

Cognitive-Behavioral Conjoint Therapy for Posttraumatic Stress Disorder: Application to a Couple's Shared Traumatic Experience

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Cognitive-behavioral conjoint therapy for posttraumatic stress disorder (CBCT for PTSD) is designed to improve PTSD symptoms and enhance intimate relationship adjustment. Phase 1 includes psychoeducation about the reciprocal influences of PTSD symptoms and relationship functioning, exercises to promote positive affect and behaviors, and conflict management skills. In Phase 2, behavioral methods are used to address avoidance and emotional numbing and to increase relationship satisfaction. Couples engage in activities to promote approaching, rather than avoiding, feared situations. Phase 3 focuses on specific trauma appraisals and here-and-now cognitions that maintain PTSD and relationship problems. This article provides an overview of the treatment, a review of the outcome research, and a case illustration of a couple with a shared trauma (a stillborn child). © 2012 Wiley Periodicals, Inc. *J. Clin. Psychol.* In Session 68:536–547, 2012.

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Epidemiological data reveal that posttraumatic stress disorder (PTSD) is one of the disorders most strongly associated with intimate relationship distress and divorce. A recent meta-analysis reveals that PTSD symptom severity also has a medium-sized correlation with intimate relationship adjustment and intimate aggression (Taft, Watkins, Stafford, Street, & Monson, 2011). Although there are effective individual psychotherapies for PTSD, these treatments do not necessarily improve the intimate relationship problems so commonly associated with PTSD. Moreover, there is evidence that pretreatment familial functioning is associated with improvement in PTSD symptoms after a course of evidence-based individual psychotherapy. Thus, to expand the reach and potency of treatments that can address the range of problems that traumatized individuals and their loved ones face, we must develop therapies that ameliorate PTSD symptoms, enhance relationship functioning, and improve the health and well-being of significant others.

In this article, we provide an overview of cognitive-behavioral conjoint therapy (CBCT) for PTSD and the theory and empirical data that support its use. We illustrate its application in a case of a couple who experienced the stillborn delivery of their child, resulting in the wife's PTSD.

CBCT for PTSD

CBCT for PTSD is a 15-session couple therapy designed to treat PTSD and enhance relationship functioning (Monson & Fredman, in press); clinical levels of relationship distress are not required

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to benefit from the therapy. The treatment is manualized and organized into three phases that are represented by the acronym R.E.S.U.M.E. Living (described below). This acronym was chosen to convey the notion that individuals with PTSD have the potential to recover and resume their lives after traumatization as the impediments of behavioral avoidance, emotional numbing, and problematic ways of thinking are addressed.

Phase 1 of CBCT for PTSD (*Rationale and Education*) focuses on psychoeducation about the reciprocal influences of PTSD symptoms and relationship functioning and uses behavioral strategies to increase positive affect and behaviors. Conflict management skills are taught early on to enhance physical and emotional safety between the partners because of evidence that these couples are at greater risk for aggression and to increase safety within the couple relationship before beginning the trauma-focused cognitive phase of the therapy. In Phase 2 (*Satisfaction Enhancement and Undermining Avoidance*), behavioral interventions, such as communication skills training, are used to combat PTSD-related avoidance and emotional numbing and to increase relationship satisfaction. Couples also engage in activities designed to promote approaching, rather than avoiding, feared situations; these activities are to double as mutually enjoyable ways of spending time together. In Phase 3 (*Meaning Making and End of Therapy*), the therapy focuses on specific trauma appraisals and here-and-now cognitions that emanate from the trauma and maintain PTSD and relationship problems. The couple uses a dyadic cognitive strategy designed to collaboratively explore problematic thoughts held by either or both partners relating to PTSD and their relationship.

Sessions are designed to be 75 minutes long and conclude with between-session assignments designed to facilitate the couple's use of the skills outside of therapy sessions. CBCT for PTSD is trauma-focused but does not include imaginal exposure techniques to process the specific traumatic events. The methods used to process the traumatic events are based on cognitive theory, which involve contextualizing trauma memories and correcting maladaptive appraisals about the trauma. Traumatic events are discussed in enough detail to promote a shared understanding among the patient, partner, and psychotherapist of what unfolded at the time of the trauma and how each partner thinks about those events. Detailed or explicit renditions of the events are discouraged. This stands in contrast to some empirically supported individual therapies for PTSD in which patients are encouraged to repeatedly review events in detail until habituation of anxiety related to feared memories occurs. We have found that processing the trauma(s) from a cognitive perspective helps to maintain the conjoint frame of the treatment and avoids the potential for partners to be unduly distressed from hearing about specific trauma details.

