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A Case Study of Cognitive-Behavioral Conjoint Therapy for Combat-Related PTSD in a Same-Sex Military Couple

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Military deployments to Iraq and Afghanistan are associated with increased risk for posttraumatic stress disorder (PTSD), depression, and relationship impairment. Unfortunately, the perceived stigma associated with seeking deployment-related behavioral health care in military settings has been a significant barrier to care. Historically, active-duty military service members involved in same-sex intimate relationships have experienced further stressors and barriers to care related to additional stigma and lack of social support. Prior federal regulations excluded sexual minorities from openly serving in the military, thereby limiting the available behavioral health services for same-sex couples. Since this ban was lifted after the repeal of the U.S. policy known as "Don't Ask, Don't Tell" in 2010, gay and lesbian service members have increased opportunities to obtain behavioral health care. One therapy that is newly available to sexual minority military couples is Cognitive-Behavioral Conjoint Therapy (CBCT), which effectively addresses co-occurring PTSD and relationship dysfunction. This case study illustrates the use of CBCT for the treatment of deployment-related PTSD in a same-sex active-duty military couple. After completing all 15 CBCT sessions, the couple reported clinically meaningful changes in the service member's PTSD symptoms, which was maintained at the 2-month follow-up. The results of this case study indicate that CBCT for PTSD can have positive treatment outcomes with military same-sex couples. Further clinical implications are discussed.

Posttraumatic stress disorder (PTSD) affects approximately 6% to 8% of the U.S. population (Pietrzak, Goldstein, Southwick, & Grant, 2011). Prevalence rates (10%–20%) of PTSD are even higher among military personnel returning from deployments to Iraq and Afghanistan (Hines, Sundin, Rona, Wessely, & Fear, 2014; Hoge et al., 2004; Milliken, Auchterlonie, & Hoge, 2007). The individual and socioeconomic costs associated with PTSD are great and include long-term psychological disability, poor physical health, greater health care utilization, missed work days, substance abuse, and suicide (Ferrada-Noli, Asberg, Ormstad, Lundin, & Sundbom, 1998; Foran, Wright, & Wood, 2013; Hoge, Terhakopian, Castro, Messer, & Engel, 2007; Kruse, Steffen, Kimbrel, Gulliver, 2011; Meltzer-Brody, Hidalgo, Connor, & Davidson, 2000). PTSD is also associated with a deleterious impact on relationship functioning (for review, see Taft, Watkins, Stafford, Street, & Monson, 2011) and contributes to marital dissatisfaction, higher divorce rates, greater verbal and physical aggression, and sexual dysfunction in military and veteran families (Beckham, Lytle, & Feldman, 1996; Calhoun, Beckham, & Bosworth, 2002; Milliken et al., 2007; Nelson Goff, Crow, Reisbig, & Hamilton, 2007; also see Monson, Taft, & Fredman, 2009). Moreover, relationship dysfunction has been found to increase risk for PTSD and depression in recently returned veterans (Sayers, Farrow, Ross, & Oslin, 2009).

Cognitive-Behavioral Conjoint Therapy (CBCT) for PTSD (Monson & Fredman, 2012) acknowledges the complex bidirectional association between PTSD and intimate relationship functioning. Similar to Integrative Behavioral Couple Therapy (IBCT; Jacobson & Christensen, 1998), CBCT prioritizes sharing thoughts and feelings within the relationship, appreciates the role of acceptance in promoting desired change, and uses themes to process relationship difficulties. However, unlike IBCT, CBCT specifically targets PTSD and does not directly address non-trauma-related relationship problems. CBCT has been successful in decreasing PTSD symptoms and improving relationship satisfaction in military veterans in heterosexual relationships (e.g., Monson, Schnurr, Stevens, & Guthrie, 2004; Schumm, Fredman, Monson, & Chard, 2013). Significantly less is known about the treatment outcomes of CBCT in military service members who are in same-sex

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relationships. Currently, CBCT for PTSD is being systematically disseminated in the U.S. Departments of Defense and Veterans Affairs. With the repeal in 2010 of the former U.S. policy known as "Don't Ask, Don't Tell" (Department of Defense, 1993), which essentially required sexual minority couples to hide their relationships, same-sex couples will have greater access to couple-based treatments. This article describes the need for PTSD treatment among sexual minority veterans, discusses barriers to behavioral health treatment for service members in sex-same relationships, and illustrates the use of CBCT for combat-related PTSD in a same-sex military couple.

