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# Cognitive–Behavioral Conjoint Therapy for Posttraumatic Stress Disorder: Application to Operation Enduring and Iraqi Freedom Veterans

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As the newest generation of veterans returns home from their duties abroad, many face the individual and interpersonal aftereffects of duty-related traumatic experiences. Despite the established association between posttraumatic stress disorder (PTSD) and relationship problems, there is a lack of evidence-based conjoint treatments that target both PTSD and relationship distress. Cognitive–behavioral conjoint therapy (CBCT) for PTSD was developed to address this need. The authors summarize knowledge on the association between PTSD and relationship functioning, as well as recent research on veterans and their partners. Following an overview of CBCT for PTSD, the authors present a case study to illustrate the application of CBCT to an Operation Enduring and Iraqi Freedom couple. © 2008 Wiley Periodicals, Inc. *J Clin Psychol: In Session* 64:958–971, 2008.

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Clinicians, policy makers, and researchers alike have called for the development of evidence-based conjoint and family treatments for posttraumatic stress disorder

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(PTSD), in light of the corrosive effects of traumatization on intimate relationships. These calls have grown stronger as the newest generation of veterans and their families return home from abroad. Along with others (e.g., Johnson, 2002), we have been developing a couple therapy for PTSD to serve these veterans and their loved ones.

In this article, we summarize PTSD's association with intimate relationship problems in veterans and some recent research specific to Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) couples. We then provide an overview of cognitive-behavioral conjoint therapy (CBCT) for PTSD and demonstrate its application through a case study involving a male veteran and his wife.

### Posttraumatic Stress Disorder and Intimate Relationship Problems

The bulk of what is known about the intersection of PTSD, partner adjustment, and intimate relationship functioning is derived from research on American Vietnam veterans and their partners and, to a lesser extent, other countries' veterans (e.g., Australia, Netherlands, Israel). These studies have consistently documented an association between PTSD and intimate relationship problems (for a review, see Monson & Taft, 2005). Relative to trauma-exposed veterans without PTSD, veterans suffering from PTSD have a greater variety of and more severe relationship problems, a higher likelihood of divorcing and to divorce multiple times, higher rates of verbal and physical aggression against partners and children, more sexual dysfunction, and more substantial impairments in emotional expressiveness. Emotional numbing symptoms seem particularly associated with relationship dissatisfaction, and hyperarousal symptoms are particularly associated with aggression. Female partners of veterans with PTSD also report a range of mental health problems and difficulties, such as depression, anxiety, and caregiver burden.

Anecdotal and empirical reports suggest that there are similarities and differences between veterans of previous conflicts and those from OEF/OIF. Compared with previous wars, perhaps one of the biggest differences with the current war is that OEF/OIF service men and women are older and more likely to be married/partnered and to have children. Women are also serving in larger numbers and in more diverse roles. In addition, a major factor affecting families is the long and uncertain lengths of deployment and redeployments. The nature of U.S. OEF/OIF service members' deployments increases household and childcare responsibilities on partners, while they are simultaneously grappling with the emotional stress of having a loved one deployed and redeployed. Compared with previous armed conflicts, technological advancements also make greater contact between service members and their families possible during deployments; the net effect of this contact is not empirically known. In light of the instrumental demands and emotional stressors placed on partners, anecdotal reports of infidelity among some of these couples are perhaps not surprising (Jenkins & Barry, 2007).

Recent research underscores the critical need for couple-based treatments for these returning veterans and their significant others. In addition to high and increasing prevalence of mental health problems among OEF/OIF service members, one of the most notable areas of rising problems was in interpersonal relationships (Milliken, Auchterlonie, & Hoge, 2007). There was a fourfold increase in these problems from the first to second waves of assessment (median of 6 months between assessments) in their large sample of OIF soldiers. In a recent study of OIF/OEF veterans who screened positive for mental health problems Sayers, Farrow, Ross, and Oslin (2008) found high rates of family difficulties among veterans after returning home from

their tour(s), noting that more than three quarters of married/partnered service members reported difficulties with partners or children. Posttraumatic stress disorder and major depression were especially associated with difficulties in family role adjustment.