CBCT for PTSD is based on our cognitive-behavioral interpersonal theory of PTSD (Monson, Fredman, & Dekel, 2010), which posits that there are cognitive, behavioral, and affective processes that interact within each individual, as well as between the individuals in the dyad, to reciprocally influence individual and relationship functioning in such a way that PTSD symptoms and relationship difficulties are maintained. At the individual level of the partner with PTSD, classical conditioning accounts for how certain sights, sounds, smells, people, and places reminiscent of the trauma trigger a fight-or-flight response similar to that which occurred at the time of the traumatic event. To manage the distress associated with these memories, those with PTSD avoid these reminders through behavioral and experiential avoidance via substance misuse, self-harm, overworking, or other forms of distraction. Emotional numbing serves as another over-learned coping strategy to manage distress. Through operant conditioning, behavioral and experiential avoidance and emotional numbing maintain PTSD symptoms because they are associated with the short-term removal of aversive emotional states. Hallmark cognitive disturbances associated with PTSD include attentional biases toward perceived threat, which can contribute to hypervigilance and aggression toward intimates and others. Those with PTSD also harbor beliefs negatively altered or confirmed by traumatic experiences that are interpersonally oriented (e.g., "I can't trust anyone," "I can't be physically or emotionally close to people because they will hurt me"). A range of disturbances in emotional content and processes are found in individuals with PTSD. Anxiety, anger/irritability, sadness, guilt, and shame are prominent among individuals with PTSD, and disturbances in the ability to identify and share emotions are common and closely tied to intimate relationship problems.

Partners of those with PTSD experience their own cognitive, behavioral, and affective responses. At the cognitive level, partners may believe they are responsible for minimizing the distress of the partner with PTSD and subsequently engage in accommodative behaviors, such as taking over chores and responsibilities, not going places that the partner with PTSD finds uncomfortable, or avoiding topics that might be distressing to the partner with PTSD. Affective responses to these thoughts and behaviors by the partner without PTSD can include a range of emotions, such as sadness, anxiety, and anger.

At the dyadic level, restricted emotional expression and decreased engagement in mutually enjoyable activities (e.g., going to movies, social outings) can contribute to problems with emotional and physical intimacy and decreased relationship satisfaction, especially when coupled with poor communication and conflict management skills. An interpersonal environment characterized by impairments in emotional expressiveness and communication further impedes trauma disclosure and the ability of partners with PTSD (and sometimes their significant others) to think about the traumatic event and challenge cognitions to promote recovery.

In the first session of CBCT for PTSD, the therapist provides the couple with psychoeducation about PTSD and its symptoms, including an explanation of how behavioral and experiential avoidance, emotional numbing, and problematic thoughts maintain PTSD and relationship problems. To strengthen the rationale for conjoint therapy, the therapist also engages the couple in a discussion of how the PTSD symptoms that they have observed exist in an interpersonal context (e.g., the partners sleep in separate beds because of the patient's PTSD-related nightmares, or the couple avoids certain social activities because of the patient's fears of crowded venues). In the second session of Phase 1, the partners are taught specific strategies for managing conflict, including primary (e.g., slowed breathing) and secondary prevention strategies (e.g., time-out) to increase physical and emotional safety in the relationship.

Phase 2 (Sessions 3 through 7) is designed to simultaneously improve relationship satisfaction and decrease behavioral and experiential avoidance and emotional numbing. Enhanced dyadic communication is used as an antidote to PTSD-related avoidance and emotional numbing and as a way to increase emotional intimacy and relationship satisfaction. Communication skills taught and practiced in each session build successively over Sessions 3 to 5 to facilitate the couple's ability to accurately listen to each other, to identify and share their feelings, and to notice the way that their thoughts influence their feelings and behaviors. The disorder is conceptualized as a third party in their relationship that gets between them, rather than a problem that resides within one partner. This is done to support the conjoint frame and to align the couple together against PTSD versus one another (e.g., communication skills are taught to shrink the role of PTSD in their relationship). The couple practices their communication skills and engages in dyadic, ideographically programmed, trauma-relevant, in vivo approach assignments designed to concurrently decrease avoidance and to serve as shared rewarding activities to increase positive feelings (e.g., going to restaurants, attending concerts).