Trauma and PTSD in Sexual Minorities

Research has indicated that civilians of sexual minority status have a higher risk for psychological symptoms than heterosexual comparisons (e.g., Bostwick et al., 2014; McCabe, Hughes, Bostwick, West, & Boyd, 2009; also see Meyer, 2003). Sexual minority status is also associated with greater trauma exposure and PTSD. For example, in a recent study examining sexual disparities in a representative U.S. sample (N = 34,653), Roberts, Austin, Corliss, Vandermorris, and Koenen (2010) found that sexual minority respondents and heterosexuals with a history of same-sex partners were more likely to endorse exposure to childhood trauma, interpersonal violence, and trauma/unexpected death to someone close compared with heterosexuals without a history of having same-sex partners. The study also found that sexual minorities were at least twice as likely to develop PTSD.

It is estimated that there are approximately 71,000 lesbians, gay men, or bisexuals serving in the U.S. military (Gates, 2010). Similar to their civilian counterparts, sexual minority service members and veterans are at an increased risk for trauma (Ray-Sannerud, Bryan, Perry, & Bryan, 2015), PTSD, depression, alcohol abuse (Cochran, Balsam, Flentje, Malte, & Simpson 2013), and suicidality (Blosnich, Mays, & Cochran, 2014; Ray-Sannerud et al., 2015) compared with heterosexual military service members and veterans. Women, while only accounting for 14% of the active-duty military, make up approximately 43% of the sexual military personnel (for review, see Oswald & Sternberg, 2014). As members of at least two military minority groups, women service members and veterans involved in same-sex relationships appear to be particularly vulnerable to interpersonal trauma and behavioral health problems. Examining a large sample of women veterans (N = 706, 35% lesbian or bisexual), Lehavot and Simpson (2014) found that women sexual minorities endorsed higher rates of childhood abuse, sexual and physical victimization before entering military service, and physical victimization during their military service as compared to heterosexual women veterans. Childhood trauma and sexual assault were predictive of PTSD and depression in both groups. However, there were stronger associations between combat exposure and PTSD and between military sexual assault and PTSD in sexual minority women veterans compared with women heterosexual veterans. Consistent with these findings, women veterans self-described as lesbian or bisexual who had previously deployed in support of Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF) were more likely to endorse past childhood trauma and report deteriorations in their postdeployment behavioral health than heterosexuals and were more likely to be heavy smokers and engage in hazardous drinking (Mattocks et al., 2013).

Role of Discrimination and Minority Status in PTSD

According to the Minority Stress Model (Meyer, 2003), the elevated risk for psychological dysfunction (e.g., depression, anxiety) in sexual minorities compared to heterosexuals can be attributed to the unique and chronic stressors associated with being a member of a marginalized group. For example, research with civilians indicates that heterosexist discrimination has direct and unique links to PTSD symptoms (Bandermann & Szymanski, 2014). Prior to 2010, which saw the repeal of "Don't Ask, Don't Tell," sexual minorities who wanted to serve in the military had to conceal their sexual orientation or risk being separated from the military (Johnson, Rosenstein, Buhrke, & Haldeman, 2015). Importantly, concealment and related anxiety is associated with higher rates of psychological symptoms, including concurrent depression and PTSD (Cochran et al., 2013; Lehavot & Simpson, 2014; for review, also see Johnson et al., 2015).

Need for concealment and fear of discrimination have fostered mistrust of military health care providers among lesbian, gay, and bisexual service members and veterans and have interfered with military health care providers' ability to provide much-needed comprehensive care (for review, see Johnson et al., 2015). In contrast, comfort disclosing sexual orientation to military health care providers is strongly associated with perceptions that the military cares about sexual minority service members' health and well-being (Biddix, Fogel, & Black, 2013). Concerns about stigma regarding sexual minority status also have contributed to barriers to treatment. Coupled with concerns about the stigma associated with PTSD, sexual minority service members may find it particularly difficult to seek care for PTSD symptoms. Furthermore, military regulations have historically prevented nonmilitary same-sex partners from seeking care for themselves or participating in their partner's treatment. With the repeal of "Don't Ask, Don't Tell," military health-care providers have more flexibility and freedom to work with sexual minority military couples dealing with trauma and trauma-related symptoms. Given the psychological benefits

of healthy intimate relationships, CBCT for PTSD may be particularly beneficial for same-sex military service members and veterans.

