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Chapter 12

COGNITIVE-BEHAVIORAL COUPLE'S TREATMENT FOR POSTTRAUMATIC STRESS DISORDER

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ABSTRACT

Despite the acknowledged association between intimate relationship problems and PTSD, surprisingly few therapies have been designed to treat PTSD and relational problems within a couple format. Cognitive-behavioral Couples Treatment (CBCT) for PTSD is a therapy designed to treat PTSD and relationship discord. CBCT for PTSD targets the cognitive and behavioral mechanisms thought to contribute to both PTSD and relationship problems. This chapter broadens the understanding of PTSD by illuminating what is known and observed about its impact on intimate relationships, and presents an overview of CBCT for PTSD, including theoretical rationale and issues relevant to treatment delivery. Preliminary research in support of CBCT for PTSD is also presented.

INTRODUCTION

The damage to relational life is not a secondary effect of trauma as originally thought. Traumatic events have primary effects not only on the psychological structures of the self but also on the systems of attachment and meaning that link individual and community (Herman, 1992).

Marvin Smith[2] is a 54-year-old Vietnam veteran diagnosed with posttraumatic stress disorder (PTSD) and major depressive disorder. Mr. Smith lives in rural New England with

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his third wife and his three dogs. He has four children from previous marriages, and though he sees his children regularly, he does not feel close to them. He was fired from his job at the post office after repeated altercations with co-workers and supervisors. Mr. Smith says he does not trust people, and in fact, one of his primary goals is to have as few social interactions as possible. He has built his life around avoidance. He rarely attends family functions. If he has to shop or do errands outside the home, he goes at night, sometimes shopping for groceries in the earliest hours of the morning.

Mr. Smith is the first to admit he is frequently angry – the anger comes over him "fast and fierce." Although he has never physically harmed his wife, he frequently yells and throws things. She has learned to retreat, leaving him alone in his workshop where he can throw tools and pieces of wood at the walls. Even when they are getting along, Mr. Smith feels distant from his wife. He is limited in his ability to feel emotions such as love and happiness, and if you ask him how he is feeling, most days he will tell you: "numb." Even when he does feel emotions other than anger, Mr. Smith finds it hard to express himself. He dislikes talking; he is afraid of what he will say and what he might do. If pressed, he will tell you he is also afraid of what he might feel. Mr. Smith's wife has stopped talking, too. She does not want to make him angry, and like him, is afraid of what he might say or do. They have created a mutual pattern of avoidance, neither of them is happy and both admit they are lonely. Mrs. Smith, like wives before her, has threatened to leave Mr. Smith if he does not get help and change.

For 15 years, Mr. Smith has been a regular patient at his Department of Veterans Affairs (VA) Medical Center, where he has received evidence-based treatment for his depression and PTSD. He meets monthly with his psychiatrist to monitor his psychopharmacological regimen. The medication seems to have helped his depression, as he has not thought about suicide in many years, and he has more energy than he used to. Urged by his wife and his psychiatrist, Mr. Smith began individual psychotherapy to specifically address his PTSD. He met for several months with a psychologist specializing in anxiety disorders. Together, they systematically addressed his most painful experiences in Vietnam. Mr. Smith and his therapist noticed that after many weeks he was feeling less jumpy and had fewer nightmares. However, he continued to isolate himself from others, his intrusive thoughts about Vietnam remained, his irritation and angry outbursts seemed relatively untouched, and he remained numb. Meanwhile, Mr. Smith and his wife continued to respond and react to each other in ways that were mutually unsatisfying, leaving them with little hope for change. He was certain she would leave him, and she was certain he had stopped trying to change.

Mr. Smith and his wife are illustrative of the insidious and reciprocal association between PTSD and intimate relationship problems. The cumulative effect of avoidant and angry behavior, ineffective or absent communication, and negative thoughts and beliefs about each other, has been devastating. The Smith's are left believing their marriage is hopelessly ruined. Only rarely do they consider that their relationship problems are intertwined with Mr. Smith's PTSD symptoms. If they do observe the connection between PTSD and their intimate relationship, they often describe it as his problem. They are unaware of the bi-directional nature of their relationship problems and Mr. Smith's PTSD symptoms. When these interlocking problems can be appreciated and understood, the potential to improve both can be realized.

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[2] The patient's name and some identifying information has been changed to protect his identity.

Mr. Smith is typical of many individuals suffering from chronic PTSD. His trauma-related symptoms occur in an interpersonal context, affecting his loved ones, and being affected by them in turn. In contrast to many individuals suffering from PTSD, Mr. Smith received, and was able to tolerate, the best available psychopharmacological and psychological treatments for the disorder. Although he benefited from the therapies, he was nevertheless left with a host of intense residual symptoms and a life that remains fragmented and unsatisfying. His treatment demonstrates the limits of the available therapies for PTSD and the almost exclusive attention paid to conceptualizing and treating PTSD from an individual perspective.

State-of-the-art psychotherapy and psychopharmacological treatments for PTSD are extremely beneficial for some clients (see Foa, Keane, & Friedman, 2000 for review). However there are limitations to these treatments. Drop-out rates are as high as 50% in some samples, and 25% to 60% of patients still meet diagnostic criteria for PTSD at the end of treatment and at follow-up periods (Zayfert, Becker, & Gillock, 2002). These treatments have also been inconsistently effective in relieving the interpersonally-oriented symptoms such as the numbing and avoidance that Mr. Smith experiences so profoundly (e.g., Glynn et al., 1999; Keane, Fairbank, Caddell, & Zimering, 1989). Moreover, few outcome studies have considered the ways intimate relationships affect or are affected by individual PTSD treatment (see Monson, Rodriguez, & Warner, in press; Tarrier, Sommerfield, & Pilgrim, 1999, for exceptions). Even more obvious trauma-related outcomes with direct intimate relationship implications, such as sexual functioning in the case of individuals with PTSD secondary to sexual victimization, are rarely investigated. A somewhat myopic approach to the treatment of PTSD and its possible outcomes and influences has been the general rule.

This chapter describes Cognitive-Behavioral Couple's Treatment (CBCT) for PTSD, a treatment rooted in a cognitive-behavioral conceptualization of both PTSD and intimate relationship problems. We begin the chapter with a review of the descriptive studies that have documented the association between PTSD and intimate relationship problems, as well as the few studies of general conjoint therapy with PTSD sufferers. The theoretical underpinnings and related interventions of CBCT for PTSD, along with an overview of the manualized 15-session therapy, follow. Initial outcome data from a trial of CBCT for PTSD with veterans and their wives is reviewed (Monson, Schnurr, Stevens, & Guthrie, 2004). We then present new analyses of data on symptom outcomes for the wives, as well as social adjustment outcomes for both the veterans and their wives. Special issues to consider in delivering the treatment (e.g., trauma disclosure, dually traumatized couples) and future directions for the treatment's development conclude the chapter.

CBCT for PTSD evolved out of our work with veterans. Clearly, the affect of trauma extends beyond veterans suffering from PTSD due to military trauma. Although most of the research on relationship issues and PTSD has been conducted in veteran samples, there is some evidence to suggest that the interpersonal problems of men and women suffering from PTSD are similar, regardless of the type of trauma experienced (Herman, 1992; Neumann, Houskamp, Pollock, & Briere, 1996). We discuss issues unique to specific types of trauma (e.g., sexuality in the case of sexual trauma) in the conclusion of the chapter. We believe this chapter will be useful to those researching and treating survivors of diverse types of traumas and their partners, and for those interested in learning more about the interpersonal aspects of trauma in general.

PTSD AND INTIMATE RELATIONSHIP PROBLEMS

Research that has examined the intimate relationships of those with PTSD reveal severe and pervasive negative effects in marital satisfaction and general family functioning, divorce, intimacy problems, aggression, compromised parenting, and high levels of caregiver burden and mental health issues in their partners. While mostly descriptive in nature, there is emerging research aimed at identifying mechanisms that contribute to these individual and relationship problems.