In Session 6, the therapist introduces a dyadic cognitive intervention that the couple uses to examine and challenge maladaptive thoughts on the part of either partner (e.g., "I am not safe unless I carry pepper spray everywhere;" "If my partner is late coming home, it means that something bad has happened to her;" "Couples in healthy relationships never argue"). The process is summarized in the acronym U.N.S.T.U.C.K.: *U*nified and curious as a couple as they join together in collaborative empiricism to examine their thoughts; *N*otice and share thoughts and feelings; (*B*rain) *S*torm alternative thoughts or interpretations, even if they seem implausible; *T*est the thoughts by considering the evidence for or against each alternative thought; *U*se the most balanced or reasonable thought(s); observe *C*hanges in emotions and behaviors that follow as a result of the new thought(s); and *K*ep practicing (i.e., generate ways of putting into practice behaviors that reinforce the new thoughts and more balanced ways of thinking). This dyadic process is used throughout the rest of the treatment in the cognitively focused work. Phase 2 ends with the couple's learning problem-solving skills in Session 7 to determine how they will engage in specific activities to keep shrinking the presence of PTSD in their relationship.

Phase 3 of CBCT for PTSD (Sessions 8 to 15) capitalizes on the couple's increased satisfaction and skills learned during Phases 1 and 2 by targeting trauma-related cognitions that maintain both PTSD symptoms and relationship problems (e.g., "I can never let my guard down and

trust anyone,” “I have to be in control at all times,” “She is too damaged to ever recover from PTSD”). We first target cognitions specific to appraisals of the traumatic event(s) and then proceed to address interpersonal beliefs disrupted by, or seemingly confirmed by, the trauma. This order was chosen because changes in how a traumatized person or his partner makes sense of the specifics of his or her trauma(s) can have cascading effects on beliefs operating in the here and now. For instance, a rape survivor who blames herself for the assault because of having been intoxicated at the time of the event may have trouble trusting her judgment in the here and now and attempt to control all aspects of her present-day environment because of fears of putting herself or others in harm’s way. If that survivor’s significant other also blames her for the event, he or she may behave in a highly controlling manner toward her and further contribute to relationship conflict stemming from the dyad’s inability to share control. However, once the traumatized individual (and/or her partner) is able to recontextualize the event as the result of situational factors that may have been beyond her control at the time (e.g., the rapist slipped a drug into the drink, had a weapon, or purposefully isolated her so that no one would be around to hear her protests), she and her partner may develop different views of trusting her current judgment.

Treatment culminates with Session 14’s focus on the potential for individual and couple-level posttraumatic growth despite one or both partners’ having experienced a traumatic event and its aftereffects. The final session (Session 15) helps the couple consolidate gains achieved in psychotherapy, to anticipate fluctuations in their individual and relationship functioning over time, and plan for how they will address inevitable lapses and promote ongoing skill use into the future.

Treatment Outcomes

An earlier, more present-centered version of CBCT for PTSD with Vietnam combat veterans and their wives (Monson, Schnurr, Stevens, & Guthrie, 2004; Monson, Stevens, & Schnurr, 2005) demonstrated statistically significant improvements in the veterans’ PTSD symptoms according to clinician interview and wives’ self-report. The veterans reported moderate improvements in their PTSD symptoms and statistically significant and large improvements in their depression, anxiety, and social functioning. Wives reported large improvements in their own relationship satisfaction, general anxiety, and social functioning.

Results of the current version of CBCT for PTSD among community participants, diverse with respect to their index traumatic event, sexual orientation, and sex of the partner with PTSD, revealed statistically significant and large pretreatment to posttreatment improvements in clinician, patient, and partner ratings of patients’ PTSD symptoms. Partners also reported large improvements in their relationship adjustment (Monson et al., 2011). A randomized controlled trial of CBCT for PTSD with a community sample is nearing completion, and a randomized controlled trial comparing CBCT for PTSD to prolonged exposure in an active duty population is currently underway.

Case Illustration

The following section provides a case illustration of CBCT for PTSD for a couple with a shared trauma—a still born child.

Presenting Problem and Client Description

Lauren was a 28-year-old, Hispanic, married woman who contacted a university-based research clinic after seeing an advertisement seeking participants for a study evaluating CBCT for PTSD. During her assessment, she identified the stillborn birth of her son as her index event and expressed concerns that her husband’s work schedule would interfere with his attending conjoint sessions. Consequently, study staff offered her the opportunity to participate as a case study examining the application of CBCT for PTSD in the individual format for individuals who were in relationships but whose partners were unable to attend sessions. The goals of the individually delivered therapy are the same as in standard CBCT for PTSD; however, only the partner with

PTSD participates in the treatment. She or he is encouraged to share session content and practice skills with his or her partner between therapy appointments. The therapist works with the client to facilitate effective sharing of therapy skills and information with the partner, independent of the therapist.

