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Marital and Family Therapy

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Clinicians have long recognized that marital and family relationships serve a potentially important role in recovery from traumatic events (Barrett & Mizes, 1988; Beiser, Turner, & Ganesan, 1989; Davidson, Hughes, Blazer, & George, 1991; Solomon, Waysman, & Mikulincer, 1990). Similarly, it has been noted that traumatic events and the aftereffects of such events can significantly affect the partners and families of those directly exposed to the trauma (see, e.g., Figley, 1985; Waysman, Mikulincer, Solomon, & Weisenberg, 1993). This recognition has led numerous authors to suggest that marital and family therapy be included, or at least considered, when developing comprehensive treatment programs for posttraumatic stress disorder (PTSD) and other psychological sequelae of trauma (see, e.g., Figley, 1988, 1989; Glynn et al., 1995). Unfortunately, despite the many suggestions about how to incorporate marital and/or family therapy into comprehensive treatment programs, no controlled studies and very few empirical data exist to address the impact of including such treatments in programs aimed at alleviating the effects of trauma. Therefore, the present review relies heavily on the theoretical and clinical writings extant in the literature on the treatment of PTSD and other trauma-related problems.

Although marital and family therapy are distinct forms of intervention with their own histories and somewhat different emphases, they share certain theoretical assumptions and characteristics (e.g., systemic focus, multiple participants). Authors who have suggested the incorporation of marital or family therapy into programs for treating posttraumatic symptoms have largely relied on the same arguments for the value of such interventions. Therefore, in the present chapter, I use the term "marital/family therapy" to refer to

those arguments offered to support the utility of these interventions. In cases where arguments or suggestions appear specific to either marital therapy or family therapy, the individual terms are used.

ORIENTATION OF REVIEW

Because systematic examination of marital/family therapies for PTSD is generally lacking, the bulk of the current review focuses on the rationale and specific goals of therapies that have been suggested in the existing literature.

The body of the present review is separated into two sections, reflecting two philosophies or arguments that appear to guide much of the literature on marital/family therapy for trauma-related symptoms. The first argument for using marital/family therapy as a treatment for posttraumatic symptoms is based on the recognition that trauma and its aftereffects can impact directly and indirectly on the families and relationships of exposed individuals (Carroll, Rueger, Foy, & Dohohoe, 1985; Jordan et al., 1992; Solomon, Mikulincer, Fried, & Wosner, 1987; Waysman, Mikulincer, Solomon, & Weisenberg, 1993). The focus of these approaches is to address the systemic disruption resulting from both the trauma exposure and the manifestation of posttraumatic symptoms by one or more family members. Thus, the intervention focuses more on relieving the distress in the traumatized relationship or family than on reducing a particular individual's symptoms. The approaches suggested by this argument are clearly based on the marital and family therapies that have been developed to address issues in other populations. For the purposes of this review, I refer to these treatment approaches as *systemic* treatments.

The second argument for including marital/family therapy approaches in the treatment of trauma-related symptoms focuses on the role of the spouse and family members in helping the trauma survivor to recover from the symptoms arising from the traumatic experience (Barrett & Mizes, 1988; Beiser, Turner, Ganesan, 1989; Davidson, Hughes, Blazer, & George, 1991; Solomon, Waysman, & Mikulincer, 1990). In this formulation, the spouse or family members represent an important source of social support for the identified patient. Marital/family treatment approaches within this formulation focus on improving the efficacy of the spouse or family in providing support to the patient. This model of marital/family treatment relies heavily on educational and skills-training approaches to treatment and draws little from the marital and family therapy traditions or the theories underlying such therapies. For the purposes of this review, I refer to these treatment approaches as support treatments.

These two approaches to marital/family therapy for trauma-related symptoms incorporate different treatment techniques and different targets of intervention. Systemic treatments tend to focus on the family or relationship

distress resulting from the trauma. In contrast, support treatments tend to focus on the symptoms of the individual who was exposed to the traumatic event. These distinctions also lead to differences in the methods used to evaluate the efficacy of treatment. Outcome evaluations for systemic treatments focus on improvements in family or relationship functioning, with a particular focus on communication. Support treatments, on the other hand, tend to evaluate outcome based on changes in the trauma-related symptoms of the identified patient.

Notably, these approaches are not mutually exclusive and there is some overlap in techniques and outcome evaluation. For example, authors who suggest systemic treatments recognize the role of the family in providing social support and (ideally) a safe recovery environment. Similarly, authors who approach the issue from the perspective of educating and training the spouse or family members acknowledge that trauma can significantly impact on members of the family who were not directly exposed to the trauma (or on multiple family members exposed to the same trauma). However, because the different philosophies lead to the use of different treatment approaches, units of analysis (system vs. individual) and measures of outcome success, they are summarized separately here.