Relationship Dysfunction and Divorce

In the National Vietnam Veterans Readjustment Study (NVVRS; Kulka et al., 1990), male veterans diagnosed with PTSD and their female partners reported more numerous and severe relationship problems, higher levels of parenting problems, and generally poorer family adjustment compared to veterans without PTSD and their partners (Jordan et al., 1992). Veterans with PTSD are less self-disclosing and expressive with their partners (Carroll, Rueger, Foy, & Donahoe, 1985) and have greater anxiety related to intimacy (Riggs, Byrne, Weathers, & Litz, 1998), compared to veterans without PTSD. Of note, Vietnam veterans with PTSD, compared with those without PTSD, are twice as likely to divorce once, and three times more likely to divorce multiple times (Jordan et al., 1992).

An epidemiological study of nearly 5,000 spouses in Ontario, Canada, investigated the association between nine mental health diagnoses and the presence/absence of marital distress (Whisman, Sheldon, & Goering, 2000). PTSD diagnosis was associated with a 3.8 times greater likelihood of being maritally distressed, second only to the 5.7 greater likelihood of marital distress with a dysthymia diagnosis. Major depression, panic disorder, and generalized anxiety disorder were also strongly associated with the presence of marital distress (odds ratios ranging from 3.2 to 3.5).

Violence

Veterans diagnosed with PTSD, compared to those without PTSD, are more likely to perpetrate verbal and physical aggression against partners and children (e.g., Carroll et al., 1985; Glenn et al., 2002; Jordan et al., 1992; Verbosky & Ryan, 1988), with rates as high as 63% for some type of physical violence in the past year (Byrne & Riggs, 1996). The severity of violent behavior is positively correlated with PTSD symptom severity (Byrne & Riggs, 1996; Glenn et al., 2002). Female partners of veterans with PTSD also report perpetrating more intimate aggression (Jordan et al., 1992).

Sexual Dysfunction

Sexual dysfunction in veterans with PTSD is significantly higher than in veterans without PTSD, with the severity of sexual dysfunction correlated with PTSD symptom severity (Cosgrove et al., 2002). Solomon et al. (1992) proposed that diminished sexual interest on the part of veterans with PTSD contributes to decreased couple's satisfaction and adjustment.

Partner's Mental Health/Caregiver Burden

The effect of PTSD seems to extend beyond the compromise of intimate relationships, and into the mental health and life satisfaction of veterans' partners. Wives of Israeli veterans with PTSD, compared to wives of veterans without PTSD, report more mental health symptoms and more impaired and unsatisfying social relations (Waysman, Mikulincer, Solomon, & Weisenberg, 1993). In addition, partners of Vietnam veterans with PTSD, relative to partners of veterans not diagnosed with PTSD, describe markedly reduced satisfaction in their lives and greater demoralization. About half the partners of veterans with PTSD endorse feeling "on the verge of a nervous breakdown" (Jordan et al., 1992). Partners of Australian Vietnam veterans, compared to a matched comparison group, also report significantly more mental health problems, including anxiety, social dysfunction, and depression (Westerink & Giarratano, 1999).

Anecdotal clinical reports indicate that significant others often demonstrate a wide variety of compensatory behaviors to offset their veteran partner's PTSD. Female partners may assume greater responsibility for household tasks (e.g., finances, time management, upkeep) and become primarily responsible for maintaining relationships in the family (e.g., children, extended family) (Maloney, 1988; Verbosky & Ryan, 1988; Williams, 1980). They also may feel compelled to care for the veteran and to attend closely to his problems, and to be keenly aware of cues that might precipitate PTSD symptoms. They often take an active role in managing and minimizing the effects of these triggers (Maloney, 1988). Gender roles in these families are often rigid and stereotypical, although role reversal can also occur (e.g., female partner becomes primary financial provider for the family), leading to conflicts (Verbosky & Ryan, 1988).

In this vein, caregiver burden in female partners of Vietnam veterans with PTSD is positively associated with their veteran partners' PTSD symptom severity. Moreover, caregiver burden explains a significant proportion of the variance in caregiver adjustment (e.g., depression, anxiety) both cross-sectionally and longitudinally (Beckham, Lytle, & Feldman, 1996; Calhoun, Beckham, & Bosworth, 2002).

Suspected Mechanisms

There have been a few attempts to isolate the contribution of PTSD to relationship problems and vice versa. For example, Jordan et al. (1992) found that the male veterans' PTSD symptoms accounted for variance in their intimate relationship distress above and beyond other factors associated with intimate relationship dysfunction (e.g., childhood behavioral problems, low parental affection, parental violence/abuse). Also using the intimate relationship data from the NVVRS, Orcutt, King, and King (2003) utilized structural equation modeling and found that PTSD had a direct relationship to the male veterans' perpetration of physical violence against their female partners. Retrospective reports of early family stressors, childhood antisocial behavior, and war-zone stressors were indirectly related to the violence perpetration through PTSD, suggesting that experiencing PTSD symptoms as a result of previous trauma potentiates an individual's risk for perpetrating intimate aggression.

In yet another study using the NVVRS data, the veterans' self-reported hyperarousal symptoms were correlated with the partners' reports of psychological and physical violence

victimization. In general, excessive alcohol use strengthened the association between hyperarousal symptoms and violence. However, the frequency and quantity dimensions of alcohol consumption were differentially associated with the relationship between hyperarousal symptoms and the perpetration of violence. The frequency of alcohol use was relatively less important than the quantity consumed to the association (Savarese, Suvak, King, & King, 2001).

Riggs and colleagues (1998) found that, of the PTSD symptom clusters, avoidance/numbing was most strongly associated with the ability of veterans diagnosed with PTSD to express emotions in their relationships. Their study suggested that emotional numbing symptoms in particular interfered with intimacy, contributing to problems in building and maintaining positive intimate relationships. Ruscio, Weathers, King, and King's (2002) study of veterans' relationships with their children further corroborates the role of emotional numbing in impaired relationship functioning.

There is some debate about the nature of the emotional numbing symptoms of PTSD. Emotional numbing has been formulated as a type of conditioned "emotional analgesia" that results from exposure to uncontrollable and unpredictable aversive stimuli – something akin to the "freezing" response (Foa, Zinbarg, & Rothbaum, 1992). An alternative conceptualization implicates the hyperarousal symptom cluster in depleting emotional resources, thereby leading to emotional numbing (Tull & Roemer, 2003). As we discuss in the next section, these emotional impairments seem to be an important key to unlocking the connection between PTSD and intimate relationship dysfunction.

Previous Studies of Conjoint Treatment for PTSD

The identification of intimate relationship problems associated with PTSD and discussion of the role of traumatized individuals' partners in trauma treatment (e.g., Byrne & Riggs, 1996; Figley, 1989; D. R. Johnson, Feldman, & Lubin, 1995; S. M. Johnson & Williams-Keeler, 1998; Riggs, 2000; Tarrier, Sommerfield et al., 1999), has not necessarily translated into treatment research efforts. To our knowledge, there have been only two controlled and two uncontrolled studies that have investigated conjoint treatment with PTSD sufferers and their partners. The samples consisted of male veterans and their female partners. The treatments employed in these studies consisted of generic forms of behavioral couple's/family therapy, meaning there was no specific focus on PTSD and its association with relationship problems.

Randomized Clinical Trials

In a study of group behavioral couple's treatment compared to a wait list control, Sweany (1987) found a significant decrease in the veterans' self-reported PTSD symptoms for those in treatment compared to the control condition. Furthermore, there were trends for improvements in the veterans' relationship satisfaction and depression. Glynn and colleagues (1999) compared individual exposure therapy alone (ET) with individual exposure therapy followed by behavioral family therapy (IE+BFT; 89% were conjugal partners) to a wait list control group. Compared with the wait list control condition, both ET and ET+BFT showed

statistically significant improvements in an index measure of re-experiencing and hyperarousal symptoms. Although there were no statistical differences between ET and ET+BFT in PTSD symptom outcomes, there was a moderate effect size advantage for ET+BFT over ET in the index of re-experiencing and hyperarousal symptoms (d = .46). There were also statistically significant advantages in social problem solving outcomes for ET+BFT compared with ET. It should be noted that there was a higher dropout rate in the ET+BFT condition (i.e., 35%), which the authors attributed to the fragility of these veterans' relationships and the delay prior to receiving BFT, given this study's serial design.