During the assessment, Lauren provided her relationship history with her husband, Bradley, and described the PTSD symptoms she was experiencing. The couple met through their church when they were teenagers and dated for 6 years before getting married. Five years into their marriage, Lauren became pregnant. She reported that both she and Bradley were excited about the news and eagerly anticipated the birth of their son and the new roles they would assume as parents. On the morning of the index event, just days away from Lauren's expected due date, Lauren experienced abdominal cramping. When Bradley returned home from work a few hours later, they drove to the hospital to check on Lauren's health and the health of their unborn child. Lauren described feelings of intense fear and horror as hospital staff tried, unsuccessfully, to detect a fetal heartbeat. She further detailed being in shock when labor was induced and, shortly thereafter, she gave birth to a stillborn baby boy, whom they named Xavier.

Lauren reported alternating feelings of numbness and grief in the weeks that followed. She and Bradley held a funeral for their son soon after his death, but Lauren reported "being in a fog" during the preparations and ceremony. Lauren stated that she often lay awake at night with fine-grained details of her son's death playing over and over in her mind. She indicated that she was experiencing intense anger, sadness, and loss. She tried to avoid these feelings, as well as any reminders that she had been pregnant. Lauren increasingly isolated herself through extended periods of watching television or going for long walks.

Lauren described herself as intensely spiritual before the loss of her son. Her church played a central role in her life, and she described her relationship with God as the "foundation on which my life was built." This changed after the death of her child. An active participant in her church before his death, Lauren ceased attending church after the stillbirth. She believed that God and those closest to her had betrayed her, and she consequently withdrew from her husband, friends, family members, and God.

Case Formulation

Lauren was diagnosed with PTSD and major depressive disorder. She had no history of prior psychological problems or treatment. Her pretreatment scores on the Posttraumatic Stress Disorder Checklist (PCL; Monson et al., 2008) and a measure of depression were each in the moderate range of severity. The case formulation was initially based on information gleaned from Lauren but the case transitioned into a couple therapy format after six sessions, and the case formulation evolved with the addition of Bradley's perspectives.

Lauren described beliefs consistent with the notion of a just world (e.g., "Good things happen to good people;" "If I serve God faithfully, then God will protect me from tragedy"). Lauren indicated that she had tried to live a life according to the principles of her faith and that she now questioned the worth of her efforts. She stated, "I was so rigid with being good and then this happened, so why be rigid anymore?" Lauren reported that she was angry at the unfairness and cruelty in the world and that she "no longer believed in happy endings in life." She reported that she was the only person in her circle of loved ones who had experienced something like this and believed, "I must have failed somehow for this to have happened."

Lauren's inability to reconcile how bad things happen to good people contributed to beliefs that she had done something to bring this upon herself and that she had been betrayed by God. Whereas Lauren alternately blamed herself and God and experienced great anger and loneliness after the death of her son, Bradley did not share in this anger or blame, and turned to family, friends, and God for support. This led to conflict between the couple because Lauren interpreted Bradley's spending time with others as a betrayal of her.

Bradley's belief that he was responsible for Lauren's happiness and that he had to fix Lauren and make her better contributed to his avoidance of discussions in which negative thoughts and feelings were shared, as well as the disclosure of his own feelings of helplessness and anxiety. Lauren reported that Bradley did not understand her feelings and that she felt alone in her grief.

At the dyadic level, difficulty sharing thoughts and feelings contributed to disturbances in their emotional intimacy and impeded Lauren's development of a healthier set of thoughts about the trauma to move on from this shared traumatic event.

Course of Treatment

Psychotherapy began in an individual format with only Lauren in attendance. Although the treatment was initially delivered in the individual format, the intervention was couple-focused, and Lauren was asked to practice the skills and share the information gleaned in session with Bradley between sessions. As mentioned previously, she attended six sessions before Bradley was invited to participate to enhance the potency of the interventions and to help her overcome her avoidance.

At the first session, the therapist gave Lauren feedback on the results of her assessment and provided an overview of the therapy. The therapist presented the cycle of symptoms associated with PTSD, starting with reexperiencing, by eliciting examples from Lauren's life and relationship. The therapist explained that Lauren's unwanted memories and nightmares were examples of her mind trying to process and make sense of what had happened. The therapist asked Lauren about her reactions to these experiences, and Lauren replied that she had trouble sleeping and tended to become angry. The therapist noted that these were examples of hyperarousal symptoms and explained the relationship between reminders of traumatic events and the body's fight, flight, and freeze responses. Lauren recognized that she avoided many things (e.g., babies, pregnant women, television shows about pregnancy, happy people), and vacillated between avoidance and emotion-numbing strategies. The therapist explained that they would be focusing on breaking this cycle during the course of therapy.

