illness and what felt to him like the loss of his most important source of emotional support right when he needed it the most.

Course of Treatment

Once the couple began to perceive their pursue-withdraw pattern as their enemy, rather than each other, Peter began to show signs of greater responsiveness to Joyce in session and a tendency to be more frank with her about his own struggles since the installation of his stents. This represented a de-escalation of their negative interaction cycle. In light of Peter's newfound openness to Joyce, Stage II of therapy focused on helping Joyce to become more attuned to her primary fears of losing her husband and to the sense of helplessness and vulnerability that these fears evoked. The therapist encouraged her to express these feelings directly to Peter in a way that would both help him understand how her perceptions of a lackadaisical attitude toward his illness on his part had triggered her posttraumatic reactions. These partners were then able to help each other regulate their anxiety, providing a safe haven where fears could be calmed and a secure base where each would feel empowered to deal with threat and danger. Peter achieved this by making active efforts to listen to and comfort Joyce, and she did the same by inviting Peter to be more open with her about his hopes, needs, and fears related to his health and to their life together. Once the couple passed through the steps of Stage II over the course of several sessions, Stage III helped them tackle the practical problem of the lifestyle changes to ensure Peter's good health over the long term.

Stage I. The following excerpt is from Stage I of therapy (Session 6). In it, Joyce speaks to the therapist and to Peter about her experiences in the relationship since Peter's surgery. She refers to instances of Peter's inattention to his health (his alcohol consumption, poor eating habits, and lack of exercise) and to their effects on her:

Joyce: Somewhere in the hospital my affection for him died. It died when I had to see him through the shakes and the shocks. It was like somebody slapped me across the back of the head and said, "You're an idiot. Wake up! Look at what you've got in front of you and recognize that this person is working really hard at killing himself!" And then I had to rat on my husband to the social worker, I had to rat on him to the doctors. I said, "Are you guys all smoking drugs? He is not doing well at all!" And then, all of a sudden, my ability to reach out was compromised. It was gone. That trust between us? Gone.

Therapist: All of that fear [heightening of primary affect]. All of a sudden, it was like you lost your lifeline, and you were being reminded of it [framing Joyce's reaction in attachment terms].

Inside you were feeling, "I need you, but I can't count on you anymore" [validation].

Joyce: So much of a relationship is trust and respect. I'm looking at this going, "This is insane! I don't even know this person!" I sure as hell don't want to hold hands with somebody who's systematically destroying himself!

Therapist: Something happened there, Joyce. You said you lost something. You said, "I don't know this person." It's as if Peter became someone else?

Joyce: Absolutely. It was just day and night, wake up and smell the coffee, quit pretending.

Therapist: Who's this other person?

Joyce: I lost my husband. He was replaced by somebody who's a medical case who doesn't want to look after himself. Instead of being husband and wife, we're now nurse and patient! I get to be a nurse. Hmm, interesting [sarcastic tone]. How do I feel attracted to someone I don't even want to be in the same bed with [angry tone]?

Therapist [lowers voice, speaks slowly, brings the conversation back to Joyce's attachment fears]: You said he's a different person. "I lost my husband."

Joyce: And he was replaced by a patient, somebody who's going to lie, who's going to hoodwink every doctor in the city! Instead of being a caring, supportive wife, the only way I can help him is to go in and call these damn doctors and say, "You're all crazy! What are you doing? Do you not see this man? Do you not see these issues?" All the alcohol, not even remotely following a diet . . . He bought a bottle of rum and a bag of peanuts on the way home from the doctor's office! [Joyce turns to Peter and says in an accusatory fashion] You're lying to your doctors—that says something about who you are! You're killing yourself, and I get to watch! Well, no thank you!

Therapist: This is where you get stuck, Joyce: "I can't count on him anymore, but I need to count on him. I'm still longing for him [empathic conjecture], but now there's this alarm that goes off and says, 'No, don't do it!'" You get mad because it feels like it's the only way to get through to him.

Joyce: I want to reach out, I want to be part of a couple, but the risk is so huge right now.

Therapist: Peter must be pretty important to you if the thought of losing him triggers all of these fears and alarms and makes you feel like you have no choice but to go after him like this [reframe].

Joyce: Well, of course! That's what this is about, isn't it?

Therapist [to Peter]: Did you know that you meant that much to Joyce? That you were her lifeline?

Peter: No. She doesn't usually tell me that. She just rips me to shreds like she did just now.

At this point the therapist actively supported Peter and continued to reframe Joyce's comments in terms of her love and need for him. The goal of these interventions was twofold: (a) to help Joyce recognize the source of her angry behavior as her fundamental need for closeness to Peter and her fear of losing him, and (b) to help Peter become more receptive to Joyce by perceiving her vulnerability rather than her animosity. This would ultimately help Peter make some of the behavior changes his physicians had suggested, because instead of experiencing Joyce as aggressive, he began to understand the depth and intensity of her feelings for him and receive her support.