Other studies of OEF/OIF service members have also found that PTSD symptoms are associated with more intimate relationship discord. For instance, in a study of recently returned male soldiers (Nelson Goff et al., 2007), self-reported PTSD symptom severity was associated with the marital dissatisfaction of both the soldiers and their female partners. Sleep problems, dissociation, and sexual problems were most strongly related to lower satisfaction for both members of the couple.

Among male National Guard (NG) members deployed to Iraq, the husbands' self-reported PTSD symptoms predicted lower relationship satisfaction (Renshaw, Rodrigues, & Jones, 2008). The same was true for the wives, except that the association between the husbands' PTSD symptoms and wives' relationship satisfaction depended on the wives' *perceptions* of the husbands' combat experiences (Renshaw, Rodrigues, & Jones, in press). When wives perceived that their husbands had experienced low levels of combat exposure and their husbands reported high levels of PTSD symptoms, the wives reported higher levels of marital distress. However, when wives perceived their husbands to have experienced high levels of combat, husbands' self-reported PTSD symptoms had no association with their wives' relationship satisfaction. These findings underscore the importance of a mutual understanding of the husband's combat experiences for wives to make more accurate attributions for their husband's behavior, rather than attributing it solely to more personal or controllable factors.

### Cognitive–Behavioral Conjoint Therapy for Posttraumatic Stress Disorder

Cognitive–behavioral conjoint therapy for PTSD assumes that the association between PTSD and intimate relationship distress is complex and reciprocal; PTSD symptoms are considered to contribute to couple distress which, in turn, exacerbates and reinforces PTSD symptomatology. The processes underlying the association probably include behavioral avoidance and communication deficits. In the cognitive realm, interacting maladaptive thought processes and content regarding the traumatic event(s) are hypothesized to maintain this recursive association.

Cognitive–behavioral conjoint therapy for PTSD has the simultaneous goals of improving PTSD in one or both individuals of the couple and improving their intimate relationship functioning. It is not a partner-coaching model where one person is the identified patient. Rather, the couple is the unit of treatment. It is a three-stage, 15-session intervention consisting of (a) treatment orientation, psychoeducation about PTSD and associated intimate relationship problems, and safety building; (b) behavioral interventions that increase approach behaviors, enhance relationship satisfaction, and promote communication skills; and (c) cognitive interventions designed to address maladaptive thinking patterns that maintain both PTSD symptoms and relationship distress. Sessions are 75 minutes each and end with out-of-session assignments designed to facilitate the couple's skill acquisition in their everyday lives.

The previous iteration of CBCT for PTSD was primarily present-centered. In a small uncontrolled study of that earlier version of the therapy with Vietnam veterans and their wives, there were statistically significant improvements in the veterans' PTSD symptoms according to clinician interview and wives' self-report. Consistent

with previous research, the veterans reported more modest improvements in their PTSD symptoms, but larger improvements in depression, anxiety, and social functioning. Wives reported large improvements in relationship satisfaction, as well as their general anxiety and social functioning (Monson, Schnurr, Stevens, & Guthrie, 2004; Monson, Stevens, & Schnurr, 2004).

With these promising results, a study was recently funded by the National Institute of Mental Health to improve the treatment and ensure that it is sufficiently flexible for a range of traumatized individuals and their intimate partners. The revised treatment, which we are currently piloting, retains the treatment goals, modular structure, session length, and dyadic focus. The most notable change in the psychotherapy is a greater focus on the meaning of the trauma itself. As in the previous version of the treatment, gory renditions of specific details of the event(s) are discouraged. Nonetheless, couples are encouraged to explore together how the PTSD-diagnosed partner(s) has come to understand the effect of the trauma on himself or herself and his or her relationship, the ways that this meaning-making has contributed to his or her emotions and behaviors, and the ways that they, as a couple, have come to relate as a result of these trauma sequelae. Trauma disclosure is encouraged to the extent that it facilitates restructuring of cognitions that have impeded recovery and maintain relationship problems. This greater focus on the historical context of the trauma is in keeping with evidence that disclosure is a protective factor against PTSD (Koenen, Stellman, Stellman, & Sommer, 2003).