Lauren was presented with a recovery model of PTSD, learning that most people experience a traumatic event in their lifetime, but that many people recover over time from those experiences. In this way, the therapist explained that PTSD can be thought of as a disorder of impeded recovery and highlighted the behavioral and cognitive barriers to a natural recovery from trauma: avoidance/emotional numbing and the way that people make sense of the traumatic event.

The therapist worked with Lauren to create both relationship and PTSD-specific goals for therapy. Lauren's goals, which focused primarily on reducing avoidance and increasing closeness with loved ones, included feeling closer and more connected to Bradley, turning to him for support, rather than turning away from him when experiencing negative emotions, having conversations with friends about how her son's death had affected her life, and returning to church and being emotionally present there.

As an out-of-session assignment, the therapist asked Lauren to complete the *Trauma Impact Questions*, a series of questions about how the trauma had affected her and her intimate relationship, why the event had occurred, and what her beliefs were about herself, her partner, and the world in general in the areas of trust, control, and emotional and physical closeness. The therapist gave Lauren a second copy of the questions and asked her to invite Bradley to complete them as well. The therapist encouraged Lauren to share with Bradley what she had learned in session and to go over the handouts in her workbook with him.

Lauren returned to the second session having completed her out-of-session assignments and reviewed the first session's material with Bradley. The therapist stressed the importance of taking a united approach to tackling PTSD. The therapist noted similarities in Lauren's and Bradley's *Trauma Impact Questions*. Both partners had noted that since the trauma, Lauren trusted herself and others much less, felt the need to be in control of things going on around her, and was much less emotionally connected with family and friends. The therapist initiated a discussion on the importance of safety in relationships, including strategies that Lauren and Bradley could use to monitor and learn about their own and the other partner's anger. Lauren reported that she experienced much anger and irritation and that it was often directed at Bradley. The therapist shared the conflict management strategies with Lauren, including slowed breathing and time-out, and she asked Lauren to practice these outside of sessions with Bradley.

Session 3 marked the beginning of Phase 2 of the therapy focused on building communication skills to increase understanding and closeness between Lauren and Bradley, as well as couple-

level activities that would serve to decrease the behavioral and experiential avoidance and emotional numbing that were maintaining PTSD symptoms and problems in their relationship. At the beginning of this session, Lauren revealed that she was pregnant. In an unemotional tone, Lauren stated that she was “of course, pleased.” Lauren said that she had not yet gone for an ultrasound, which was overdue, and that she was not taking prenatal vitamins, both of which were sources of conflict in her marriage. Lauren explained that she was trying to protect herself from possible hurt by not acknowledging the pregnancy. The therapist segued into a discussion on the role of avoidance in PTSD and queried whether Lauren’s disengagement from the pregnancy might be a form of avoidance. Lauren expressed that despite her efforts to ignore her pregnancy, she already cared deeply about the fetus and that her strategies were not working. By the conclusion of the session, Lauren committed to stop avoiding, to start taking prenatal vitamins, and to schedule an ultrasound.

The therapist explained that the sharing of emotions, both positive and negative, is the glue that holds relationships together and that avoidance of experiencing and sharing emotions can erode closeness in relationships. Lauren stated that she often closed herself off physically and emotionally from Bradley when she was feeling upset and noted a growing distance between them. The therapist introduced paraphrasing to Lauren as a strategy to facilitate sharing of her thoughts and feelings between sessions with Bradley and additional close others. The therapist practiced paraphrasing with Lauren by asking her to respond to two prescribed questions from the protocol: “What has PTSD made you and Bradley avoid?” and “What would you and Bradley do if you avoided less?” During the in-session practice, the therapist recorded Lauren’s responses, thus beginning Lauren’s list of approach tasks to be targeted during the course of therapy. The therapist encouraged Lauren to practice paraphrasing with Bradley on a daily basis at home.

During Sessions 4 and 5, Lauren gained additional skills to help her communicate PTSD-related thoughts and feelings with Bradley. Lauren reported that channel checking (i.e., clarifying whether the purpose of a conversation is to share thoughts and feelings or to problem-solve/make decisions) was particularly beneficial to the couple because of Bradley’s tendency to default to problem solving in their relationship. Lauren reported that when she tried to share her negative feelings with Bradley, he often tried to cheerlead her into feeling better, or he would try to suggest ways to fix things. Both of these tendencies made Lauren feel frustrated, angry, invalidated, and more distant from Bradley. Lauren came to Session 6 indicating that Bradley continued to switch to problem solving during conversations and that she was becoming increasingly frustrated and discouraged about their relationship. Lauren said that she wanted to share with Bradley what she was feeling and thinking as she progressed through therapy, but felt that she was struggling to do so.