THEORETICAL RATIONALE

Rationale for Systemic Treatment Approaches

In some cases (e.g., natural disasters, motor vehicle accidents, homicide of a family member), couples or entire families experience the same trauma. In these cases, the family system is likely to be disrupted, and the logic behind offering treatment to the family is relatively straightforward. However, even in cases where only one member of a family directly experiences the trauma, there is growing empirical evidence that the effect of trauma extends to the families of these individuals. For example, combat veterans with PTSD appear at risk for significant relationship problems (Card, 1987; Carroll, Rueger, Foy, & Donohoe, 1985; Jordan et al., 1992; Waysman, Mikulincer, Solomon, & Weisenberg, 1993). Veterans with PTSD tend to be less satisfied with their intimate relationships (Carroll et al., 1985; Jordan et al., 1992). Furthermore, these relationships are less cohesive and expressive, and more conflictual and violent than are the relationships of veterans without PTSD (Carroll et al., 1985; Jordan et al., 1992; Solomon et al., 1987). Partners of Vietnam veterans with PTSD also report significantly less satisfaction with their lives than do partners of Vietnam veterans without PTSD (Jordan et al., 1992). The impact of PTSD on the partners of veterans, however, may extend beyond the detrimental effect on the relationship. Beckham, Lytle, and Feldman (1996) found that psychological distress among the partners of

Vietnam veterans with PTSD was significantly associated with the severity of symptoms reported by the veteran. Also, Waysman and colleagues (1993) found that wives of Israeli veterans with PTSD reported greater psychiatric symptoms and impaired social relations compared to the wives of veterans without PTSD. The authors attributed this difference to rigid and conflictual family interactions. The presence of significant family and marital disruption provides the impetus for the application of many of the marital/family therapy approaches to posttraumatic symptoms reviewed here.

By definition, systemic treatments are focused on the responses of the marital or family system to the traumatic event rather than on the posttraumatic symptoms of one or more of the family members. Successful outcome is evaluated via improvement in family functioning (primarily on the basis of improved communication and reduced conflict). Within this framework, two intervention strategies have been suggested: (1) family therapy—focused on alleviating conflict and promoting communication with the entire family system, and (2) marital therapy—focused on aiding dyadic communication and reducing conflict between spouses.

Rationale for Supportive Treatment Approaches

The primary rationale offered for providing supportive therapy to the spouses and family members is the recognition that these persons serve as important source of social support for trauma survivors. Indeed, intimate partners typically serve as an individual's primary source of social support (Beach, Martin, Blum, & Roman, 1993; McLeod, Kessler, & Landis, 1992; Syrotuik & D'Arcy, 1984). This is particularly important given the role of social support in the recovery from a traumatic experience (Barrett & Mizes, 1988; Beiser, Turner, & Ganesan, 1989; Davidson, Hughes, Blazer, & George, 1991; Solomon, Waysman, & Mikulincer, 1990). It is argued that educating and supporting family members of trauma survivors may help them to provide more useful support to the victim, fostering recovery. Another argument for attending to the needs of family members is the suggestion that the partners of trauma survivors may knowingly or unintentionally sabotage treatment of the survivor (Foa & Rothbaum, 1998).

METHODS OF COLLECTING DATA

As the literature does not appear to include a comprehensive review of the use of marital/family therapy in the context of trauma, the current review relies exclusively on original sources. As an initial attempt to identify articles and chapters, searches were conducted using the PsycLIT and PILOTS databases. Articles and chapters that included at least one of the terms "marital therapy," "couples therapy," or "family therapy," and at least one of the

terms "PTSD," "posttraumatic stress disorder," "trauma," "disaster," "combat," "rape," or "assault" were identified. This search resulted in a list of approximately 150 publications. Titles and abstracts of the identified articles were then reviewed to identify those most likely to include empirical data and/or specific descriptions of therapeutic approaches. Because issues pertaining to the treatment of children are to be addressed in a separate review, articles and chapters that addressed the treatment of childhood trauma specifically were eliminated from this review. The remaining articles and chapters were used for the bulk of the present review. In addition, relevant works cited in these articles and chapters were identified; these works were obtained if they were not already included in the review.

Although many authors have been willing to discuss the potential value of incorporating marital/family therapy into programs to treat trauma survivors, few have outlined specific techniques or approaches that might be of value in this endeavor. Instead, marital/family therapy is often included among a variety of other potential adjunct therapies that could be incorporated into a comprehensive treatment program. In many cases, the suggestion to include marital/family therapy constituted a single paragraph or brief section in a much larger discussion of treatment issues. In such cases, the authors seemed to rely on readers' existing knowledge of marital/family interventions, or they referred readers to sources for general descriptions of such approaches. For the purposes of the present review, I summarize marital/family techniques and approaches that have been suggested specifically for the treatment of trauma survivors.

SUMMARY OF THE LITERATURE

Systemic Treatment Approaches

Family Interventions

By far, the most detailed delineation of systemic family therapy with trauma survivors has been put forth by Figley (1983, 1985, 1986, 1988, 1995). This program has as its goal to "*empower* the family to overcome and learn from their ordeal and, in so doing, be more prepared to handle future adversities" (Figley, 1995, p. 351; original emphasis). Within this framework, the therapist works to foster skills that lead to the effective exchange of information, problem solving, and conflict resolution. Figley (1986, 1995) describes five phases of family therapy with traumatized families: (1) commitment to therapeutic objectives, (2) framing the problem, (3) reframing the problem, (4) developing a healing theory, and (5) closure and preparedness. This therapy, as it is conceptualized, is relatively brief, and the therapist serves primarily as a facilitator, encouraging family members to develop and refine their own skills for dealing with extreme stressors. Success is measured not only by improvement

in current family functioning, but also in the family's ability to better cope with future difficulties (Figley, 1995).