Another change is the increased and early attention paid to altering couple-level interactional patterns that maintain avoidance. We now place a greater emphasis on activities that simultaneously serve as approach behaviors and increase positivity in the relationship. The result of leveraging in vivo approach activities in this manner early in treatment contributes to couples having a sense of working together as a team to combat the “slippery culprit” of avoidance and inducing behavioral activation and pleasant feelings while doing so.

Language such as describing avoidance as a “slippery culprit” is used throughout the therapy to externalize PTSD and its maintaining factors outside of the partner(s). This is done to keep the dyadic focus of the therapy and to unify the couple against PTSD’s effects on the relationship. We ask questions about how the couple can “shrink the role of PTSD” in their relationship and encourage the couple to “talk back to PTSD” (i.e., cognitions that maintain PTSD).

Lastly, the treatment has been adapted so that it is more flexible with respect to the kinds of couples presenting for treatment. These may include couples in which one member is a returning OEF/OIF veteran, who tend to be older, have children at home, and have more acute symptoms of PTSD; couples in which the traumatized individual is female; same sex couples; and, couples in which one member is the victim of noncombat trauma.

The revised treatment consists of three stages captured in the acronym RESUME Living (see Table 1). The acronym is designed to convey a recovery orientation—PTSD is a disorder of impeded or interrupted recovery that can be successfully treated. It also seeks to imbue a hopeful philosophy; every couple possesses the potential for recovery and healing as these impediments are removed.

Stage 1 consists of two sessions that serve to introduce treatment and to increase positivity between the partners. In the first session, the therapist provides the couples with a rationale for treatment and psychoeducation about PTSD and its symptoms, an explanation of how avoidance and problematic thoughts maintain PTSD, and ways that PTSD can contribute to relationship problems. During this stage, the

Table 1

*Stages and Sessions of Cognitive–Behavioral Conjoint Therapy for Posttraumatic Stress Disorder (PTSD)*

RESUME Living	
Stage 1: <u>R</u> ationale for Treatment and <u>E</u> ducation about PTSD and Relationships	
Session 1	Introduction to treatment
Session 2	Safety building
Stage 2: <u>S</u> atisfaction Enhancement and <u>U</u> ndermining Avoidance	
Session 3	Listening and approaching
Session 4	Sharing thoughts and feelings—emphasis on feelings
Session 5	Sharing thoughts and feelings—emphasis on thoughts
Session 6	Getting UNSTUCK
Session 7	Problem solving
Stage 3: <u>M</u> aking Meaning of the Trauma(s) and <u>E</u> nd of Therapy	
Session 8	Acceptance
Session 9	Blame
Session 10	Trust issues
Session 11	Power and control issues
Session 12	Emotional closeness
Session 13	Physical intimacy
Session 14	Posttraumatic growth
Session 15	Review and reinforcement of treatment gains

therapist collaborates with the couple to develop out-of-session assignments to increase positive behaviors and to draw attention to them as quickly as possible. In addition, each member of the couple is asked to answer questions about his or her understanding of the effects of trauma and PTSD on themselves and their relationship and beliefs in trauma-related domains. The second session focuses on enhancing a sense of safety in the relationship. It is important that negative relationship behavior with known corrosive effects on satisfaction be decreased as quickly as possible to promote a safe environment for healing. Couples are provided with psychoeducation about the role of PTSD in relationship functioning as it relates to dysregulation in the fight or flight system (i.e., they are likely to fight or flee in their interactions), as well as primary (e.g., noticing early warning signs in oneself and one's partner) and secondary (e.g., negotiated time outs) prevention strategies for managing conflict. In couples presenting with a pattern of chronic avoidance or flight response, they are encouraged to “time in”; thoughts and behavioral deficits that prevent engagement are explored.