The therapist initiated a discussion about ways to incorporate Bradley more fully into Lauren’s recovery. Lauren admitted that she wanted Bradley to come to the sessions but had previously been reluctant to ask in case he refused. The therapist discussed with Lauren the implications of switching to the couple format. For example, they would not return to the individual format, the therapist would meet alone with Bradley to assess his individual functioning and bring him more formally into the therapeutic relationship, and information shared thus far in therapy could be introduced in couple sessions. She encouraged Lauren to discuss these considerations with Bradley, using their best communication skills. The next day, Lauren and Bradley contacted the therapist to say that they wanted to proceed with couple treatment for the remainder of the sessions.

Before initiating the conjoint format, the therapist met with Bradley for several hours to answer his questions, to begin building a relationship with him, and to conduct an individual assessment. Structured clinical interview revealed no current psychopathology or a history of such. The therapist also scheduled two sessions with the couple to review material from Sessions 1 to 5. During these sessions, Lauren was encouraged by the therapist to explain key material to Bradley through the handouts in her workbook while the therapist provided a supportive role in clarifying and answering questions. During these transition sessions, Bradley shared that it was difficult for him to see Lauren upset and that as Lauren became increasingly despondent

and isolated in the months after their son's death, he felt responsible for making Lauren better. His inability to do so was frightening for him.

During Session 7, the therapist fine-tuned a hierarchy of approach tasks the couple could work on together based on the information that Bradley brought to the therapy. At the top of the hierarchy was a visit to the hospital where their son had died. The couple agreed to spend time sitting in the car in the parking lot of the hospital before Session 8. Lauren expressed resistance to the idea but agreed that it was a good next approach task for her in treatment.

The couple cancelled the next two sessions. Lauren sent an e-mail explaining that her father had needed emergency surgery at the hospital where her son had died and that she had skipped over the hierarchy of approaches and had gone straight to the hospital to visit him during the emergency. Lauren reported that the visit had put her in a spiral of intense feelings of sadness, grief, and anger, and that she was feeling overwhelmed, exhausted, and numb. Lauren wrote that she had tried to share some of this with Bradley, but that he had tried to problem solve with her. In response, she decided to spend a few days with her sister and stopped sharing her thoughts and feelings with him.

The couple arrived at the next session without having completed any out-of-session work. Lauren was quiet and reserved in contrast to past sessions. Noting the shift in affect and the absence of out-of-session work, the therapist expressed concern and curiosity. Lauren indicated that she was unsure if she wanted to continue in psychotherapy. She reported that it was getting too difficult for her and that she was too tired to continue to "poke at PTSD." She said, "I would rather face things when they come up naturally than seek out difficult challenges." The therapist validated Lauren's concerns and encouraged the couple to explore Lauren's thoughts and feelings using their communication skills. She asked them to apply the dyadic cognitive intervention to one of Lauren's therapy-related cognitions: "Therapy is hurting rather than helping me."

Lauren expressed her frustration with Bradley over his inability to listen to her feelings without trying to change them. Bradley paraphrased and then shared how difficult it was for him to see Lauren so upset because he cared deeply for her and wanted her to feel better. The therapist validated Bradley's distress and encouraged Lauren to paraphrase his desire to support and care for her. The therapist discussed how Bradley's attempts to protect Lauren from her distressing feelings were potentially getting in the way of her recovery. The therapist also explained the importance of sharing both positive and negative emotions in intimate relationships and asked Lauren and Bradley to problem solve how they would do this between sessions with greater success. Significant progress was made when Bradley reconsidered the beliefs that he was failing as a husband if Lauren was not happy and that he needed to protect Lauren from things that upset her.

After reengaging in therapy, the couple proceeded to make significant gains across the remainder of treatment. Despite "hating" the U.N.S.T.U.C.K. process because it forced Lauren to face the thoughts that she had been trying to avoid, Lauren and Bradley came to enjoy and look forward to the exercise, tackling increasingly difficult cognitions together. A particularly important thought that Lauren and Bradley challenged together using the U.N.S.T.U.C.K. process focused on control (see Figure 1).

Therapist (T) : Based on our discussion of control and PTSD, do you have any thoughts you'd like to share?

Lauren (L) : No matter what I do, even if I put in 100% control, I can't control what happens with my new baby.

T : Can you tell Bradley what you feel when you say that?