Initial sessions are devoted to establishing rapport and trust between the therapist and family members, as well as defining the therapist's role as a consultant to the family. The second phase of therapy focuses on identifying and addressing the family's trauma-related difficulties. This includes examining family members' previous attempts to cope with their problems and reactions, and the obstacles to successful coping. The therapist then works to enhance family supportiveness and communication skills to enhance the exchange of ideas and self-disclosure. The family then spends time reviewing troubling memories associated with the trauma. As family members share their reactions to the trauma, a new consensus view of the trauma and the family's reaction begins to develop. Finally, the individual perspectives are brought together to form a family healing theory—or a single story about the trauma and its aftermath—that allows the family to agree on what has happened and how it will cope with a similar event in the future (Figley, 1985).

To date, there are no published controlled studies that examine the efficacy of Figley's treatment. The intervention appears to use techniques that have been developed within the tradition of family therapy with a focus on the trauma. None of the papers describing this therapy (Figley, 1983, 1985, 1986, 1988, 1995) included data from validated measures to support the efficacy of this treatment in alleviating the symptoms of PTSD or the systemic disruption associated with the disorder. None of the papers presented case studies to provide support for the efficacy of the treatment. Case descriptions were provided to illustrate the treatment techniques.

RECOMMENDATIONS

This family systems approach appears most appropriate for addressing disruptions in the family following trauma. It is recommended that it be used in conjunction with (or following) other techniques that are designed to address PTSD symptoms more specifically. *Strength of evidence: D.*

A similar, though slightly different approach to family therapy is offered by Erickson (1989), who describes an adaptation of Williamson's (1982a, 1982b) consultation process. This model of family therapy was developed to intervene in families where young adults are struggling to become independent from their parents. Thus, this treatment may be most applicable when young adults are traumatized and must then struggle to claim (or reclaim) independence from a family that becomes overprotective. Erickson (1989) applies this treatment program in the case of a family whose oldest daughter (approximately 22 years of age) had recently been raped. However, it is suggested that the approach would be equally viable with couples, extended families, and close friends. Notably, Erickson suggests that this approach to

treatment is most appropriate for "those families who were functioning adequately before the [trauma] and whose dynamics and interaction can incorporate the kind of self-disclosure and supportiveness demanded" (p. 273). Erickson includes a brief description of assessment issues pertinent to this decision.

Similar to Figley's (1995) treatment described earlier, the goal of Erickson's (1989) therapy is to aid the family in integrating the trauma into the family system and thereby strengthen family cohesion through more effective communication skills and mutual support. Within this treatment program, tasks are designed to help family members to (1) recognize the trauma as a family crisis that requires a shared response, (2) recognize and respond to the needs of each family member, (3) encourage appropriate self-disclosure and affective responses, and (4) understand that the damage caused by the trauma is not irreparable. With these goals in mind, Erickson describes a treatment that incorporates both individual and family sessions to address the needs of the rape survivor and her family.

Initially, the survivor is seen separately from her family for sessions in which she is encouraged to talk about her rape experience. The family is seen (independent of the rape survivor) and each member is encouraged to share his or her reactions to the rape. In the second stage of treatment, the survivor and the family are seen in separate, small groups, where family members are again encouraged to explore the events of the rape and the impact on the family. Each family member, including the survivor, is then asked to write an unstructured "autobiography" of his or her experience of the rape. The therapist then evaluates the readiness of the family for sharing and supporting the victim as she shares her story. When it is determined that the family is ready (this may first require traditional family therapy), the victim invites the family to join her. The survivor briefly shares her story of the rape. Then, over the course of 3 consecutive days, the survivor and the family discuss in detail the events of the rape and its impact on the family.

To date, there are no published controlled studies that examine the efficacy of Erickson's (1989) treatment. There were no data presented in the paper describing this therapy to support its efficacy in the treatment of posttraumatic symptoms at the systemic or individual level. There were no clinical case studies presented to support the efficacy of this treatment. The techniques were illustrated with a case example, but no outcome data were presented.

RECOMMENDATIONS

As the only illustration of this treatment approach presented it as an adjunct to individual treatment of the rape survivor, it is recommended that the family therapy be used only in conjunction with (or following) other techniques designed to address PTSD symptoms more directly. *Strength of evidence: F.*

Harris (1991) presents a family crisis intervention model for dealing with posttraumatic reactions arising from a recent trauma. Illustrating the treatment with the case of a family whose 18-year-old daughter was raped, Harris describes a 5-step problem-solving intervention for families in crisis as a result of a trauma. These stages bear a strong resemblance to the stages delineated by Figley (1989). The first stage of therapy is devoted to building rapport and trust between the therapist and family. The second stage involves (1) identifying problems that must be addressed immediately, (2) improving communication, and (3) improving family social support. The third stage of treatment consists of examining possible solutions to the problems. With the survivor's permission, this stage includes a discussion of his or her psychological problems. In the fourth stage, the therapist works to encourage the family to take concrete action in order to solve previously identified problems. If it is deemed necessary by the family and/or therapist, the final stage of the intervention, follow-up, allows for further treatment of the family following the crisis.