Cognitive-Behavioral Conjoint Therapy for PTSD

CBCT for PTSD simultaneously targets PTSD symptoms and intimate relationship distress using a conjoint framework in which the relationship is viewed as the unit of treatment. The CBCT protocol consists of three phases and includes fifteen 75-minute sessions. It includes cognitive and behavioral interventions designed to improve communication, undermine behavioral and experiential avoidance, and change maladaptive trauma-informed cognitions in both partners. Skills targeted in treatment are practiced as part of in- and out-of-session assignments. Participation in CBCT for PTSD has been associated with notable improvements in PTSD symptoms, relationships satisfaction, and partner's behavioral health symptoms in heterosexual military and veteran couples across several case studies and uncontrolled studies (Blount, Fredman, Pukay-Martin, Macdonald, & Monson, 2015; Monson et al., 2004; Monson et al., 2011). A recent randomized controlled trial established the efficacy of CBCT for veterans with PTSD (Monson et al., 2012). More specifically, CBCT for PTSD resulted in statistically significant and clinically meaningful improvements in PTSD, comorbid symptoms, and relationship satisfaction compared with waitlist. Overall, the extant literature suggests that CBCT for PTSD can effectively treat PTSD in a wide range of couples.

The Couple

The couple in this case study included a female active-duty military service member with combat-related PTSD and her nonmilitary partner. The pseudonyms "Teresa" and "Monica" are used in this paper in order to protect their privacy. Both provided written informed consent for the publication of the case study. Teresa was a U.S. Army noncommissioned officer with 6.5 years of active-duty service. She identified herself as a lesbian and had an extensive history of trauma including childhood abuse, sexual assault, and deployment-related traumas. During her childhood, she was physically and emotionally abused by her biological mother. At 6 years old, she was removed from her mother's custody and placed in an orphanage in a developing country. She remained at the orphanage until she was 15 years old, when she was adopted by an American family and brought to the United States. She attended 2 years of college, during which time she was raped, and then joined the military. She did not report the rape and stated that she had taught herself to avoid thinking about it completely over the years.

At the time of treatment, Teresa had deployed twice in support of OIF and once in support of OEF. While deployed, she was exposed to numerous PTSD Criterion A events as defined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR; American Psychiatric Association, 2000). These events included exposure to human remains, the combat-related deaths of fellow service members, and exposure to personal life threat. As a military intelligence analyst, she was often exposed to human remains during military intelligence collection details and was required to view photos of dead and mangled bodies and videos of gruesome executions. During one of her deployments, four friends were killed as a result of a roadside attack. At the time of her assessment, she reported being distressed by her previous sexual assault, seeing the bodies of two elderly women on her first deployment, losing her friends to a roadside attack during her second deployment, and seeing video of an Afghan civilian being beheaded by the Taliban on her third deployment.

Teresa identified the viewing of the video of the beheading as her index event (i.e., the traumatic experience causing her the most distress and consequently the focus of treatment). Although not physically present during the beheading, she expressed significant distress at seeing the footage, leaving her feeling angry and fearful for her own life during the remainder of the deployment. She was particularly distressed by the fact that the man appeared to be randomly selected from the crowd and had been used as a tool to terrorize the villagers. She also reported experiencing considerable guilt for the event, explaining that if she had collected the "right" information then the military could have prevented the man's death. Importantly, she expressed similar guilt-laded cognitions related to the loss of her fellow American soldiers.

Teresa sought behavioral health services, stating that she wanted to know how to deal with PTSD issues as they had recently been getting worse. She presented with anger, irritability, guilt, frequent nightmares, disturbed sleep, intrusive and distressing thoughts about her deployment-related traumas, and avoidance of thoughts and feelings. Her nightmares included images of body parts, funerals, and rocket attacks and were entangled with scenes from her time at the orphanage as a child. She also experienced chronic pain secondary to a back injury and a degenerative spinal condition. Although her physical and psychological symptoms caused impairment, she was still able to adequately perform her work-related duties. However, she was planning on voluntarily separating from active duty within a year.

Teresa's psychological history indicated previous depression, alcohol abuse, and suicide ideation without plans, preparation, or intent. Following her third deployment, she presented to a military treatment facility for symptoms of anger and was treated with biofeedback. She explained that the biofeedback increased her anger, and

she consequently discontinued treatment after a month. She had no additional treatment for her behavioral health problems.

Monica identified herself as a lesbian Hispanic woman in her twenties. She had a high school education and did not work outside of the home. She was physically and emotionally abused as a young child but did not meet diagnostic criteria for PTSD or depression. Monica and Teresa met several months prior to Teresa's third deployment and, consequently, had spent the first year of their relationship geographically separated. Once Teresa returned from her deployment, the couple relocated together to Teresa's next duty station. Although PTSD had been present for the entirety of their relationship, both members of the couple reported high relationship satisfaction. Teresa acknowledged that Monica was one of the few people from whom she did not withdraw. The couple had plans to marry within the year. Since gay marriage was not legally recognized in the state they resided, the couple was saving money to travel to California, where they could be wed. The couple also shared future plans of fostering and/or adopting high-risk children, which served as a motivating factor for seeking treatment. More specifically, the couple stated that they wanted to treat the PTSD so that they would be better prepared to meet the emotional needs of children who had also experienced abuse or neglect.