In Stage 2 (Sessions 3 through 7), the therapist focuses on enhancing relationship satisfaction and undermining avoidance. Improved communication is considered to be a primary vehicle to undermine avoidance and enhance the relationship milieu. In tandem with idiographically programmed trauma-related in vivo approach assignments, we use enhanced dyadic communication as an antidote to PTSD-related avoidance and a means of increasing intimacy. Communication skills presented and practiced in each session build sequentially on each other over several sessions to help the couple identify and share their feelings and notice the way that their thoughts influence their feelings and behaviors. The couples use these communication skills to discuss PTSD-related content and to problem-solve how they will collaboratively address PTSD-related behavioral avoidance.

With a foundation of improved satisfaction, communication skills, and decreased behavioral avoidance, the third stage of CBCT for PTSD targets trauma-related

cognitions. The therapist teaches the couple a process that they can use together to challenge cognitions that are maintaining PTSD and relationship problems. We have moved away from using traditional thought records, to teaching the couple a process that can be used in real time. This process follows the acronym UNSTUCK:

Unify as a couple (this is not an opportunity for one member to confront and judge the other's cognitions, but rather to join together in collaborative empiricism).

Notice or pinpoint the thoughts keeping them stuck.

Share alternative thoughts or interpretations, with an emphasis on a range of options.

Table test the thoughts [externalize the thoughts to look at them more objectively (table) and evaluate the evidence and functionality of them (test)].

Use the best thought(s).

Changes in emotions and behaviors that ensue as a result of the new thought(s).

Keep practicing (recognition that it requires effort to change one's mind when there have been entrenched patterns of thinking).

We sequence the cognitions targeted in this stage, with an initial focus on historical cognitions specific to the traumatic event (e.g., acceptance, blame) and then a focus on interpersonal beliefs disrupted by the trauma (e.g., trust). This sequence is chosen because changes in the ways in which a traumatized person makes sense of the specifics of his or her trauma(s) can have cascading effects on beliefs operating in the here-and-now. The following case example illustrates the changes that can occur in schema-related beliefs as a result of reconstruing traumatic events.

Treatment culminates with a session on the potential for benefit finding and posttraumatic growth and how they, as a couple, can move forward by creating a better life together. We underscore the likelihood of variations over time in relationship satisfaction and perhaps trauma-related symptomatology into the future. The therapist collaboratively develops a plan for how the couple will address these variations as they occur.

In applying CBCT for PTSD, we routinely assess PTSD symptoms and relationship satisfaction over the course of therapy. We use the Posttraumatic Stress Disorder Checklist (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993) and Dyadic Adjustment Scale (DAS; Spanier, 1976). We administer the PCL and a single question about general relationship happiness every other session to track progress (the full DAS might be used pre- or posttreatment, or both).

### Case Illustration

#### *John's Presentation*

John presented to the urgent care center of a Department of Veterans' Affairs Medical Center at the prompting of his wife, Jennifer. The night prior, Jennifer threatened to leave John and to take their 2-year-old son, Tim, with her if John did not get some professional help. John stated that Jennifer perceived him to be "out to lunch," not helping with childcare or household tasks. He complained that she "nags me about not spending any time at all with her and Tim." John also stated that Jennifer had accused him of having an affair because he was not affectionate toward her and seemed to want to be alone when he was (rarely) home. John denied any prior mental health history, but reported a family history of depression and substance dependence. His medical history included a torn anterior cruciate ligament

(ACL) during his military service. John screened positive for possible PTSD and substance abuse problems. He was referred to the specialized PTSD program at the facility.

Upon initial assessment in the PTSD program, John reluctantly admitted that he was struggling with PTSD symptoms related to his experiences in Iraq. John indicated that his most traumatic event occurred in the context of his and his fellow soldiers' responsibility for foot and Humvee patrol of an area near Fallujah. A number of Iraqi children played in this area. John told of his and other service members playing soccer with the children in a vacant lot within the patrolled area when they were not on active patrol. He also shared that he gave some of the items from care packages Jennifer had sent to him (like Pez candy dispensers) to the children.