To date, there are no published controlled studies that examine the efficacy of Harris's (1991) treatment. No data were presented to support the efficacy of this therapy in the treatment of posttraumatic symptoms at the systemic or individual level. One brief, clinical case study is presented to illustrate the techniques used in this treatment. One telephone contact 3 months after treatment indicated that the rape survivor felt that the rape was "no longer a major issue to be overtly confronted" and that the family "reported a general feeling of happiness and comfort with one another" (p. 206). It should be noted that the rape survivor was seen in individual therapy during the time that the family was treated, and that this individual treatment was still going on at the time of the 3-month telephone call.

RECOMMENDATIONS

As the only illustration of this treatment approach presented it as an adjunct to individual treatment of the rape survivor, it is recommended that the family therapy be used only in conjunction with (or following) other techniques designed to address PTSD symptoms more directly. *Strength of evidence: F.*

Several other authors have presented general guidelines, but not specific techniques, for conducting family therapy with trauma survivors and their families. The guidelines/goals suggested for such treatments are similar to those included in the treatment strategies described earlier and include the following:

- Removing the survivor from the role of identified patient (Williams & Williams, 1980)
- Educating families as to the impact of trauma (Mio & Foster, 1991; Williams & Williams, 1980)

Use of both individual and family sessions (Mio & Foster, 1991; Rosenheck & Thompson, 1986)
Developing mutual support and communication skills (Williams & Williams, 1980)
Clarifying roles and values (Mio & Foster, 1991; Williams & Williams, 1980)
Resolving specific emotional disruptions such as rage, shame, or guilt (Brende & Goldsmith, 1991; Williams & Williams, 1980)
Identifying and breaking patterns of trauma repetition (Brende & Goldsmith, 1991)

Marital Interventions

Several authors have proposed the use of systemic interventions that focus on the marital dyad rather than on the larger family system. However, only two of these studies have been presented in any detail in published works. One of these interventions, critical interaction therapy (Johnson, Feldman, & Lubin, 1995), is conceptualized as operating within the larger framework of family therapy as described by Figley (1989, 1995). The other, emotion-focused marital therapy (Johnson, 1989; Johnson & Williams-Keeler, 1998), presents the application of an established treatment for marital distress to cases where one member of the couple has been traumatized.

Johnson, Feldman, and Lubin (1995) present a treatment approach that focuses on general patterns of marital interaction that commonly occur among Vietnam veteran's families. Notably, these authors present this approach as an alternative to holding disjointed sessions (i.e., separate sessions with the veteran and family members) (Rosenheck & Thompson, 1986). At a general level, Johnson and colleagues argue that families of trauma survivors engage in a pattern of behavior that they term the "critical interaction." The interaction is a "repetitive conflict that is covertly associated with the traumatic memory" (p. 404). Critical interactions are described as following a set sequence of events. Specifically, a marital conflict arouses distressing emotions, leading the veteran to focus his attention on a parallel event from Vietnam. The veteran then withdraws from the spouse (or has an explosive rage reaction) that effectively ends all communication between the partners. Partners experience feelings of fear, anger, and hopelessness that prevent attempts to resolve the conflict and develop their own narratives of the conflict. The lack of resolution leads to a repetition of the conflict. Critical interaction therapy utilizes a specific series of interventions with the goals of (1) teaching the couple about their interactional process, (2) pointing out the connections to the veteran's traumatic experiences, (3) allowing the veteran and spouse to stop blaming one another and, instead, to offer support, and (4) promoting better problem solving and communication. The sequence of interventions described by Johnson and colleagues is as follows:

The couple engages in free discussion.
A conflict occurs that results in the veteran withdrawing (this can be a subtle behavior).
The therapist inquires about the traumatic memory that the conflict elicited.
The spouse is asked to physically comfort the veteran (e.g., hold his hand).
The veteran is asked to tell the traumatic story to his spouse.
The therapist points out how this memory is related to the repetitive conflict.
The veteran is asked to check with and comfort the spouse.
The therapist reviews the sequence of events.
The therapist assigns homework to help the couple structure behavior around conflicts at home.
These behaviors are rehearsed in session.

To date, there are no published controlled studies that examine the efficacy of critical interaction therapy (Johnson et al., 1995). The paper describing this therapy did not include data to support its efficacy in the treatment of posttraumatic symptoms at the systemic or individual level. There were no clinical case studies presented to support the efficacy of this treatment. The techniques were illustrated with case examples.