Importantly, both Monica's and Teresa's families knew of their sexual orientations. They received emotional support for their relationship from Monica's family. However, Teresa's adoptive family was less supportive. The couple reported that it was very difficult to visit Teresa's family as a couple. If Teresa visited her adoptive parents alone, her adoptive mother would not discuss Monica and would reportedly pray for Teresa to stop being gay. Teresa expressed feeling betrayed by her adoptive mother, who had discussed Teresa's sexuality with extended family members without Teresa's permission. Their lack of support for the couple's relationship created strain between Teresa and her adoptive family and reinforced PTSD-related beliefs that people cannot be trusted and that it is not safe to share emotions.

Baseline Assessment

Teresa's and Monica's assessment scores are present in Table 1. The PTSD Symptom Scale–Interview (PSS-I; Foa, Riggs, Dancu, & Rothbaum, 1993; Foa & Tolin, 2000), a 17-item structured interview that assesses the presence, frequency, and intensity of PTSD symptoms for a single traumatic event (i.e., watching video footage of a beheading), was administered at baseline by a trained evaluator. According to her responses on the PSS-I, Teresa met DSM-IV-TR (2000) diagnostic criteria for PTSD, with her score placing her in the mild to moderate range. She also completed the PTSD Checklist–Stressor Specific (PCL-S; Weathers, Litz, Herman, Huska, & Keane, 1993), a 17-item self-report measure that assesses the severity of PTSD symptoms within the past month and has sound psychometric properties (e.g., Weathers et al.; Keen, Kutter, Niles, & Krinsley, 2008). Although the previously recommended clinical cut-off score for the PCL is 50, more recent findings suggest that a cut-off score of 39 is more appropriate for active-duty military populations (Dickstein et al., 2015). Teresa's PCL-S score of 49 was clinically significant and comparable to the mean baseline PCL scores reported in prior CBCT treatment studies (e.g., $M = 50.3$, $SD = 11.0$, Monson et al., 2012). Although Teresa had a history of depression, her symptom endorsement on the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) was in the nonclinical range. Additionally, she denied current suicidal ideation or intent on the Beck Scale for Suicidal Ideation (Beck & Steer, 1991; Beck, Steer, & Ranieri, 1988). Following her baseline assessment, Teresa was presented with treatment options that included an individual evidence-based treatment for PTSD as well as CBCT for PTSD. She expressed strong interest in treating her PTSD within a conjoint framework. After she discussed treatment options with her partner, Teresa decided to start CBCT for PTSD.

Table 1
Assessment Results at Pretreatment, Posttreatment, and 2-Month Follow-Up

	Pretreatment	Posttreatment	Follow-Up
Teresa's Scores			
PTSD Symptom Scale-Interview (PSS-I)	19	–	–
PTSD Checklist-Stressor Specific (PCL-S)	49	39	36
Beck Depression Inventory-II (BDI-II)	9	10	9
Couples Satisfaction Index-32 (CSI-32)	159	–	147
Monica's Scores			
PTSD Checklist-Stressor Specific (PCL-S)	19	–	–
PTSD Checklist-Collateral	37	32	32
Beck Depression Inventory-II	3	3	1
Couples Satisfaction Index-32	152	–	157

Note: Clinical Cut-off Scores: PSS-I: Mild 16-20, Moderate 21-30, Severe 31-51; PCL-S: ≥ 39; BDI-II: Mild 14-19, Moderate 20-28, Severe 29-63; CSI: Clinical Relationship Distress Total ≤ 109

Prior to their first session, Monica completed a PCL-S based on her perception of Teresa's symptoms. Notably, there was a 12-point difference between Teresa's and Monica's report of Teresa's PTSD symptoms on the PCL, with Teresa reporting greater PTSD symptoms. Monica's responses on the PCL-S (based on her own childhood history of abuse) and BDI-II were within normal range. She denied past or current suicidal ideation or a history of behavioral health treatment. Prior to treatment, both Teresa and Monica completed the Couples Satisfaction Index (CSI), a 32-item self-report measure of relationship satisfaction with strong psychometric properties (Funk & Rogge, 2007). Their scores on the CSI placed them in the highly satisfied range. Although CBCT for PTSD targets relationally distressed couples, recent findings indicate that it is an effective PTSD treatment for couples with high relationship satisfaction as well (Shnaider et al., 2015).