Uncontrolled Trials

Two other uncontrolled treatment studies of conjoint therapy have been reported. Using group behavioral couple's therapy with combat veterans, Cahoon (1984) found statistically significant improvements in the veterans' PTSD symptoms and coping ability (as rated by the group leaders; paired sample effect sizes of d = .47 and .72, respectively). Although the veterans in her study reported non-significant improvements in problem-solving and emotional communication (paired sample effect sizes d = .41 and .18, respectively), the veterans' female partners reported significant improvements in marital satisfaction and problem-solving communication (paired sample effect sizes of .34 and .56, respectively). Rabin and Nardi (1991) also provided a cognitive-behavioral group treatment with Israeli combat veterans and their wives, which included psychoeducation about PTSD. Minimal objective outcome data is reported from this study; however, 68% of the traumatized men and their wives reported relationship improvements. This study did not find a decrease in the veterans' PTSD symptoms.

CBCT FOR PTSD: TREATMENT DEVELOPMENT AND RATIONALE

CBCT for Individual Psychopathology

CBCT has received widespread validation for treatment of couple's distress and dysfunction (see Christensen & Heavey, 1999, for review), and has been extended and empirically tested in the treatment of individuals suffering from a variety of clinical problems. With regard to depression, alcohol and drug dependence/abuse, and agoraphobia, CBCT is equally or more efficacious than individual or group therapy in treating the primary clinical problem. Moreover, it has a variety of additional benefits including increased relationship satisfaction, decreased intimate aggression, less time separated, fewer divorces, more efficient treatment (i.e., greater gains, quicker), less attrition from treatment, and treatment-delivery cost savings (e.g., Arrindell & Emmelkamp, 1986; Daiuto, Baucom, Epstein, & Dutton, 1998; Jacobson, Fruzzetti, Dobson, Whisman, & Hops, 1993; O'Farrell & Fals-Stewart, 2000; O'Leary & Beach, 1990).

Taking into account the devastating and largely untreated relationship problems associated with PTSD, some preliminary evidence supporting the efficacy of behavioral couple's therapy for PTSD, and the established efficacy of CBCT for a variety of other individual problems, we developed a couple's treatment that simultaneously targets the

symptoms of PTSD and intimate relationship problems. The dual goals of improving PTSD and relationship functioning are consistent with the notion that there is a complex, reciprocal association between PTSD and intimate relationship problems, rather than a simple linear cascade in one direction or the other. Many aspects of PTSD effect couples and cause distress, and distress and tension in a couple's relationship exacerbates physical and psychological illnesses as well (Schmaling & Sher, 2000). Appreciating this circular causality, CBCT for PTSD is inherently systemic in its conception, and, as the name indicates, founded in cognitive-behavioral formulations of PTSD and relationship discord.

Baucom and colleagues (1998) outlined three different types of couple-based interventions that can be used when at least one person has psychological problems: partner-assisted, disorder-specific, and general couple functioning. CBCT for PTSD is a disorder-specific intervention, as the goals are to address the ways in which the couple's interactions and cognitions maintain the anxiety and avoidance cycle that are hallmark of PTSD. Relationship issues that affect or are affected by the disorder are the focus of intervention. For example, if financial issues are an area of conflict for the couple, but seemingly unrelated to PTSD, the financial issues are not specifically addressed. An underlying assumption of CBCT for PTSD is that individual improvement in PTSD symptoms might not occur or continue if the couple system has not adjusted or improved in a manner that promotes treatment gains. Moreover, CBCT for PTSD holds the potential to ameliorate the mental health problems often experienced by significant others.

Cognitive-Behavioral Rationale

Cognitive and behavioral theories have been put forth to explain both PTSD and relationship discord. In brief, Mowrer's (1960) two-factor explanation of conditioned fears has been used to explain the development and maintenance of PTSD symptoms (e.g., Foa & Kozak, 1991; Keane, Zimering, & Caddell, 1985). Classical conditioning processes account for the origins of the anxiety response, while operant conditioning processes explain its maintenance (i.e., negative reinforcement of fear through behavioral avoidance). In the case of intimate relationship discord, non-reinforcing, conflictual, and/or abusive behavior and communication are the behavioral elements theorized to contribute to relationship problems (e.g., Jacobson & Margolin, 1979). Cognitive conceptualizations of relationship discord hold that selective attention to negative events, distress maintaining attributions, unrealistic and/or unshared expectancies, conflicting assumptions, and differing standards contribute to dissatisfaction and conflict (Baucom & Epstein, 1995). Similarly, information processing theory explains the cognitive processes through which traumatic memories and associated affects are stored and maintained. It also addresses the adjustments, such as schema accommodation and assimilation, that are necessary to reconcile traumatic events with existing beliefs and expectations (Ehlers & Clark, 2000; Lang, 1977).

As shown in Figure 1, we theorize that there are overlapping behavioral and cognitive mechanisms that underlie the association between PTSD and relationship discord. These mechanisms act to maintain or exacerbate both PTSD and relationship problems.

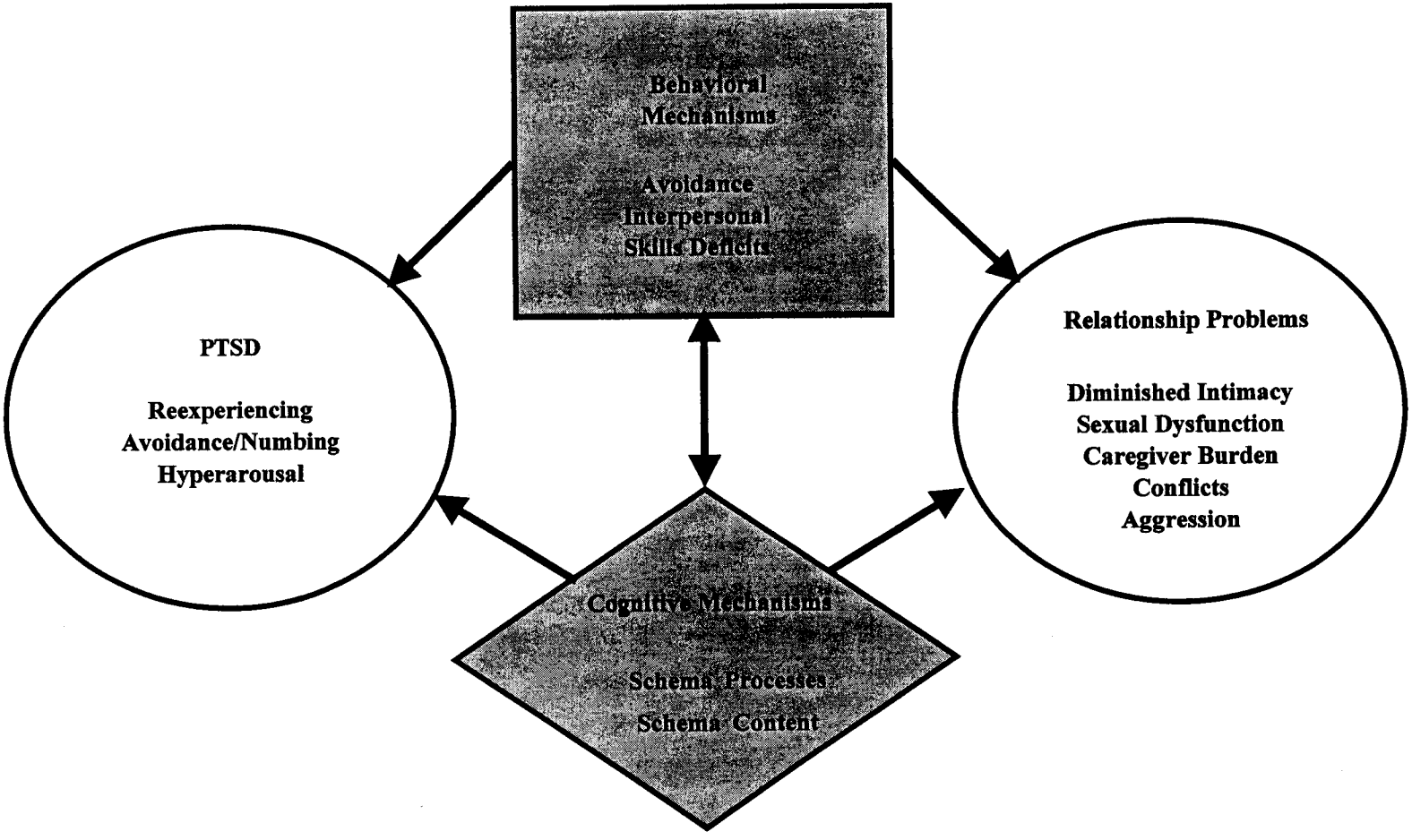

Figure 1. Behavioral and cognitive mechanisms underlying the association between PTSD and relationship discord.