L : It's scary. It's life or death for me. I don't think I could survive this again. But I know it's true. It makes sense. But to let go of even the idea of having control feels like I'm leaving the door open for something bad to happen.

Bradley (B) : Umhm . . . From what I understand, you don't want to give up control because the thought of something like that happening again is unbearable and to let go of the thought of having complete control invites another trauma.

<p>U = United and curious N = Notice your thought S = (Brain) Storm alternatives T = Test them out U = Use the most balanced C = Changed feelings and behaviors? K = Keep practicing</p>	<h2 style="text-decoration: underline;">BIG PICTURE</h2> <p>"I can't control what happens to my inner organs."</p>	<p>"If God's plan is for a baby to be taken away before being born, then nothing I do or don't do can change that outcome."</p>
<p>"The effort involved in trying to control everything related to my pregnancy has a cost to my body and emotions."</p>	<div style="border: 2px solid black; border-radius: 50%; padding: 10px; width: fit-content; margin: auto;"> <p>Noticed Thought: "If I don't control everything related to my pregnancy I am opening the door to another trauma."</p> </div>	<div style="border: 1px solid black; border-radius: 50%; padding: 10px; width: fit-content; margin: auto;"> <p>"It's impossible to control everything related to my pregnancy."</p> </div> <p>"There are other women who have smoked, drank, and were in war, and they had fine pregnancies."</p>
<p>C: Feelings? Conflicted. Less self-blame. Less fear. Behaviors? Attend more social events. Take more risks.</p>		<p>K: Repeat this U.N.S.T.U.C.K. process on this thought or a similar thought.</p>

Figure 1. U.N.S.T.U.C.K. worksheet completed in session by Lauren and Bradley on a control-related thought.

- T** : It sounds like a lot of your thoughts are linked. Remember when we talked about blame and you identified the thought "I am to blame for Xavier's death" and "I could have prevented his death." Let's come up with a thought related to control and work through it. Do you have any ideas for a thought that may be keeping you stuck?
- B** : What about, "If I don't control everything, I'm giving way for this to happen again?"
- L** : Yes . . . "If I don't control everything related to my pregnancy, I am opening the door for another trauma."
- T** : I've noticed that you are getting better as a couple at zeroing in on your noticed thought.
- B** : So . . . brainstorming . . . what do you think, Lauren?
- L** : "I can't control everything. It's impossible to control everything related to my pregnancy." Is that a thought?
- B** : Yah, put that down. That's a good one.
- T** : Share with us where that thought came from.
- L** : It makes sense to me, but my mind is torn. I know I'm trying to control everything, and I feel that I can prevent this from happening again, and at the same time I know that that's not realistic. It's like a small little part in my brain gets that it's not realistic, but there's a big part in my brain saying, "I've got to control everything."
- T** : It sounds like you're opening the door to healing thinking. You're not necessarily going to believe new thoughts at first. That's why we ask you to do this exercise over and over. You're retraining your mind. You're chipping away at PTSD thinking. It takes practice, like building muscles. And that's the "Keep Practicing" part of this worksheet. I'm delighted to hear you say that there's a battle going on in your mind, because that's more than half of the battle.
- L** : Hmm . . . Yes. Because when we were talking earlier and saying that there are people that have drank alcohol and taken drugs and were in wars and starving countries, and they were not in complete control, and they had fine pregnancies, and their babies were fine. So, that's why there's that small part in my brain that knows that my thought isn't entirely true.

- T : So, why don't we put that one down on the worksheet?
- L : There are other women who have not had ideal pregnancies?
- B : You can put it exactly as we talked, "There are other women who have smoked, drank, and been in war, and they had fine pregnancies."
- L : Okay. I don't know if I have it exactly right.
- B : That's okay. I get what you're trying to say.
- T : What if you flipped your noticed thought on its head? What about people who have access to the best doctors, like Celine Dion? She went through multiple in vitro cycles and had access to the best medical care and lost multiple pregnancies. Does that bring up any alternative thoughts for you both?
- B : When we went to the bereavement group, we met a couple, and they expressed that they had been trying to conceive for 7 years and had spent a lot of money, and when they eventually got pregnant, their baby was stillborn at 35 weeks. They went through all of this, and they spent a lot of money, and they went to the best doctors. Maybe we can say something like, "All of the planning and taking all of the necessary planning and prepping won't necessarily bring a positive planned outcome."
- L : So, like what I was saying, to try to control everything won't necessarily bring about a positive outcome.
- B : Yah.