Course of Treatment

Phase 1: Treatment Rationale and Psychoeducation about PTSD Symptoms and Relationship Functioning

Phase 1 of CBCT treatment is comprised of two sessions and includes an orientation to treatment, psychoeducation about PTSD and relationship functioning, and safety building. In the first session, the couple discussed the ways in which PTSD had manifested in their relationship. Much of their discussion focused on Teresa's discomfort with being around others, which had impacted the couple's social life, as well as her frequent nightmares, irritability, tendency to be overly alert in public places, and avoidance of trauma reminders and crowds. Monica's responses to Teresa's distress, which were meant to comfort, often accommodated the PTSD symptoms. For example, the couple discussed secluding themselves inside a bathroom on the 4th of July in order to avoid the sound of the fireworks and leaving movie theaters early when Teresa would become anxious. The couple also avoided discussions about Teresa's deployment experiences, the content of her nightmares, and trauma-related thoughts and feelings. Toward the end of the session, the couple established behaviorally specific treatment goals for improving their relationship (i.e., improving communication and increasing emotional intimacy through sharing feelings) and for decreasing PTSD symptoms (i.e., nightmares, irritability, and hypervigilance). At the end of session, the couple was asked to review treatment-related handouts, catch each other doing something nice each day in order to enhance positivity within the relationship, and complete the Trauma Impact Questionnaire (TIQ). The TIQ asks each member of the couple to independently reflect on what they perceived caused Teresa's traumatic event, the impact the trauma has had on their relationship, and how the trauma has shaped their thoughts about trust, control, emotional intimacy, and physical intimacy.

The couple returned to the second session having completed all of their out-of-session assignments. During the preceding week, they were able to easily identify one another's positive behaviors and continued to do so for the remainder of treatment. The couple had also completed the TIQs, and their responses were shared in session. Teresa's responses on the TIQ led to further discussion of whether Teresa's deployment-related trauma or rape should be the focus of treatment. The couple reported that if they were asked to focus on the rape, then they would not continue with the protocol. The provider reviewed the role of avoidance in maintaining PTSD and discussed the potential cost of maintaining that avoidance. Eventually, the couple and provider agreed to focus on the trauma involving seeing the video of a man being beheaded, which Teresa stated was causing her the most daily distress, but remain open to the idea that they may need to discuss the rape in the future. During the session, Teresa expressed concerns that she would be made fun of or misunderstood if she shared her trauma-related thoughts and feelings with Monica. However, Monica expressed a desire to hear more about Teresa's trauma experiences and agreed to approach the conversations in a supportive manner. The remainder of the session focused on enhancing relationship safety through increasing awareness about anger and distress and introducing individual (diaphragmatic breathing) and couple-level (time-out procedures) interventions to decrease conflict, which were then practiced in session.

Phase 2: Communication Skills Training and Couple-Level In-Vivo Exposure Approach Activities to Enhance Positivity and Decrease Avoidance

Phase 2 of treatment, which consisted of Sessions 3 to 8, focused on undermining experiential and behavioral avoidance through communication skills training (i.e., listening using paraphrasing, sharing thoughts and feelings, and problem-solving) and couple-level approach activities (approaching avoided people, places, situations). In Session 3, the role that avoidance plays in maintaining PTSD was emphasized and paraphrasing skills were introduced. Teresa and Monica practiced paraphrasing while discussing what they avoided as a result of PTSD in their relationship. Much of this discussion focused on their avoidance of sharing trauma-related memories and nightmares. Teresa expressed concern that sharing her memories would traumatize Monica. In response, Monica assured her that she would not become distressed by the content of Teresa's memories and inquired about the best ways to respond to her partner's trauma-related reactions. During

the paraphrasing exercise, Teresa shared that it was the anniversary of a fellow soldier's death, and she was able to acknowledge her sadness to her partner. Interestingly, both partners endorsed a decrease in their emotional closeness following this in-session activity (self- report reduced from 10 to 8 on a 0 to 10 scale), which appeared largely attributable to Teresa's tendency to interpret Monica's statements as commands or criticisms.

In Sessions 4 and 5, Monica and Teresa used their paraphrasing skills to discuss thoughts and feelings related to having PTSD in their relationship. During Session 4, Teresa discussed feeling sad about the opportunities they had missed as a couple as a result of PTSD and anxiety they had about how PTSD may impact their relationship in the future. While she anticipated feeling happy when they were experiencing less PTSD, she also expressed feeling a little anxious about letting go of the PTSD since it had been a part of her life for several years. Monica shared that she felt sad that Teresa had experienced trauma and suffered from PTSD and predicted that she would feel excited for Teresa when they decreased the PTSD. She anticipated feeling less protective of Teresa and less stressed by Teresa's symptoms in the future. At the end of Session 4, the couple was asked to start engaging in activities designed to undermine their behavioral avoidance, and they agreed to go to a movie theater together.