Behavioral Mechanisms

Avoidance is considered to be a key behavioral culprit responsible for maintaining PTSD and relationship distress. This notion is supported by the previously reviewed research implicating the avoidance and numbing PTSD symptom cluster in diminished relationship satisfaction, intimacy, and emotional expression. Likewise, the avoidance of affective expression in intimate relationships has long been associated with reduced relationship satisfaction and intimacy in couples in general (see Gottman & Levenson, 1986, for review).

Avoidance can manifest within the couple context in a myriad of ways. Examples of more overt trauma-related behavioral avoidance includes sleeping in separate beds because of nightmare-disturbed sleep, not dining in restaurants or going to movie theaters, unwillingness to be in crowded areas, or not attending family gatherings or engaging in family interactions. However, avoidance may also present more subtly in the form of experiential avoidance. Experiential avoidance, or avoidance of private experiences (e.g., feelings, memories, behavioral predispositions, thoughts) (Hayes & Gifford, 1997), is another form of avoidance that has been associated with PTSD (Boeschen, Koss, Figueredo, & Coan, 2001). Within the couple's relationship, experiential avoidance may present in extreme efforts to avoid conversations or conflict, decrease in sexual activity due to discomfort with arousal, and general social isolation. Experiential avoidance limits the intimacy that the couple shares through its restrictions on emotional experiencing and expression.

Interpersonal skills deficits, including poor communication and conflict management skills, are other behavioral mechanisms connecting PTSD and relationship discord. These deficits are well documented in individuals with PTSD (Frueh, Turner, Beidel, & Cahill, 2001), and communication problems are the most often cited problem in distressed couples (Whisman, Dixon, & Johnson, 1997). Poor communication skills are an impediment to garnering social support, a consistent and robust predictor of PTSD (Brewin, Andrews, & Valentine, 2000). Communication skills also effect the nature and likelihood of trauma disclosure, which fosters the development of a more cogent trauma narrative and emotional processing of traumatic memories. Emotional disturbances associated with PTSD, such as alexithymia or difficulties with identifying and expressing emotions (Monson, Price, Rodriguez, Ripley, & Warner, 2004), are suspected to be associated with emotional communication deficits and their related intimacy impairments. Limited conflict management and problem-solving skills also mediate the relationship between the hyperarousal symptoms of PTSD and aggressive relationship behavior.

Cognitive Mechanisms

How people think about themselves and their most intimate loved ones is inextricably tied to their behaviors and emotions. We theorize that there are inter-related cognitive processes and content that account for the association between PTSD and relationship problems. Furthermore, the cognitions at play within each member of the couple are considered to interact at the dyadic level to create and maintain impairments in both individual and couple functioning.

Irrational and/or dysfunctional thought content about self and others is implicated in both PTSD and relationship discord (Baucom, Epstein, & LaTaillade, 2002; Ehlers & Clark, 2000). These individual thoughts and beliefs are heuristically organized and stored in semantic structures called schemas. Individual and dyadic dysfunction arises from reliance on enduring, rigid, and maladaptive schemas in making meaning of experiences and the

environment (Young, 1994). Problematic schema content salient to both PTSD and intimate relationship functioning has been outlined by McCann and Pearlman (1990). These five themes include safety, trust, power/control, esteem, and intimacy, and are applied to schema content about self and others.

The Smith's case from the chapter's introduction illustrates problematic schema content pertinent to their intimate relationship functioning and Mr. Smith's PTSD symptoms. Mr. Smith's concerns about his ability to control his behavior reflect negative schema content about his self-safety, and his diminished other-trust is observed in his distrust of his wife's intentions and actions. These beliefs are traced to his assault while in the military. Ms. Smith has minimal trust and perceived ability to influence Mr. Smith's behavior. These themes, with their attention to the interpersonal dimension, fit nicely within the conjoint therapy frame.

Schemas are also involved in several cognitive processes identified in both PTSD and relationship problems. Schemas guide attention to selected information in the environment. Selective attention to threat cues is a cardinal cognitive tendency in PTSD (McNally, 1998), and selective attention to negative behaviors in couples is frequently cited as a factor in couple's discord (Baucom et al., 2002). Anecdotal and empirical literature supports our observation that individuals with PTSD often selectively attend and appraise partners to be exhibiting threatening, blaming, and critical behavior toward them (Beckham, Roodman et al., 1996; Glenn et al., 2002). Alternatively, we have observed veterans with PTSD to selectively attend to and appraise threatening behavior toward their partners and families by others, resulting in over-controlling, protective and hypervigilant behaviors with their family members. Biases in memory recall, especially those that are mood-congruent, also effect the couple's interactions and PTSD. When feeling anxious and irritable, individuals with PTSD may make more frequent and severe distress-maintaining attributions about their partner's behaviors, which initiates a cycle of diminished relationship satisfaction and more anxiety and irritability.

A dynamic process is thought to exist between schema content and experience; an individual's perception of external events is influenced by their schemas, but schemas are also malleable to external experiences. When external information is *assimilated* into existing schemas, the information is perceived to be congruent with the content of the schemas, and is incorporated into the existing schemas. In schema *accommodation*, external information is perceived to be discrepant with existing schema content, and the schemas change to account for the information (Piaget, 1971).

The assimilation of traumatic experiences into existing schemas is one hypothesized cognitive contribution to PTSD and relationship dysfunction (Horowitz, 1986). When assimilating traumatic material, individuals can alter their perceptions of the circumstances surrounding the traumatic event in order to maintain their existing belief systems. Self-blame and just world thinking such as "Good things happen to good people and something bad happened to me. Therefore, I must have done something bad," are signs of assimilation (Resick & Schnicke, 1993). In some cases, clients hold pre-existing negative beliefs about themselves and/or others, and the traumatic situation is easily assimilated into, and reinforces, their problematic schemas. Individuals with a developmental history of traumas may be more likely to have this pattern of schema validation (McCann, Sakheim, & Abrahamson, 1988).

Schemas do not develop or exist in an interpersonal vacuum. Sometimes significant others of traumatized individuals can reinforce the detrimental effect of assimilation by suggesting or stating that the traumatized individual did something to cause or contribute to

their traumatization. Veterans, especially those who served in Vietnam, often describe messages that they received upon homecoming that reinforced their sense of culpability in killing others during their military service. Examples include being spit on by others at airports, and hearing phrases such as "Baby Killer" directed at them. Sexual assault victims have also found their role in their victimization questioned by the legal system and others (e.g., "What were you wearing?"). Significant others, like victims, may fall prey to assimilation in an effort to retain a (false) sense of control and predictability. However, assimilation ultimately interferes with the emotional processing of traumatic experiences, and leaves people with negative feelings about themselves and others (Cason, Resick, & Weaver, 2002).

Schema over-accommodation is another theorized cognitive pathway bridging PTSD and relationship discord. In over-accommodation, schemas are radically changed in an effort to reconcile traumatic experiences that are incongruent with existing schemas. For example, victims might believe pre-trauma that the world and others are generally safe, and that they have power to influence outcomes. When faced with a traumatic event in which they were harmed and helpless, they may over-accommodate their schemas by coming to believe that they are powerless to protect themselves and unsafe with others. Other typical manifestations of over-accommodation related to both PTSD and intimate relationships that we frequently encounter include, "Nobody can be trusted," "If I get close to someone, something bad will happen," "She [partner] is trying to control me."