RECOMMENDATIONS

This approach appears most appropriate for addressing disruptions in the relationship that are associated with trauma or posttraumatic symptoms. However, the increase in support offered by the partner may be helpful in reducing PTSD symptoms. In the absence of data to support this contention, though, it is recommended that it be used in conjunction with (or following) other techniques that are designed to address PTSD symptoms more specifically. *Strength of evidence: F.*

The second approach to conducting marital therapy with trauma survivors, emotion-focused marital therapy, represents an attempt to apply a treatment program with established efficacy for treating marital distress to the situation in which one member of the couple has experienced trauma. The techniques of emotionally focused couple therapy (EFT) are described in detail elsewhere (see Johnson, 1996; Johnson & Greenberg, 1994). Briefly stated, the approach is short term (12–20 sessions) and experiential, with a focus on "reprocessing the emotional responses that organize attachment behaviors" (Johnson & Williams-Keeler, 1998, p. 29). EFT has been divided into nine steps that Johnson and Williams-Keeler (1998) suggest parallel the three stages of therapy for trauma survivors described by McCann and Pearlman (1990). Specifically, Johnson and Williams-Keeler describe the first four

steps of EFT (assessment, identification of interaction patterns, identification of underlying feelings, and labeling negative interaction patterns as the problem) as representing the stabilization phase of treatment. Steps 5 through 7 of EFT (owning the fears that arise in a relationship, acceptance of these by the partner, and asking for needs to be met appropriately) reflect the stage of building capacities in treatment of trauma survivors. Finally, Steps 8 (developing new ways of coping) and 9 (integrating new interaction patterns into the relationship) parallel the integration stage of McCann and Pearlman's (1990) treatment.

To date, there are no published controlled studies that examine the efficacy of EFT with trauma survivors. However, ample data support the efficacy of EFT with distressed couples more generally (Dunn & Schwebel, 1995; Johnson & Greenberg, 1985) and also in cases where the woman in the couple is depressed (Dessaulles, 1991). Johnson and Williams-Keeler (1998) suggest that EFT has been used effectively with couples in which one or both partners have been traumatized by abuse, violent crime, natural disasters, and combat, but they cite only one published case study (Johnson, 1989). Johnson (1989) describes the successful treatment of a couple in which the woman was an incest survivor; however, no standardized assessments were included to support this claim. The techniques of EFT, as they pertain to work with trauma survivors, are illustrated with case examples by Johnson and Johnson and Williams-Keeler.

RECOMMENDATIONS

Emotion-focused marital therapy has been found effective in reducing marital distress generally, and these papers suggest that it also is effective in the context of trauma. The increase in support offered by the partner may be helpful in reducing PTSD symptoms. However, in the absence of data to support this contention, it is recommended that it be used in conjunction with (or following) other techniques that are designed to address PTSD symptoms more specifically. *Strength of evidence: D.*

Two systematic studies of marital therapy with Vietnam combat veterans were found in the literature search. Both were conducted as dissertation studies.

Cahoon (1984) examined the impact of offering couples counseling to veterans attending rap group treatment at local Vet Centers. The couples treatment was adapted from existing marital therapy techniques and focused on communication and problem-solving skills training. Couples treatment was conducted in a group format in seven weekly sessions, lasting 90–120 minutes each. Participants were not randomly assigned to treatment groups. Participants in the couples groups were veterans recommended for the treatment by therapists at the Vet Centers. A small minority of the veterans who

were approached agreed to enter couples treatment, and only nine couples completed the seven-session treatment.

Veterans who completed the seven-session course of couples therapy showed some improvement on self-reports of affective and problem-solving communication. Due to the small sample size, these changes failed to reach statistical significance ($p < .10$). The effect sizes were 0.18 and 0.41 for affective and problem-solving communication, respectively. The partners who completed the couples treatment reported statistically significant improvements ($p < .05$) in global marital distress and problem-solving communication. The effect sizes for the partners were 0.34 and 0.56 for general distress and problem-solving communication, respectively. These gains were accompanied by significant improvements in rap group leaders' ratings of coping ability (effect size = 0.72) and PTSD symptoms (effect size = 0.47).

RECOMMENDATIONS

As the only illustration of this treatment approach presented it as an adjunct to group treatment of the combat veteran, it is recommended that the marital therapy be used only in conjunction with (or following) other techniques designed to address PTSD symptoms more directly. *Strength of evidence: B.*

In the only controlled study of marital therapy with traumatized individuals, Sweany (1988) randomly assigned 14 couples, in which the male partner suffered from combat-related PTSD, to an 8-week marital treatment or a wait-list condition in which treatment was delayed by 8 weeks. The marital intervention consisted of eight weekly, 2-hour sessions based on behavioral marital therapy (Jacobson & Margolin, 1979). This intervention focused on improving communication, increasing positive marital interactions, teaching problem-solving skills, and enhancing intimacy.

The groups were compared immediately posttreatment using standardized self-report measures of marital adjustment, depression, and PTSD symptoms. Results indicated marginally significant group differences, with the treated group showing some improvement in marital satisfaction, depression, and PTSD symptoms. However, the improvements were relatively small (effect sizes were not calculable given the data reported). Changes in veterans' and partners' reports of marital satisfaction showed significant differences. Participants in the treatment group showed greater improvement that did those in the wait-list group. The treated group of veterans reported a significantly larger reduction in PTSD symptoms than did veterans in the control group. None of the other 13 comparisons reached the level of statistical significance.