While reviewing their assignments in Session 5, the couple reported that they had been able to remain in the movie theater and that Monica had only caught Teresa engaging in a safety behavior once during the duration of the movie. During the session, a cognitive model of emotions was presented, and the couple was asked to discuss their PTSD-related thoughts. While Monica's thoughts were generally well balanced, Teresa endorsed several thoughts that reinforced the PTSD, including: "I have to protect myself from others"; "If I share my feelings, then I will relive the trauma"; "Only people who have deployed can fully understand how I feel"; and, "I always have to be on guard." Unlike in Session 3, the couple's emotional closeness improved as a result of their discussions in both Sessions 4 and 5 (increased self-report rating from 8 to 10), likely due to an increase in a shared understanding of each other's thoughts and feelings.

Between Sessions 5 and 6, the couple went to the movie theater again, and Teresa experienced significant discomfort during this approach assignment. At the beginning of Session 6, Monica reported that Teresa was considering discontinuing with treatment as a function of this distress. The couple was praised for continuing to undermine the PTSD by coming to the session, talking to one another about their thoughts and feelings, and remaining at the movie theater despite Teresa's anxiety. Teresa expressed concern that if she talked about her trauma, it would increase her nightmares. The therapist used this thought to introduce and practice the UNSTUCK process. UNSTUCK is an acronym that refers to seven dyadic cognitive intervention exercises and strategies that allow couples to conjointly evaluate unhelpful thoughts and identify more balanced ways to think about situations (Monson & Fredman, 2012). The acronym stands for "United and curious; Notice your thought; (Brain)Storm alternatives; Test them out; Use the most balanced; Changed feelings and behaviors; Keep practicing." Through this process, the couple worked together to notice a thought that perpetuated emotional distress, generated more helpful and realistic thoughts through Socratic questioning, tested the alternative thoughts and chose the most balanced ones, discussed how this new thought changed their feelings and behaviors, and discussed ways to continue practicing the new thoughts. The couple was able to generate several alternative thoughts, including, "I have avoided discussing my traumas for years and still have nightmares," and "I have been talking more about my trauma and have not experienced an increase in my nightmares." At the end of session, the couple agreed to continue with treatment and was asked to use the UNSTUCK process to work on the thoughts, "If I talk about my traumas, I will hurt/damage Monica," and "Teresa should have talked to me about the trauma before coming to treatment."

The couple's first attempt to use the UNSTUCK procedure outside of session largely resulted in generating additional stuck points. Consequently, the process was reviewed and refined in Session 7. The couple also practiced conjoint problem-solving while discussing what they would do for their next out-of-session approach assignment. During the practice, Teresa expressed a disinclination to continue with the approach assignments. With probing, the couple was able to identify two thoughts ("Because I get angry in uncomfortable situations, I should not go," and "Avoidance protects my partner and our relationship") that reinforced their avoidance. The couple was assigned these thoughts as out-of-session UNSTUCK exercises.

By the end of Phase 2, Teresa's PTSD symptoms, as measured by the PCL-S, had decreased by 9 points from the baseline assessment (from 49 to 40). Additionally, her depressive symptoms on the BDI-II remained in the minimal range, and she continued to deny suicidal ideation. Moreover, both Teresa's and Monica's relationship satisfaction continued to be in the highly satisfied range.

Phase 3: Dyadic Cognitive Interventions for Trauma-Related Beliefs Maintaining PTSD and Relationship Difficulties

The final phase of treatment, which included Sessions 8 through 15, focused on making meaning of the trauma

by applying the UNSTUCK procedure to thoughts held by the couple that impeded recovery and disrupted relationship satisfaction (see Table 2 for list of stuck points processed in treatment). At the beginning of Phase 3, Teresa's ambivalence about processing her trauma reemerged. In Session 8, she voiced the concern that a 4-month treatment protocol would be insufficient to decrease her chronic PTSD symptoms. The therapist responded by reviewing the cognitive and behavioral mechanisms that maintain PTSD and having the couple discuss examples of significant changes in their lives that occurred over a short period of time (e.g., results of going through basic military training). Despite Teresa's anxiety, the couple was able to successfully examine the thought, "We (the Americans) should have done something to save the man, who was beheaded," and generate the alternative thought, "Given the situation, there was nothing that I could have done to prevent this event, even though I wish it did not happen." Teresa expressed the concern that this exercise would not remove the image of the beheading from her mind. The provider validated her concern, acknowledging that the goal of the exercise was not to forget the memory but instead address the thoughts that maintain secondary emotions and complicate recovery from trauma.