Translating Mechanisms to CBCT for PTSD Interventions

Figure 2 shows the CBCT for PTSD interventions used to address the behavioral and cognitive mechanisms underlying PTSD and relationship problems. The treatment begins with behavioral interventions designed to decrease avoidance and anxiety and enhance interpersonal skills. As indicated by the open arrow in Figure 2, we capitalize on these behavioral improvements with interventions that address the cognitive mechanisms linking PTSD and relationship problems. A session-by-session review of the treatment is presented in the next section.

Behavioral Intervention

Trauma exposure techniques, such as prolonged imaginal and in vivo exposure, are interventions naturally extending from a behavioral explanation of PTSD. In CBCT for PTSD individuals do not systematically confront specific traumatic memories with the goal of anxiety habituation. Rather, congruent with the rationale underlying anxiety management treatments successfully used in treating PTSD (e.g., Stress Inoculation Training; Kilpatrick, Veronen, & Resick, 1982), fear conditioned at the time of the trauma is generalized to many situations and experiences, and better management of this anxiety decreases avoidance and consequently PTSD. CBCT for PTSD also embraces the notion that there are multiple emotions in addition to anxiety that surround traumatic memories and reminders (e.g., guilt, shame, anger), which is consistent with cognitive conceptualizations of PTSD (Resick, 2001). We argue that relaying specific trauma details is less important than fully experiencing, expressing, tolerating, and processing the myriad emotions attached to them for treating PTSD and relationship problems.

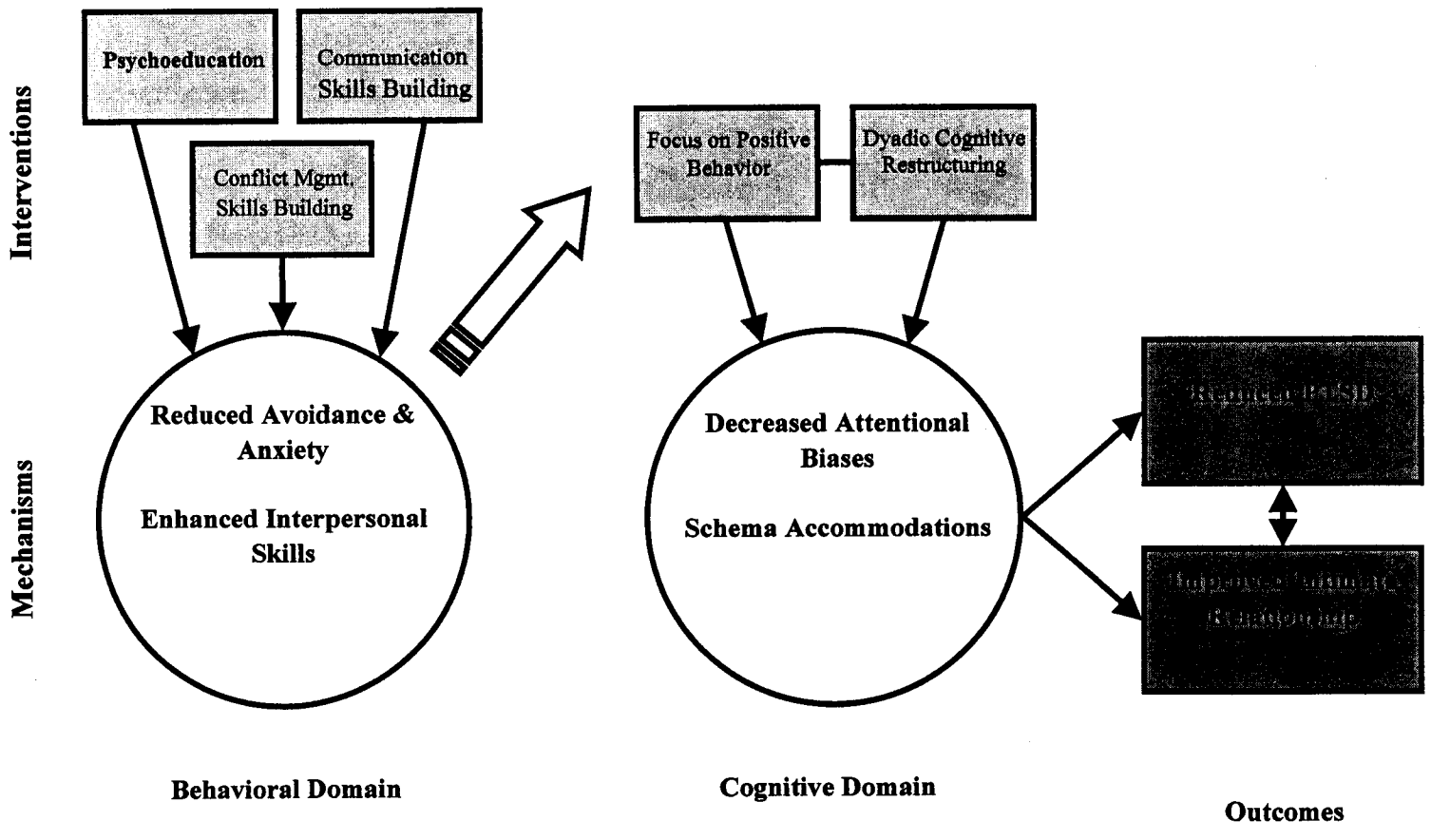

Figure 2. Interventions and mechanisms of Cognitive-Behavioral Couple's Treatment for PTSD. Improvements in the behavioral mechanisms facilitate the cognitive interventions. These interventions ultimately ameliorate both PTSD and intimate relationship problems.

CBCT uses psychoeduction, conflict management, and communication skills to address avoidance and negative behavior patterns contributing to PTSD and relationship distress. Psychoeducation about the role of avoidance in maintaining anxiety and obstructing intimacy is the first step in "avoiding avoidance." Psychoeducation sets the stage for the following behavioral interventions by helping couples to increase understanding of their behaviors, and to provide them with a sense of competence as they learn specific ways of changing their behavior. Psychoeducation is provided throughout the therapy, with continued rationale, support and reminders about the goals of the various interventions.

The couple's awareness of the detrimental role of their avoidant behavior is heightened through psychoeducation, and yet they may not have the skills, or proficiency, needed to cope with a less avoidant approach to life and their relationship. Conflict and communication skills are developed to discuss and manage increasingly distressing issues previously avoided, and help overcome anxieties and tensions associated with confronting feared situations and experiences. The problem-solving communication and conflict management skills are also built early on in CBCT for PTSD to curb the devastating effects of conflictual and abusive behavior on relationships, and to improve management of PTSD hyperarousal symptoms such as anger and irritability.

Improved emotional communication skills facilitate discussion of trauma-related thoughts, feelings, and behaviors, thus providing couples with the opportunity to directly address the issues contributing to PTSD. Emphasis is placed on improved emotion identification, emotional expression, and reflection of their partner's emotions. We also stress the importance of tolerating emotional experience and expressing these emotions within the couple's relationship in order to combat experiential avoidance and increase the couple's intimacy.

An early and continuing focus is placed on increasing and noticing positive couple behavior, while using the above interventions to decrease negative behavior contributing to PTSD and relationship problems. Increasing positive behavior is as important as decreasing negative behavior in improving intimate relationships (Baucom et al., 2002), and highlighting positive behavior helps counter the negative attentional biases associated with PTSD and relationship discord. Again, we provide psychoeducation about these findings, which enhances couple's compliance with behavioral interventions that might seem artificial or awkward in the context of a generally discordant relationship (e.g., scheduling "dates") and helps cast doubt on their generally negative cognitions.

Cognitive Interventions

With improved communication and conflict management skills, the second half of CBCT for PTSD involves activating and modifying problematic schemas contributing to PTSD and relationship discord. As discussed in the mechanism section above, couples have interacting individual schema content that contribute to their individual and dyadic dysfunction. Dyadic cognitive restructuring techniques are used to modify the irrational and/or dysfunctional thoughts and beliefs that comprise their schemas. Schema accommodation, or the development of more balanced, realistic, and healthy schema content as it relates to trauma experiences and the nature and expectations of their intimate relationship, is the overarching goal of this cognitive phase of treatment. Schema accommodation is theorized to simultaneously facilitate emotional processing of traumatic events and improve relationship satisfaction.