RECOMMENDATIONS

Behavioral marital therapy has been found effective in reducing marital distress in general, and this result suggest that it is effective in reducing distress

in the context of trauma. In addition, the study suggests that marital therapy may be effective in reducing symptoms of PTSD. However, as most of the veterans in this study received prior (or concurrent) individual or group treatment focused on PTSD symptoms, it is recommended that the marital therapy be used only in conjunction with (or following) other techniques designed to address PTSD symptoms more directly. *Strength of evidence: A.*

Supportive Treatment Approaches

Most of the suggestions to incorporate support treatments for spouses and/or family members occur in the context of treatment programs aimed at reducing symptoms of PTSD. In this context, specific suggestions for the treatment of partners and/or family members are rarely spelled out in detail. Rather, they are briefly mentioned as potential adjuncts to the treatment techniques used to address the PTSD symptoms (see, e.g., Blanchard & Hickling, 1997; Foa & Rothbaum, 1998; Keane, Albano, & Blake, 1992). When specific suggestions are made as to what should be included in such treatments, they typically include education of the family members about PTSD and/or the treatment being undertaken with the survivor, support groups, and stress management programs.

The most detailed description of supportive therapy for spouses of trauma survivors involves the Koach program developed in Israel (Solomon, Bleich, Shoham, Nardi, & Kotler, 1992a). The Koach project includes a monthlong, extensive, multifaceted treatment program with a variety of intervention approaches (the reader is referred to Solomon et al., 1992a, for a detailed account of the program). The component of interest to the present review is the inclusion of veterans' wives in the treatment. The strategies used with the wives are detailed by Rabin and Nardi (1991). Briefly, wives were invited to attend two treatment sessions prior to the initiation of the veterans' program. In the first session, the wives were allowed to discuss the difficulties that they were experiencing as a result of their husbands' symptoms. The second session involved a discussion of posttraumatic symptoms and information about basic behavioral and cognitive principals as they relate to chronic PTSD symptoms. During the first week of the veterans' treatment program, wives were invited to a daylong workshop in which cognitive coping skills, effective use of operant strategies to reinforce husbands' positive behavior, and communication skills were taught. During the second week of the veterans' program, wives and family members participated in a "family day," for which the veterans organized entertaining activities for the families. At this time, staff members held informal talks with the wives of the veterans. During the last 2 weeks of the program, veterans and their wives participated in three couples groups aimed at sharing common problems, improving communication and problem solving skills, and encouraging the veterans to view their partners as sources of support. Finally, these couples groups served as

the basis for continuing self-help groups after the 1-month treatment was completed. The efficacy of the Koach program is unclear (see Solomon et al., 1992b). The effect of including the wives and the couples aspect of the treatment program has not been examined.

RECOMMENDATIONS

Among those who treat trauma survivors, there is clear, rationally derived support for the inclusion of some supportive marital/family treatment. However, the absence of any empirical support for the inclusion of such programs makes strong recommendations difficult. At this point, it would seem reasonable to include such supportive treatment when it is requested by the survivor and/or the partner and to work carefully with the survivor to coordinate such an intervention with the treatment of the survivor. *Strength of evidence: D.*

SUMMARY

In summary, the literature on the use of marital and family therapies with survivors of trauma is severely lacking. A number of authors suggest the use of such treatments to address disruption in the family or to increase the support available to the trauma survivor. These treatments tend to be skills-focused, with much emphasis placed on improving communication, problem solving, coping, and mutual support. Unfortunately, there have been very few empirical examinations of the efficacy of such interventions. Even in the clinically focused literature, careful case studies with standard assessments are lacking.

The two methodologically sound empirical examinations that were found in the literature included very small samples ($N = 9$ couples and $N = 14$ couples). However, the results of these studies suggest that marital treatment focused on communication and problem-solving skills may help reduce marital distress and (in one case) PTSD symptoms. These studies are also limited in that they included only trauma survivors identified as Vietnam combat veterans. Until the results of these studies are replicated with larger samples and survivors of other types of trauma, it remains premature to recommend marital therapy for the treatment of PTSD or PTSD-related marital distress.

Most of the other marital and family treatments described in the existing literature on the treatment of trauma survivors are limited to clinical descriptions without systematic data collection to support their efficacy. Authors provide substantial rationale for the use of family and marital therapies either alone or in conjunction with other treatments for trauma-related symptoms, and there is general consensus on the techniques that might be used in such an approach. However, the lack of empirical support for such treatments means that it is difficult to know if and when they should be used or how they should be incorporated into other treatment programs.