On the day of the index event, John and others had just finished formally patrolling the area. They decided to go back to the vacant lot where the children often played to get some exercise. There were several children there, including a boy approximately 8 years old that John particularly liked. As they were walking toward the lot, John reported that he saw this boy running toward what looked like a package on an adjacent road. John stated that he saw the boy reach down to pick up the package, and an explosion immediately occurred. John saw the boy's body fly up in the air, with fragmented sights of blood, flesh, and smoke rising up from the road. When he got to the site, he looked down to see the boy's body severed into parts, with a Mickey Mouse Pez dispenser that he had given the boy next to the boy's shoe. John described these particular images as frequent objects of his nightmares, intrusive memories, and flashbacks.

Although he had intended to make a career in the Army, after John returned from Iraq, he wanted to get out as quickly as possible. After his discharge, he "burned through jobs." He had worked for several construction companies in the prior 6 months, trying to find working conditions that were "quiet." He also had problems with authority in those positions— "They want to drive around in their F-150s, smoking cigarettes, drinking coffee, and making lots of money off of me and the other young guys." The winter season was approaching, and John was concerned about what he was going to do for work. He preferred working outside so that he didn't feel so "closed in" and overwhelmed by sudden noises. John stated that Jennifer was "on my back" about money— "She's always nagging me about how we're going to make rent and pay for Tim's food and clothes when I'm not working." Jennifer was planning to take a second job, in addition to her para-educator job to make ends meet. John was concerned about Jennifer taking on a second job because he knew that Jennifer expected him to take care of Tim while she worked in the evenings and on weekends. John admitted that he avoided Tim. He noted that Tim's crying and day-to-day demands were very stressful to him.

### *Case Formulation*

Based on the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Text Revision (DSM-IV-TR*; American Psychiatric Association, 2000), John was diagnosed with PTSD, major depressive disorder, and alcohol abuse. His score on the PCL was in the moderate range of severity, and his score on the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996) was in the moderate range. At the conclusion of the assessment, John was offered a range of therapies, including CBCT for PTSD. He discussed this option with Jennifer, and Jennifer expressed interest.

They came to a conjoint session with the psychotherapist during which an overview of CBCT for PTSD was provided. The couple agreed to commit to a course of the therapy and shared their relationship history.

### *Relationship History*

John and Jennifer were married when they were 22 and 21 years old, respectively. They both indicated that they were happy in the less than year of marriage prior to John's first deployment to Afghanistan. This deployment was relatively uneventful. They described their anticipation about seeing each other after John's first deployment. John had some time off when he returned, and they took a trip to a national park to camp and hike. It was during their trip there that Jennifer conceived a child. They both agreed that they were very happy when they discovered that she was pregnant, even though they had not planned on her getting pregnant so quickly. After their self-described honeymoon period, both agreed that they settled back into their relationship, greatly anticipating the birth of their first child. Both expressed their excitement when Tim was born.

When Tim was about one year old, John was told that he was being deployed again, but this time to Iraq. By this time, word of greater fighting and conflict in Iraq had spread, and John was to be deployed near Fallujah. This deployment was not as easy on John and Jennifer as the prior deployment. Jennifer was left with the burden of caring for a young child, and John was entering a more dangerous area with thoughts of Jennifer and Tim. Yet, John remained committed to his career in the Army, and they used the available resources to stay in contact with one another. Jennifer noticed that John corresponded less this time, and that when he did e-mail or call, the communication was brief. He seemed preoccupied. Jennifer attributed John's behavior to the difference in this mission compared with the last. She felt lonelier this time and more stressed from work and rearing an infant. Yet, she was steadfast in her commitment to John, and expressed disdain about other women on the base that she had heard were cheating on their deployed husbands. Jennifer anticipated John's homecoming, counting the days off on a calendar. It was incredibly difficult when his tour was extended, but she indicated that she "kept her eye on the prize of John coming home."

When John returned home, Jennifer indicated that his homecoming was different than before. Although he seemed pleased to see her and Tim, he also seemed distant and aloof. She noticed that he was drinking more and that he was not as talkative or interested in holding and playing with Tim as before. She also noticed that, although they had sexual relations immediately after he returned, he seemed uninterested in her physically. Jennifer and John agreed that, within 2 or 3 months of John's return, they were arguing about John's lack of attention toward Jennifer and Tim, and that John had decided to leave the military. Jennifer stated that John did not want to talk about what happened in Iraq and that he did not want to talk about his reasons for leaving the Army. She described feelings of desperation that John, and consequently their marriage, was potentially forever changed.