In Sessions 9 and 10, the couple examined beliefs involving how they attributed blame surrounding the trauma. Teresa accepted significant blame for both the index event and for having PTSD. The couple examined the thought, "I should have exposed myself to more traumas so that I would not be bothered by this event," and decided that the thought, "If I had exposed myself to more traumas, my PTSD symptoms may have become worse" was a more realistic belief. They were asked to work on the thought, "I am to blame for having PTSD because I joined the Army" as an out-of-session assignment but had difficulty making progress on this thought. Consequently, the stuck point was reevaluated in Session 10; with additional prompts by the therapist, the couple was able to generate several alternative thoughts, including: "It was not my intent to develop PTSD when I joined the Army"; "I did not know that I was going to be exposed to the types of traumas I was exposed to"; and "The trauma caused the PTSD, and I did not cause the trauma." With the help of her partner, Teresa decided to use "Although I feel guilty, I am not logically responsible for developing PTSD" as an alternative thought to the stuck point.

During this session, the couple explored possible reasons for Teresa's desire to hold onto her stuck points, which she acknowledged was to maintain a sense of safety (i.e., "If I caused the PTSD, then I can protect myself from harm in the future by changing my actions"). During this session, the role that trust-based beliefs have in recovery was highlighted. While discussing stuck points involving trust, the couple also processed how hurt Teresa felt as a result of her adoptive family's rejection of her relationship with Monica and worked on the thought, "I can never trust my mother with my personal information again."

The couple experienced a setback in the week between Sessions 10 and 11. Teresa avoided a 4th of July celebration; however, Monica opened the apartment windows to ensure they would still hear the fireworks. Teresa also avoided completing their out-of-session UNSTUCKs (i.e., "Hearing firecrackers is dangerous"; "Maintaining my PTSD-related thoughts is helpful"). At the beginning of the session, she expressed a lack of desire to confront her PTSD at this time but stated that she realized that she needed to do it for the couple's future. Reasons for continuing with treatment were reviewed, and treatment-interfering stuck points were identified. The couple also discussed feelings and thoughts surrounding Teresa's relationship with her adoptive mother, who disapproved of Teresa's sexual orientation. Her perceived familial rejection contributed to beliefs that maintained her PTSD (i.e., "I don't belong

Table 2
Examples of Teresa's and Monica's Stuck Points Addressed During Course of Treatment

Teresa
We could have done something differently and saved the man, who was beheaded.
I am responsible for the beheading because I did not collect enough information.
His people should have done something to save him.
If I am happy, then I am not honoring my friends who died in combat.
If I share my feelings, then I will relive the trauma.
If I share my feelings, then I am weak.
If I do not share my thoughts and feelings, then I can protect myself.
Real soldiers do not show weakness.
I always have to be on guard.
Avoidance protects my partner and me.
People cannot understand me.
My family is not interested in me.
I have to forget the memory in order to recover from PTSD.
I should not try because it won't help.
I can never trust my mother with personal information again.
I don't belong because something is wrong with me.
Monica
Teresa should have talked to me about her trauma experiences before coming to treatment.
I should not ask Teresa about her trauma experiences because she will be irritable.

because there is something wrong with me"). During this session, the couple identified several control-related stuck points (i.e., "I have to control my emotions so that I don't look weak"; "I have to give up control in order to avoid confrontation with others"; and "If I don't have complete control over a situation, then I am unsafe") to work on outside of session.

Stuck points related to emotional intimacy, physical intimacy, and posttraumatic growth were identified and evaluated in Sessions 12, 13, and 14, respectively. Examples of the thoughts the couple worked on during these sessions include: "If I show my emotions, then other people will take advantage of me"; "It is not OK to be physically affectionate with family and friends"; and "I have to maintain my PTSD symptoms in order to honor my fallen comrades." As with the previous stuck points, the couple was able to work together to identify more helpful alternative beliefs. However, Teresa had difficulty accepting these alternatives, and in Session 13, Monica shared her frustration with Teresa's resistance to changing her perspective. They were able to openly discuss this in session and problem-solve ways to optimize use of the skills they learned in treatment. Together the couple reflected on the increase in sharing trauma-related thoughts and feelings and discussed the importance of continuing to explore alternative thoughts in Session 15.

Throughout Phase 3, Monica proved to be skilled at asking open-ended questions in a spirit of curiosity to help Teresa generate new beliefs about her trauma history. She also gained a better understanding of the role of avoidance in maintaining PTSD and began to actively find ways to undermine behavioral and experiential avoidance in their relationship. With the exception of the week between Sessions 10 and 11, the couple continued to actively approach avoided people, places, and situations. Specifically, the couple sat in the front of the movie theater, continued eating at crowded restaurants, went to the mall, visited a crowded waterpark, attended a gay pride parade, discussed the contents of Teresa's nightmares, and placed flowers on a gravesite to honor the anniversary of a friend who died in combat. Teresa reported that, while the approach exercises were still uncomfortable, it was easier to talk herself into doing them.