Consistent with a previous individual cognitive psychotherapy for PTSD (Resick & Schnicke, 1993), we have incorporated McCann and Pearlman's (1990) themes of safety, trust, power/control, intimacy and esteem, into the treatment. We have elaborated and adapted these themes to emphasize how they can manifest, effect, and be potentially resolved within the conjoint context. Attention is paid to the couple's interacting thoughts and beliefs in each of these areas.

CBCT FOR PTSD: ASSESSMENT AND SESSION OVERVIEW

Prior to initiating CBCT for PTSD, we highly encourage clinicians in research or practice to consider some form of assessment. Formal pre-treatment assessment helps ensure that the intervention is appropriate for the couple, and pre-/post-treatment assessment helps the clinician and couple to appreciate the improvements made over the course of treatment.

Assessment

We do thorough assessments of each individual and their dyadic functioning. We caution against using CBCT for PTSD if the pre-treatment assessment reveals that either member of the couple has emergent mental health issues such as current substance dependence (not necessarily abuse), mania, psychosis, or prominent suicidality or homicidality. We also do not consider the treatment to be appropriate for couples in which there are current severe levels of intimate aggression. These safety issues need to be addressed prior to embarking on a course of CBCT for PTSD.

We provide clients with feedback from the assessment about their PTSD symptoms, relationship functioning, and associated psychological issues prior to the first session of CBCT for PTSD. This feedback facilitates treatment goal setting, psychoeducation, and the goal-oriented focus of treatment. In our experience, couples are eager to have information about their assessment results, and these results have enhanced treatment delivery.

We use both clinician interview and self-report methods for assessing PTSD, and self-report measures for assessing frequently co-occurring problems (e.g., anxiety, depression, affective control, substance abuse/dependence). Relationship variables assessed include self-reported relationship satisfaction, intimate aggression, and adult attachment style. We also assess their communication skills with a 10-minute videotaped (can be audiotaped) communication sample about a moderately distressing topic for behavioral coding, which is also used in the course of treatment. The assessment measures are further described in the section on preliminary research supporting CBST for PTSD.

Treatment Sessions

CBCT for PTSD consists of 15 sessions comprised of three treatment phases: (1) treatment orientation, psychoeducation about PTSD and its related intimate relationship problems, and safety building; (2) communication skills training; and (3) cognitive interventions. Each 75-minute session begins with an overview of what is to be accomplished in the session. Out-of-session assignments conclude each of the sessions (see Table 1).

Table 1. Cognitive-Behavioral Couple's Treatment for Posttraumatic Stress Disorder Session Overview

Session 1	Introduction of Treatment Model, Frame and Contract
Session 2	Psychoeducation About PTSD, Relationships and Avoidance
Session 3	Safety Building
Session 4	Introduction of Communication Skills Training
Session 5	Listening and Paraphrasing
Session 6	Assertive Speaking
Session 7	Problem-solving versus Emotional Communication Channels
Session 8	Identification, Sharing and Reflection of Feelings
Session 9	Cognitive Overview
Session 10	Safety Issues
Session 11	Trust Issues
Session 12	Power and Control Issues
Session 13	Intimacy Issues
Session 14	Esteem Issues
Session 15	Review and Reinforcement of Gains

Treatment Orientation, Psychoeducation, and Safety Building

The first three sessions of the treatment are focused on introducing the treatment rationale to the couple, providing psychoeducation about PTSD and relationship problems, and building a collaborative therapeutic relationship. As part of this latter goal, the therapist and couple work together to define the couple's goals for treatment related to both PTSD and their relationship. Although CBCT for PTSD it is a structured treatment of 15 sessions, it is crucial that the couple be able to articulate what they see as the most problematic issues and the goals that are most meaningful to them.

In the first session, treatment expectations are outlined; the phase-oriented, here-and-now, goal-focused, and time-limited nature of the treatment is presented. We also discuss the conjoint treatment frame, and specifically the conceptualization that PTSD and relationship interactions are reciprocally related. The issue of trauma disclosure is candidly addressed, and possible concerns, desires, and prohibitions of disclosure are solicited from each member of the couple. The expectation for out-of-session assignments (i.e., we carefully use this phrase versus "homework" based on feedback from patients) is provided in this session, and is supported with an elaborated rationale. As noted above, specific treatment goals are mutually developed, and each member of the couple signs a treatment contract containing these goals and the above treatment expectations.

The importance of simultaneously increasing positive behaviors and decreasing negative behaviors is presented in this session. This leads to the first out-of-session assignment that asks couples to monitor for daily occurrences of their partner's positive behaviors. The couple is also asked to read psychoeducation material about PTSD and its connection to relationship functioning together prior to the next session. Finally, each partner is asked to write a "Statement of My Core Beliefs" as it relates to themselves and their partner in the five content areas of safety, trust, power/control, intimacy, and esteem. They are asked to consider how trauma or life experiences might have affected these beliefs. Examples from these statements

are incorporated into the psychoeducation about PTSD and its connection to relationship functioning in the next session.

Session two is devoted to providing a cognitive-behavioral conceptualization of PTSD and relationship discord. The maintenance of PTSD through avoidance strategies, including experiential avoidance is stressed. The role of experiential avoidance as it ties together PTSD symptoms, couple behavior patterns and couple dysfunction is explored. The concept of habituation is presented to the couple as a rationale for approaching uncomfortable and distressing topics. Out-of-session assignments include asking the couple to continue to monitor for positive partner behavior on a daily basis, and to together read a handout that reviews the material presented in this session on the role of avoidance in PTSD and relationship functioning.

The third session is spent exploring the existence of very negative behaviors such as intimate aggression, threats to leave the relationship, and ongoing infidelity. In this session, conflict management skills, including "Time-Out" procedures, are also presented and practiced. Psychoeducation materials related to common communication problems are also provided as an introduction to the communication skills training.

Communication Skills Training

Sessions four through eight focus on enhancing the couple's problem-solving and emotional communication skills by developing listening/paraphrasing; assertiveness; emotional versus problem-solving communication; and emotion identification, sharing, and reflection skills. In the fourth session, the couple views (or listens to) their pre-treatment communication sample with the therapist to support the rationale for communication skills training, and to allow the couple to observe their communication from a more objective perspective. The couple is asked to audiotape 10 minutes of their communication each week in their home during this treatment phase, utilizing their improved communication skills. These audiotapes are reviewed with the couple in the subsequent session to troubleshoot and provide positive feedback to the couple.

The "Relationship Log" is also introduced in this phase of treatment. This dyadic monitoring form is used to increase the couple's awareness of their individual thoughts, feelings, and behaviors related to events that occur within their relationship. The couple is asked to complete the form together on positive and negative relationship events on a daily basis. There are two versions of the Relationship Log, with the first mirroring the focus on behavior and emotions in this second phase of treatment. The second version builds upon the first version, and includes monitoring of cognitions targeted in the next phase of treatment.

Cognitive Interventions

In the final phase of treatment, the couple's communication skills are used to address the underlying and interacting cognitions that contribute to the association between PTSD and relationship problems. The theorized primary role of thoughts and beliefs in feelings and behaviors is introduced in session nine. We also describe how previous experiences, including traumatic experiences, effect a person's thoughts and perceptions of the world, themselves, and others. We incorporate their previously written statements about their respective core beliefs in this psychoeducation.

The five themes discussed above (i.e., safety, trust, power/control, intimacy, and esteem) are introduced over five sessions and used as topics for in- and out-of-session dyadic

cognitive restructuring. The Relationship Log is used to elucidate each member's thoughts, feelings, and behaviors about relationship events, including those pertaining to each of the five themes. The couple is also asked to identify recurring underlying problematic schema content, which we describe as "core beliefs" to the couple. The Relationship Log also provides for consideration of alternative thoughts that result in more healthy feelings and behaviors. The couples are encouraged to draw upon their communication skills and to adopt an attitude of curiosity and non-judgment as they explore each of their thoughts and beliefs held in these areas. These sessions conclude with out-of-session assignments to conjointly use the Relationship Log about relationship events central to the couple's identified problematic core beliefs and themes. The couple's Relationship Logs are reviewed at the next session for additional support in restructuring and positive feedback.