At the present time, then, it is recommended that marital and family therapy be used as adjuncts to treatments that are focused on the alleviation of PTSD symptoms, and not be seen themselves as treatments for PTSD. However, as marital and family disruption is frequently a problem among trauma survivors, it is also recommended that clinicians evaluate the need for marital and family therapy when treating trauma survivors. When such a need is identified, it is recommended that marital/family therapy occur concurrently or following treatment of the survivor's PTSD symptoms. Furthermore, it is recommended that marital/family therapy focus on improving communication and reducing conflict among family members. This may entail communication around current problems or issues related to the trauma and its aftermath. It is important to note that though these therapies tend to focus on functioning of the dyad or family, improvements made in these areas may contribute to alleviation of PTSD symptoms. Also, several of the techniques outlined here incorporate some form of exposure to the traumatic material (i.e., telling family members of the trauma, discussions of traumatic themes). To the extent that such discussions constitute effective exposure exercises or other reparative experiences, it is possible that marital and family interventions could serve directly to reduce PTSD symptoms.

FURTHER CONSIDERATIONS

Indications and Contraindications

The general absence of any empirical data regarding marital/family therapy for PTSD means that decision criteria for when to incorporate these therapies into other treatment programs, or the consequences of not including such treatment when it is warranted, are largely unknown. However, some guidelines can be derived from the descriptive literature reviewed here. The authors generally suggested that family therapy is most appropriate when the family system is largely intact and functioning well prior to the traumatic event. In these cases, treatment can focus on the impact of the trauma on the system. When the system is dysfunctional prior to the trauma, more traditional family therapy may be necessary prior to addressing the trauma-related problems.

Only rarely, and almost exclusively in the case of traumatized children, have authors suggested that marital/family therapy represent the exclusive, or even primary, mode of treatment for posttraumatic psychological symptoms. Rather, authors tend to suggest that marital/family therapy may be an important adjunct to other forms of treatment that are aimed more directly at alleviating posttraumatic symptoms. Even in cases where family therapy is recommended as the primary form of therapy (see, e.g., Erickson, 1989; Figley, 1995), concurrent or preliminary individual treatment with the trauma survivor is often recommended to help address specific PTSD symptoms or difficulties around initial retelling of the traumatic experience. Nothing is known about the efficacy of marital and family interventions alone as treatments for PTSD or other posttraumatic symptoms. Thus, pending further investigation, it is recommended at this time that, in the case of traumatized adults, marital and family therapy be conducted only in conjunction with (or following) treatment of the traumatized individual (or individuals) with interventions shown effective in reducing symptoms of PTSD.

Systemic approaches to marital and family intervention assume disruption in the system. Although it is clear that a large number of traumatized individuals experience difficulties in their intimate relationships (see, e.g., Jordan et al., 1992; Riggs, Byrne, Weathers, & Litz, 1998), there are clearly some families that find satisfactory ways to cope with trauma. Thus, the decision to include marital or family therapy in a treatment plan for a traumatized individual should be based on the identification of a significant disruption or dissatisfaction in the family.

The inclusion of interventions aimed at increasing spousal or family support during individually focused treatment for PTSD has not been carefully examined. It would seem clear that offering education about the disorder and information about the chosen treatment approach to a spouse or other family member could be helpful for the treatment, but it is not clear that it is necessary in all cases. Interventions with significant others should be attempted when the therapist and traumatized client agree that it might aid the treatment being conducted to address the trauma symptoms. When a therapist suspects that family members might interfere with treatment, intentionally or inadvertently, intervention with the family members also seems warranted. It is important to note that family interference may be motivated by a variety of factors and the intervention strategy chosen to address the problem should reflect the issues in the particular family in question.

Family Violence

Many authors have noted the distress that may arise as a result of living with a family member who has been traumatized (see, e.g., Figley, 1985; Waysman, Mikulincer, Solomon, & Weisenberg, 1993). Indeed, this distress represents one of the primary rationales for engaging in marital or family therapy. However, in some cases, the distress arises from the actions of the traumatized individual. For example, rates of family violence are significantly higher among veterans with PTSD than among those who do not have the disorder (Jordan et al., 1992; Riggs, Byrne, Weathers, & Litz, 1998). There is considerable debate within the field of family violence as to whether it is appropriate to conduct marital or family therapy when violence is occurring within the family or dyad. The identification of what treatment for family violence is most effective and safest remains unclear and is likely dependent on

a complex decision process based on factors such as the severity and frequency of the violence as well as its objective and subjective consequences. Generally, we recommend that clinicians proceed cautiously in applying marital and family therapy in trauma-related cases where violence is occurring within the family. Consultation with professionals familiar with the treatment of family violence is highly recommended.

Separation/Lack of Commitment

Though not discussed explicitly, except in the case of emotion-focused marital therapy, the lack of commitment to the current relationship on the part of the survivor and/or the spouse is probably a contraindication for the use of marital therapy for PTSD.

Other Considerations in Using Marital/Family Therapy with Trauma Survivors

No discussion of comorbid disorders as they relate to the use of marital/family therapies was found in the literature reviewed here. However, marital therapy has been found helpful in treating depression (see, e.g., Jacobson, Dobson, Fruzetti, Schmaling, & Salusky, 1991) and alcohol abuse (see, e.g., O'Farrell, 1994) either alone or in conjunction with other interventions. As these disorders represent much of the comorbid psychopathology associated with PTSD, it is possible that such interventions will prove helpful in the case of PTSD with comorbid depression and/or substance use. However, clear recommendations regarding the use of marital or family therapy in cases of PTSD with comorbid psychological disorders are not possible at this time.