Outcome and Prognosis

For the PCL, a 5- to 10-point change is considered clinically reliable, whereas a 10- to 20-point change is classified as clinically meaningful (Monson et al., 2008). As seen in Table 1, by the completion of treatment, Teresa experienced a clinically meaningful decrease in her PTSD symptoms on the PCL-S from 49 to 39, which was decreased even further to 36 at the 2-month follow-up. Although the PSS-I was only administered at baseline, she did not meet *DSM-IV* criteria for PTSD according to the PCL-S at the end of treatment or at follow-up. Monica also noted a decrease in Teresa's PTSD symptoms at posttreatment, which was maintained at the 2-month follow-up. Notably, each partner's perceptions of Teresa's PTSD symptoms were markedly more similar at posttreatment and follow-up compared with baseline, suggesting that the couple had a greater shared understanding of the level of PTSD in their relationship. Both Teresa and Monica endorsed minimal depressive symptoms at posttreatment and follow-up and denied suicidal ideation and intent. Their relationship satisfaction remained high throughout treatment. At the 2-month follow-up session, the couple reported that they were still using the skills they acquired in therapy, including catching positive behaviors, sharing thoughts and feelings, undermining avoidance, and trying to maintain balanced thinking. Teresa noted that she was much more comfortable sharing her trauma-related thoughts and feelings with Monica and was no longer afraid that Monica would make fun of her or not understand. Monica confirmed that Teresa was disclosing more information about the past deployments, although the couple still had not processed Teresa's thoughts and feelings about her rape that occurred when she was in college.

Discussion

From the beginning of treatment, Teresa and Monica appeared motivated to diminish the role of PTSD in their relationship in order to be better prepared to face the next stages of their lives (i.e., separating from the military, finding a job outside the military, getting married, and serving as foster/adoptive parents to children from high-risk homes). Despite this motivation, Teresa experienced significant ambivalence about approaching her trauma-related thoughts and feelings, which she and Monica were able to overcome as a couple. During treatment, Teresa reported feeling supported as a lesbian soldier by her immediate command and was beginning to take Monica to military family functions. However, they still had concerns about whether they would be accepted by the larger military community. Their concern was likely reinforced by the military's previous stance on individuals of sexual minority status serving in the military, as well as Teresa's personal experience with familial rejection. Importantly, the rejection she felt from her adoptive family for being a lesbian interacted with PTSD beliefs, making it even more difficult to connect with others. Having the opportunity to address the PTSD within a conjoint framework helped Teresa challenge maladaptive beliefs about herself and her relationships and played a pivotal role in completing the treatment protocol. Overall, the couple reported high satisfaction with CBCT for PTSD and expressed gratitude for the opportunity to participate in treatment as a couple.

Notably, Teresa and Monica were relationally satisfied prior to treatment and were out to their families, friends, and to several of Teresa's military colleagues, including her immediate supervisors. They felt comfortable being identified as a couple in public. Since the couple was comfortable being "out" as lesbians in public, the majority of their approach exercises mirrored those assigned to military heterosexual couples (i.e., having a date night at a crowded restaurant). However, approach assignments may need to be modified for same-sex military couples who are not out to family, friends, or the military community. Many of the skills taught in CBCT for PTSD can be used to help navigate the coming out process. For example, the UNSTUCK process can be used to examine thoughts related to coming out that cause individual or relational distress (e.g., "Everyone will reject me if I come out"; "My partner does not love me since he refuses to openly acknowledge our relationship"). The UNSTUCK process can also be used to examine thoughts that reinforce internalized heterosexism, especially since many of these beliefs are likely to intersect with trauma-related thoughts (e.g., "I am broken").

Importantly, while Teresa and her partner were in treatment, the Supreme Court of the United States ruled that the Defensive Marriage Act was unconstitutional. One consequence of this ruling was that spouses of sexual minority service members became eligible for dependent care benefits (i.e., access to military healthcare). Two years later, in the case of *Obergefel versus Hodges*, the Supreme Court of the United States ruled that the fundamental right to marry is guaranteed to sexual minorities, requiring all states to issue marriage licenses to same-sex couples. As a result of these landmark decisions, same-sex military couples can openly pursue couple- and family-based treatments within the military health-care system. Consequently, it is important that mental health-care providers working within military systems consider ways to best serve the needs of same-sex families. This case study demonstrates that CBCT for PTSD can have positive treatment outcomes with a military lesbian couple. Additional work is needed to determine whether the treatment outcomes for this couple generalize to other military same-sex couples dealing with PTSD.

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