The final session is spent reviewing and reinforcing gains made in treatment and anticipating challenges into the future.[1]

PRELIMINARY RESEARCH SUPPORTING CBCT FOR PTSD

Our group has previously reported the primary outcomes from a pilot study of CBCT for PTSD with 7 couples (Monson, Schnurr et al., 2004). In each couple, the husband was diagnosed with PTSD secondary to Vietnam combat experiences. The characteristics of these veterans and couples are consistent with the characteristics of current treatment-seeking veterans in the VA (Rosenheck & Fontana, 2003). More specifically, the veteran participants were Caucasian, and the mean ages of the husbands and wives were 56 (range = 53-58) and 51 (range = 42-59) years, respectively. Their median length of marriage was 29 years (range = 2-35). Three couples had a history of physical aggression, and three veterans were previously divorced. The VA rated five of the veterans as 100% permanently disabled and one was rated as 50% disabled due to their military service-related PTSD. The remaining veteran received non-VA entitlements for a physical disability. None of the recruited couples dropped out of the treatment.

The inclusion criteria were a current diagnosis of PTSD and an intimate partner willing to participate in treatment. Exclusion criteria for both the PTSD-identified participant and partner were substance dependence not in remission for at least three months, current uncontrolled bipolar or psychotic disorder, or severe cognitive impairment. Couples currently experiencing severe intimate aggression or a desire to separate or end their intimate relationship were also excluded.

Pre- and post-treatment assessments were conducted using clinician-administered, behavioral, and self-report instruments. The Clinician Administered PTSD Scale (CAPS; Blake et al., 1995) is a structured clinician interview that measures PTSD diagnostic status and symptom severity consistent with the Diagnostic and Statistical Manual – Fourth Edition (DSM-IV; American Psychiatric Association, 1994). PTSD diagnostic status was based on a minimum level of severity (overall severity = 45) and DSM-IV symptom criteria (symptom frequency = 1 and intensity = 2 to be counted) on the CAPS. Total CAPS symptom severity was the primary outcome. Psychology doctoral students trained to reliability in the CAPS, who were uninvolved in the study and blind to assessment period, conducted the CAPS.

[1] The treatment manual is available from the first author.

The PTSD Checklist (PCL-S; Weathers, Litz, Herman, Huska, & Keane, 1993) is a 17-item self-report measure of the PTSD symptoms found in the DSM-IV. Partner ratings of the PTSD-identified veterans' symptoms were also obtained using the PCL (PCL-P). The Beck Depression Inventory (BDI; Beck, Ward, Mendelsohn, Mock, & Erbaugh, 1961) is a 21-item self-report measure designed to assess degree of depressive symptomatology. A cut-score of 14 is recommended for identifying clinical levels of depression. The Spielberger State-Trait Inventory-Trait Scale (Spielberger, 1983) consists of two 20-item scales: State Anxiety and Trait Anxiety. The Trait Anxiety scale (STAI-T) score results were used because of its greater test-retest reliability (.81 versus .40 for State Anxiety). The Dyadic Adjustment Scale (DAS; Spanier, 1976) is a 32-item self-report inventory designed to measure satisfaction in intimate dyads. Social functioning was assessed with subscales of the Social Adjustment Scale (SAS; Weissman & Bothwell, 1976). The psychometric properties of the measures used in the study are well established (Beck, Steer, & Garbin, 1988; Crane, Allgood, Larson, & Griffin, 1990; Forbes, Creamer, & Biddle, 2001; Spielberger, 1983; Weathers, Keane, & Davidson, 2001; Weissman, Prusoff, Thompson, Harding, & Myers, 1978).

The first two authors and a clinical social worker specializing in PTSD treatment delivered the current manualized version of CBCT for PTSD described above. The study therapists observed each other's treatment sessions to ensure adherence to the treatment.

There were statistically significant improvements in the clinician (CAPS) and partners' (PCL-P) ratings of the veterans' PTSD symptoms across treatment, with pre- to post-treatment effect sizes greater than $d = 1.00$. The veterans' self-reported improvements in PTSD symptoms (PCL-S) were not statistically significant, but the pre- to post-treatment effect size change ($d = .64$) was larger than those found in previous outcome research with veterans (e.g., Creamer, Morris, Biddle, Elliot, & Rabin, 1999; Keane et al., 1989). Given the small sample size, reliable change (improvement or deterioration) criteria for the symptom outcomes were also applied on an individual basis to assess the consistency of results (Foa, Zoellner, Feeny, Hembree, & Alvarez-Conrad, 2002). Using these criteria, all 7 veterans were improved according to the clinician assessors (CAPS), 5 were improved according to the partners (PCL-P), and 4 were improved according to self-report (PCL-S). Three veterans no longer met criteria for PTSD diagnosis, according to clinician assessment, at the end of treatment. Moreover, the veterans self-reported statistically significant and large effect size improvements in depression (BDI) and anxiety (STAI-T) ($d = 1.55$ and 1.01, respectively). Five and 3 of the veterans reported reliable improvements in their depression and anxiety, respectively.

There were marginally significant ($p = .07$) improvements in the wives' relationship satisfaction (DAS) in this small study, with an effect size change of $d = .92$. However, the veterans' relationship satisfaction (DAS) did not change across treatment ($d = .05$).

Our prior study (Monson, Schnurr et al., 2004) did not report on the wives' symptom outcomes and social adjustment outcomes for both the veterans and their wives. These findings are presented in Tables 2 and 3. Consistent with the initial report, we used paired sample *t*-tests to test pre-post change, as well as paired sample effect sizes (*d*) to assess the magnitude of change. Reliable change criteria were applied to the symptom outcomes.

Table 2 shows that the wives reported marginally significant improvements in their PTSD symptomatology, with 6 reporting reliable improvements. It is important to note that only one of the partners endorsed a PTSD Criterion A event (i.e., spousal abuse by ex-husband) and had a pre-treatment score on the PCL-S (62) greater than the recommended cut-score for

PTSD screening (44) (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996). This partner had a 26-point decrease on the PCL-S across treatment, with her post-treatment score below the recommended cut score. While there were no statistically significant improvements in the wives' depression, this may be attributable to only 3 of the 7 wives scoring in the depressed range on the BDI at pre-treatment assessment. Importantly, 2 of these wives reported reliable improvements in their depression, and their scores were in the non-depressed range on the BDI post-treatment. There were statistically significant improvements in the wives' anxiety (STAI-T); the effect size was large. Five of the wives reported reliable improvements.

Table 2. Wives' Outcomes for Cognitive-Behavioral Couple's Treatment for Posttraumatic Stress Disorder

	Pre-treatment		Post-treatment		*t*(6)	*d*	Reliable Change[a]
	M	*SD*	*M*	*SD*			
PTSD (PCL-S)	34.43	13.99	27.14	11.16	-1.96*	.80	6 improved
Depression (BDI)	12.00	8.70	9.29	7.99	-1.41	.66	2 improved[b]
Anxiety (STAI-T)	51.57	12.79	43.00	11.65	-3.16†	1.29	5 improved

*$p < .10$.
†$p < .05$.
Note: $N = 7$ couples. PCL-S = PTSD Checklist-self-report. BDI = Beck Depression Inventory. STAI-T = State-Trait Anxiety Inventory – Trait Scale. [a]The reliable change criteria were PCL ± 5, BDI ± 5, and STAI-T ± 6 points. [b]Three were in the depressed range at pre-treatment assessment, and these two were in the non-depressed range at post-treatment assessment.

Table 3. Social Functioning Outcomes for Cognitive-Behavioral Couple's Treatment for Posttraumatic Stress Disorder

	Pre-treatment		Post-treatment			
	M	*SD*	*M*	*SD*	*t*(6)	*d*
Veterans						
Spouse	2.52	.37	2.21	.30	-2.38*	.97
Housework	2.16	.52	1.84	.42	-3.13*	1.28
Immediate family	2.31	.53	1.94	.39	-3.21*	1.31
Extended family	1.87	.30	1.98	.50	.56	.23
Social	2.82	.33	2.67	.45	-.63	.26
Wives						
Spouse	2.61	.46	2.27	.39	-3.44*	1.40
Housework	1.81	.57	1.94	.39	1.24	.51
Immediate family	2.12	.34	1.75	.44	-2.40*	.98
Extended family	1.84	.38	1.61	.33	-2.56*	1.04
Social	2.39	.47	2.08	.43	-3.94†	1.61

*$p < .05$.
†$p < .01$.
Note: $N = 7$ couples. Domains of functioning are subscale scores on the Social Adjustment Scale. Lower scores reflect better functioning.