As mentioned earlier, there are times when couples or entire families experience a particular trauma simultaneously (or one member is directly traumatized, while the others are traumatized indirectly by the same event). It is also possible for more that one member of a family to have experienced distinct traumas (e.g., the wife of a combat veteran is raped). Little is written about the added complexity of conducting marital/family therapy when multiple members of the family have experienced different traumas (see Balcom, 1996, for an exception). It would seem likely that cases in which multiple family members have experienced traumas would be more amenable to the systemic interventions than to the supportive interventions described earlier. However, it may be important to incorporate some supportive techniques into the intervention. Alternatively, it might be possible to conceptualize treatment of multiply traumatized families as constituting a "group treatment" for traumatized individuals. Regardless of the specific approach taken with these cases, it is likely that the marital or family intervention will prove significantly more complicated than in cases where a single member of the family is the direct victim of trauma. As is the case with regard to comorbidity, specific recommendations about how best to treat multiply traumatized families needs further study.

FUTURE DIRECTIONS

In general, the use of marital and family interventions to address the problems of trauma survivors has been neglected by clinicians and researchers alike. Although a number of authors have suggested that addressing the needs of families and couples in the aftermath of trauma is a good idea, only a few have described specific interventions that might be used. Almost none of these approaches have been investigated empirically, and only one small, randomized, controlled clinical trial was identified in the literature. Clearly, this is an area in need of substantial research and development. Clinical experience and empirical data indicate that trauma and posttraumatic symptoms create substantial disruption in the relationships and families of survivors (see, e.g., Jordan et al., 1992; Riggs, Byrne, Weathers, & Litz, 1998). It is also apparent that social support plays an important role in recovery from trauma. Thus, it seems likely that interventions aimed at reducing family distress and improving support within the family could be very useful in alleviating some of the problems faced by trauma survivors.

The absence of systematic research as to the efficacy of marital and family therapy in treating posttraumatic difficulties means that many questions regarding the application of such treatments are also unanswered. There is little or no guidance offered regarding decisions as to when and with whom marital/family therapy should be incorporated into a treatment program (or represent the primary form of therapy) for PTSD. In the absence of clear guidelines, it would seem important for clinicians to evaluate the presence of marital/family disruption and the functional link between the family problems and the individual's PTSD symptoms. The decision to included marital/family treatment and how to combine such treatment with individual PTSD-focused treatment depends on the presumed impact of each treatment on both family and individual distress; that is, if the marital/family problems appear to result from the PTSD symptoms but would not interfere with the individual's treatment for PTSD, marital and/or family treatment might be postponed until after the individual treatment. It is possible that the alleviation of PTSD symptoms may result in improved family functioning. Alternatively, if it seems that the marital/family problems will interfere with individual treatment, the two may have to occur concurrently. A few contraindications for this approach have been suggested (e.g., family violence, lack of commitment, prior family dysfunction), but these arise from general issues related to marital and family therapy. There are no empirical data to support these contentions in the specific case of PTSD.

As might be expected based on the limited literature examining marital

and family therapy for survivors of trauma, numerous questions remain regarding specific aspects of the application of these treatments. Many of these issues reflect the status of trauma-related treatments in general; however, the lack of empirical studies examining marital and family therapies leaves therapists with very little guidance for making decisions in these areas. First, it is not clear whether certain forms of marital/family therapy would be more successful than others for survivors of specific trauma; that is, would it be possible to specify marital/family treatments that are more appropriate for working with survivors of child abuse and others that would be more appropriate for families of combat veterans? Similarly, it is not clear whether some treatments would be better than others when treating a family exposed to a particular trauma compared to a family coping with the aftermath of a trauma directly experienced by a single member. It is also unclear whether the treatment of a family that was intact prior to the trauma (e.g., a family trying to cope with the daughter's rape) is different or similar to the treatment of a family that formed subsequent to a trauma (e.g., a couple that married after a veteran returned from combat). The impact of the chronicity of PTSD symptoms (i.e., whether the treatment is begun in the immediate aftermath of the trauma or years later) has also not been examined with regard to marital/family treatments.

One additional issue that arose in the context of this review has to do with the unit of analysis in terms of treatment outcome. Some approaches to marital/family therapy attend to the disruption in the dyad or family resulting from trauma, and treatment outcome is evaluated in terms of family functioning. Other approaches focus on treatment of the spouse and/or family as a means of augmenting individual treatment for PTSD, and outcome is evaluated in terms of reduced PTSD symptoms. This difference in outlook raises significant issues with regard to the direction of future research in marital/family therapy, but it may also impact on outcome evaluations of other treatment approaches. Given the strong evidence that trauma is disruptive to family functioning, it seems potentially valuable to include marital/family functioning as one measure of outcome in future treatment studies, regardless of the treatment modality under examination.

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