Outcome and Prognosis

At the end of treatment, Lauren and Bradley each completed a Posttraumatic Stress Disorder Checklist for Lauren and a measure of relationship satisfaction. The self-rated and partner-rated PCL scores were below the cut-score for likely PTSD and demonstrated marked improvements compared with pretreatment. Independent clinician assessment of PTSD symptoms by interview indicated a remission in PTSD diagnosis and substantial improvements in symptom severity. Moreover, both of their relationship adjustment scores on the Dyadic Adjustment Scale (DAS; Spanier, 1976) were well within the nondistressed range, as they had been pretreatment. Bradley expressed that although he had not thought it possible, he felt closer to Lauren and more confident in their marriage than ever. Lauren stated that her relationships with Bradley and other loved ones had greatly improved. Lauren expressed that she felt more confident in her marriage moving forward and in her own ability to both survive and work through difficulties in life. Before coming to the final session, Lauren and Bradley organized their couple workbook with special tabs and dividers so that they could easily identify the key tools, skills, and worksheets that had helped them in the course of therapy. They were both pleased about the gains they had made during the 17 sessions and how much they had removed PTSD from their lives as a couple. They stated that they were grateful to have done this work before the birth of their new baby and were eagerly anticipating Lauren's delivery in the coming weeks.

At the 3-month follow-up assessment, Lauren and Bradley reported that their daughter, Angela, was born with some minor complications, which resulted in her staying in the hospital for a month. Despite this challenge, Lauren and Bradley reported that "things were amazing" and that they were enjoying their new roles as parents. On the PCL, both rated Lauren's PTSD symptoms as further decreased from the posttreatment assessment. Bradley's relationship satisfaction remained within the satisfied range. In contrast, Lauren's scores on the DAS placed her in the distressed range, perhaps due to the stress of being a new parent to an infant needing extended hospital care on a daily basis.

Clinical Practices and Summary

This case illustrates several important points. First, it demonstrates the transition from an individual frame to a conjoint one. The salience of the couple conflicts, the fact that the partner was already quite involved in completion of out-of-session assignments, and our belief that there was a high likelihood that Lauren would have prematurely terminated if treatment had

not more formally involved her husband, led to the decision to transition to the standard CBCT for PTSD delivery in a conjoint format. Second, the case demonstrates the need to remain flexible within the fidelity of the treatment frame. Typically, we advise against adding extra sessions to the treatment, but in this case, we believed that it was clinically indicated to ensure that there was a solid and shared knowledge base within the couple before proceeding forward.

Third, this case highlights a common occurrence in trauma-focused treatment—ambivalence about continuing therapy once trauma-focused work begins—and offers strategies for addressing this ambivalence in session. The therapist encouraged Lauren and Bradley to use the content and skills they had learned in therapy to explore Lauren's ambivalence about continuing (i.e., psychoeducation about the role of avoidance in PTSD, sharing thoughts and feelings, addressing ambivalence-related thoughts with the U.N.S.T.U.C.K.). The end result was that Lauren and Bradley came to view Lauren's ambivalence as PTSD-related avoidance, and they made a renewed commitment to challenge PTSD together through therapy.

Fourth, this case further illustrates the ability of CBCT for PTSD to serve as a stand-alone treatment for PTSD, irrespective of the presence of clinical levels of relationship distress at the outset of treatment. We recommend CBCT for PTSD as a frontline treatment for traumatized individuals who present for PTSD treatment and are partnered, because it is an efficient means of treating PTSD and addressing the range of relationship processes (e.g., relationship distress, symptom accommodation) that can impede recovery from trauma or interfere with the delivery of individual therapy for PTSD. In addition to yielding the desired benefits for the individual with PTSD, research is documenting positive couple-level outcomes and improvements in the health and well-being of intimate partners participating in the therapy (Monson et al., 2004, 2005, 2011). Because of its trauma-focused nature, we do not recommend using the full course of CBCT for PTSD in conjunction with existing evidence-based individual therapies for PTSD that are also trauma-focused in nature. If an individual therapy for PTSD is to be endeavored, we recommend providing at least Phase 1 of CBCT for PTSD to the couple to help both partners appreciate the interpersonal nature of PTSD and the rationale for doing trauma-focused treatment, as well as to decrease the most negative behaviors in the couple's relationship.

Finally, this case demonstrates the value of using a conjoint approach with couples who have experienced the same trauma. We leveraged alternative perspectives on the same event to promote flexibility in thinking and the development of a more multidimensional and helpful trauma narrative. This was evident in the current case involving the stillborn birth of a child, but may also be applicable for couples who share other traumas such as motor vehicle accidents, robberies, or natural disasters, and who are at high risk for relationship distress or dissolution.

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