With regard to social functioning, Table 3 shows that the veterans reported statistically significant improvements in their functioning within their household (i.e., spouse, housework, immediate family), with effect sizes approaching $d = 1.0$ and above. However, there were no changes in their more extended relationship functioning (i.e., extended family, social). The wives endorsed statistically significant improvements across all social functioning domains, with exception of housework, with effect sizes nearly $d = 1.0$ and above.

CONSIDERATIONS IN IMPLEMENTING CBCT FOR PTSD AND FUTURE DIRECTIONS

Our preliminary data suggest that CBCT for PTSD holds promise to be an effective and efficient treatment for those with PTSD. It also seems to have important benefits for their loved ones. Improvements in partner functioning are to be appreciated in and of themselves, given the established caregiver burden and resource stresses placed on partners of individuals with PTSD. Partner improvements and relationship enhancement might also facilitate relapse prevention, and potentiate further gains to be achieved by the PTSD-identified partner. In implementing CBCT for PTSD and looking to its future, there are several issues that we encourage researchers and clinicians alike to consider.

Chronic Conditions Versus Cure

In developing CBCT for PTSD we paid special attention to the chronic course of PTSD and intimate relationship issues. Approximately 40% of individuals diagnosed with PTSD will continue to exhibit symptoms 10 years after its onset (Brunello et al., 2001). In the population of veterans we treat, most have faced an enduring problem – one that they and their families have dealt with for decades. Although we believe CBCT for PTSD will ameliorate PTSD, we do not hold it out as a *cure* for PTSD. Likewise, research into successful relationships indicates that it is the way that couples deal with problems that predicts intimacy and satisfaction, not their ability to rid themselves of the problem. Underscoring this reality, recent research indicates that approximately one-third of couples' presenting problems never go away, and these problems may not need to be resolved in order to have a satisfying intimate relationship (Driver, Tabares, Shapiro, Nahm, & Gottman, 2003).

In our work with couples we clearly state that a successful therapeutic outcome is not necessarily the eradication of PTSD symptoms (although we do not rule that out!) or an end to any further disagreements or conflicts. Rather, positive outcomes are measured by decreases in functional impairments, diminished severity of symptoms, enhanced coping, heightened intimacy, greater relationship satisfaction, and briefer and less devastating conflicts. Learning ways to adapt and cope with enduring problems has an important role in improving and maintaining healthy individual and relationship functioning (Wile, 1993).

Dually Traumatized Couples

Dually traumatized couples may be more the rule than the exception when working with couples in which the initially identified individual with PTSD has a female partner. This is based on epidemiological data indicating a two to one prevalence of PTSD in women versus men (e.g., Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). In addition, previous research suggests that people who have a psychological disorder are more likely to marry or cohabit with people who also have a psychological disorder (Du Fort, Kovess, & Boivin, 1994). The partner may have experienced primary traumatization prior to or during their intimate relationship as a result of family-of-origin violence, exposure to domestic violence perpetrated by their partner with PTSD or previous partner, sexual assault, or some other type of trauma. Also, a number of authors have discussed vicarious or secondary traumatization of these partners as a result of strong emotional connections with the trauma victim (Figley, 1989; Nelson & Wright, 1996).

The treatment principles and interventions of CBCT for PTSD are considered to be sufficiently broad and flexible to meet the challenges of couples with their respective psychopathology. Therapists should anticipate possible reactions to disclosures and distressing topics, monitor for any changes in risk factors (e.g., suicidality, aggression, substance use) for both members of the couple, and stress the importance of emotional and physical safety throughout treatment. Although structured clinician assessment of PTSD for the partners was not conducted in our pilot study, we highly encourage future research and clinicians pursuing CBCT for PTSD to use this form of assessment with the partners.

Trauma Disclosure

As described above, in the first session of CBCT for PTSD we explicitly discuss with the couple that there is no requirement that either of them disclose specific information about their trauma history. In general, we encourage clients to talk about their trauma history as it relates to here-and-now thoughts and feelings, and discourage in-depth, gory, and/or gratuitous retellings of their experiences. We have adopted this approach to avoid possible vicarious traumatization of partners. Moreover, several clinical trials support the efficacy of anxiety management and cognitively-focused approaches to PTSD treatment (e.g., Foa et al., 1999; Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998; Resick, Nishith, Weaver, Astin, & Feuer, 2002; Tarrier, Pilgrim et al., 1999). Even if clients do not share details of their traumatic experiences, beliefs and emotions linked to their traumas will be evoked, which provides opportunities for habituation, schema accommodation, emotional processing, and greater mastery and tolerance of these emotions.

Type of Trauma

By their very nature, interpersonal traumas appear to be especially likely to lead to intimate relationship problems, and may be particularly well suited for CBCT for PTSD. For example, Follette and Pistorello (1995) have outlined various problems found in couples in which the woman has been a victim of childhood sexual assault, and also suggest the use of

interventions to address experiential avoidance. Some specific problems related to sexual assault/abuse may include re-triggering of traumatic memories and sensations, dissociation, or flashbacks during the couple's sexual relations; hyper- or hyposexuality; problems with libido; or general negative attitudes about sex. Revictimization is clearly of concern with victims of interpersonal violence (Messman-Moore & Long, 2000), and is an issue that should be specifically assessed and addressed within the conjoint context (i.e., past or current emotional, physical, or sexual abuse within the relationship).

Taking into account these considerations, we are currently pilot testing CBCT for PTSD in other traumatized samples. Thus far, we have treated couples in which the PTSD-identified individual is female with a sexual trauma history. Based on these and previous experiences, we are in the process of expanding the session related to intimacy to have a more specific focus on sexuality.

Positive and Dyadic Focus

In further developing CBCT for PTSD, we intend to bolster the strengths-based and positive focus of the interventions and better ensure that the interventions are delivered in a dyadic and interactional fashion. We are considering the addition of other out-of-session assignments designed to increase positive emotion and behavior within the couple and to highlight already existing strengths in the relationship (e.g., reminiscent writing about thoughts and feelings in the beginning of their relationship, caring and pleasurable activity scheduling). We also continue to refine the manual descriptions to promote the dyadic delivery of the intervention. Clinicians, especially those less familiar with couple's/family interventions in general, have expressed less comfort with conceptualizing and treating the trauma-related thoughts, feelings and behaviors within the couple's context. Thus, we are providing more explanation and examples of how these issues are addressed through the couple's interacting thoughts, feelings, and behaviors. We hope that this will further guard against the treatment devolving into an individual focus with an identified patient and observing partner.

CONCLUSION

It is time to move beyond traditional intrapersonal conceptualizations of PTSD. The pernicious and pervasive intimate relationship problems associated with PTSD are well established by now, and we are beginning to appreciate the complex and reciprocal association between the two. An individual's intimate relationship holds great promise in warding off the development of PTSD, buffering its impact when it does develop, and serving as a key ingredient in the treatment of it. This is in keeping with a growing body of literature that recognizes the potential for intimate relationships to heal or exacerbate mental and physical illnesses (Snyder & Whisman, 2003).

We are faced with the challenge of treating a substantial number of people with PTSD who have not responded or fully responded to existing individual treatments. We need to broaden our treatment scope to address co-occurring problems, such as intimate relationship problems, that are of great importance in the lives of those who suffer from PTSD. Clinicians

and couples themselves tend to think of the conjoint modality as useful for couples' problems only. Couples treatment is useful for treating individual pathology as well. The preliminary but promising results of CBCT for PTSD suggest that this is the case for those with PTSD, as well as their partners. We hope that clinicians and researchers alike will shift their attention toward illuminating the mechanisms connecting PTSD and relationship problems, and capitalizing on the potential healing power of intimate relationships in the trauma recovery process.

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