Stage II. In Stage II of therapy, the therapist helped Joyce explain to Peter how his illness had triggered her posttraumatic stress reactions. Instead of criticizing or attacking him, she began speaking about how abandoned and alone she felt, and about how this sense of isolation had triggered flashbacks to the horrors that she had witnessed in Rwanda and emotionally charged memories of her previous abusive relationships. The therapist supported Peter to hear and understand this so that he could comfort Joyce effectively. The following excerpt is from session nine:

Peter [to Joyce]: I need to understand better how much it's hurting, why it's hurting so much for you. I'm affecting you so much now. I want to go there with you [referring to the intrusive

- memories and the flashbacks]. I need to go there with you, because we're grasping at whatever we can here to try to move through this. I'm lonely too.
- Joyce: This isn't fun. I realize now how this all fits together: my past, your health, these flashbacks I've been having. This isn't someplace I want to be. This is a place I want to run from. You're probably right about needing you to come with me, because I'm not so sure I can get through this by myself. But I don't feel safe doing it. I don't feel safe asking you for help. I'm so scared right now [softening].
- Therapist: It's really hard right now because you've felt burned before. On the one hand, you're saying you need that safe place, that "gift" that Peter gave you [the sense of security she felt at the beginning of their relationship], on the other hand, it feels like it's too hard to reach out to him right now. Do you hear him saying, "I want to be here for you, I want to learn how to respond to you"?
- Joyce: I'm not sure if I can get there. I've had to work so hard for so long at protecting myself: as a kid from my father, in my relationship with Jack, in Rwanda, and now here. I've had to work at building the biggest bloody wall I could, to find a safe place within myself because I couldn't find that safe place anywhere else. [To Peter] I try to talk to you, I try to tell you that I'm having flashbacks, that all of this is mixing together. Please don't hang me out to dry [continued softening].
- Therapist: It sounds like that when you see Peter as neglecting his health, those flashbacks start for you. When this happens, when you feel this intense fear, you feel unsafe and lonely. How can Peter put a hole in the wall or climb over it to come and be with you so that you can experience some of that safety that you felt with him before? This wall might help you feel safe for a little while, but it's also keeping you alone with all of this, which just makes things worse.
- Joyce: I'm feeling so ripped up. I need you [to Peter] to not do things that create tension in our lives. I don't want to watch you kill yourself.
- Therapist: So, when you feel this vulnerability, you're saying, "I need you to be here. I need to know that you're here, that you're going to be here." Can you ask Peter for that right now [enactment to encourage a new type of response from Peter]?
- Joyce: I need you. This whole thing hurts. I'm glad you're getting it. I need you so much. Please . . . [she cries softly].
- Peter: I'm so sad. It really bothers me that this should affect you so deeply. I don't ever want to hurt you.
- Therapist: Can you look at him, Joyce? Can you see that?
- Joyce: I do! It helps. But it doesn't make me feel safe yet.
- Peter: Actions speak louder than words.
- Joyce: That's right. I need to feel consistent safety to rebuild that trust somehow. We can't keep playing with our lives. I can't keep going to the office and coming home and to see you drinking on the couch once Vanessa's [their daughter] gone to bed. It doesn't matter if you have one drop or the whole bottle. Seeing you like that, now, after all that's happened, sets all of this stuff off inside of me.
- Peter: I'm going to do everything I can to try [reaches for Joyce's hand].
- Therapist: You're offering; you're extending your hand to her.

At the therapist's direction, the couple repeated this type of exchange for several sessions. As they did so, they began to move closer together. With Peter's support, Joyce's intrusive PTSD symptoms began to subside. She started to feel safe with him and began opening up to him more frequently. They started taking walks again together, which had been one of the ways in which they bonded emotionally before Peter's coronary ailments. Joyce reported in one session that she felt particularly safe during a trip the couple took to Europe, because she experienced Peter as present and engaged in looking after her. When it became clear that these changes were stable, the therapist moved into Stage III of EFT.

Stage III. Once a couple has re-established a secure emotional tie, it is useful to discuss longstanding problems that sparked their negative interactional cycle at the beginning of

treatment. In the case of Joyce and Peter, this involved a detailed discussion of their lifestyle as a couple and of the changes that each of them could make to ensure Peter's physical health and Joyce's sense of emotional stability. Peter mentioned that he was considering joining a gym, and Joyce suggested that she accompany him ("I could lose a few pounds, too," she said). Peter also started talking about taking concrete steps to reduce his consumption of alcohol. He began opening up to Joyce about how alcohol had been filling a void in his life that he was not sure how to fill otherwise. Joyce thanked Peter for his openness and said that this made her feel safer and closer to him, even if he did not have the solution right away. Joyce even offered to reduce her own alcohol intake and support Peter through whatever feelings might emerge as he delved into the void that he mentioned. The therapist reflected the couple's new way of interacting with and talking to each other: Instead of blaming each other or becoming defensive, they now spoke openly of their fears and their confusion. They offered mutual support once they sent and received clear signals of distress and longing. All through this process, the therapist acted as a process consultant, following interactional and emotional processes and gradually shaping deeper emotional engagement and more responsive moves in the interactional dance (Johnson, 2004).

Outcome and Prognosis

At the time of writing, Joyce and Peter are still in Stage III of EFT. They are exploring new ways to develop a healthier lifestyle and they are doing so together. Joyce reports that her flashbacks and intense episodes of fear and panic have subsided for the most part, but when they do occur, she reaches out to Peter for support, who gladly offers it. For these reasons, the prognosis is good. It will be important, however, for both partners to be aware of their own fears, longings, and vulnerabilities, how they behave when they experience them, and how these behaviors affect each other. The therapist reminds Peter that seemingly innocuous comments, gestures, or situations can trigger Joyce's PTSD reactions, and he reminds Joyce that any sarcasm or criticism only serves to alienate him and make it harder for him to deal with his medical problems.

Clinical Practices and Summary

As this case and the budding literature on EFT suggest, this approach appears to be an effective element in the treatment of PTSD. EFT is suited to numerous aspects of the clinical presentation of PTSD, including difficulties with affect regulation, isolation, flashbacks, and dissociation. EFT also offers a systematic map to understanding the chaos that PTSD symptoms and attachment anxieties create in a love relationship and a systematic map to treatment. As the scientific evidence of the link between social support and PTSD would suggest, the perception of emotional availability from a significant other within the context of a safe, supportive, and loving relationship seems to make a vital contribution toward the reestablishment of interpersonal connections that are crucial to overcoming the effects of this disorder.

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