At the conclusion of the conjoint session, the couple each completed the DAS, and an individual session with Jennifer was scheduled to screen for mental health disorders. Each of them scored in the moderately distressed range on the DAS, and this was fed back to them at the first session of CBCT for PTSD. The psychotherapist pointed out that despite their distress, both had indicated on the DAS a commitment to improving the relationship. Jennifer's screening session

revealed no history of significant mental health problems, but some mild depression according to the BDI, which Jennifer attributed to the distress in her marriage. She was diagnosed with adjustment disorder with depressed mood.

### *Course of Treatment*

Both John and Jennifer seemed anxious when they arrived at the first session of CBCT for PTSD. The therapist reinforced the couple for making the commitment to their relationship and to themselves to do the therapy. She noted that she would be talking more than usual in this session and outlined the goals of the first session of therapy. Being aware of the heavy didactic load of this first session, the therapist sought to quickly engage the couple while presenting the material. She began with an explanation of the reexperiencing symptoms of PTSD, stressing that these symptoms represented ways in which John relived or replayed the traumatic events that he experienced in Iraq. She asked how John tended to relive his experiences, and John responded that he could not get some particular images out of his mind and that he often had nightmares about the events. Jennifer also reminded John that he had problems when he heard the sounds of the nail gun hammering nails at work. The therapist used this example to segue to the hyperarousal symptoms of PTSD, pointing out that John's heightened startle reaction to those sounds was one example of these types of symptoms. She explained that this and other symptoms, such as trouble sleeping, irritability, and hypervigilance, were signs of John's heightened state of arousal. She commented that this is a very adaptive response when there is *actual* danger, but the misfiring of his system all of the time is a drain on the mind and body and negatively impacts on their relationship and family. Drawing Jennifer into the psychoeducation, the therapist inquired about ways that she saw John having his system on high alert. Jennifer stated that John slept very poorly and that he had begun sleeping on the couch after he woke up in the night. Jennifer also shared that John was irritable and sometimes angry toward her and Tim, but that he later seemed to feel bad about it.

The psychotherapist asked the couple, "John, what do you notice you want to do when you think about the events and then feel stressed?" John quickly commented, "I want to escape." The therapist used this answer to begin describing the avoidance symptoms of PTSD. The therapist asked Jennifer if there were ways that she noticed that John "escaped," to which Jennifer responded, "Yeah, he leaves all of the time." The therapist asked the couple about any other ways in which John seemed to escape, hoping that one of them would bring up John's drinking. With a seemingly knowing look exchanged between the two of them, John then brought up that he sometimes drinks to get away from things and also to fall asleep. The therapist transitioned to discuss the emotional numbing symptoms of PTSD separate from the avoidance.

The therapist described the dynamic interplay among the symptoms and pointed out that most people are exposed to traumatic events and that most people have a natural recovery from those events. She stressed that something had gotten in the way of John's recovery and that it was absolutely possible to remove those barriers and "RESUME Living."

She then presented the rationale for the cognitive and behavioral elements of the treatment: "In those individuals who do *not* naturally recover from bad things happening to them, something blocks their recovery. In this therapy, we believe that there are two types of barriers to your recovery—one barrier is avoidance and numbing out. In the short run, it feels good to escape, but in the long run, PTSD

stays alive and well in your relationship. PTSD's avoidance and numbing are also major culprits causing your relationship problems because you wind up feeling distant and cut off from each other. The other barrier that keeps you from living is the way that each of you makes sense of things. There are ways in which people that have been exposed to trauma, and their partners, make sense of traumatic events that can be barriers to resuming life. In this therapy, we're going to target both of those barriers so that you can be individually, and as a couple, better." The couple was assigned their first out-of-session practice.

The psychotherapist began the second session by asking John and Jennifer how the practice had gone. Jennifer immediately noted that John had not caught her doing something nice every day. He had written down responses on about half of the days. The therapist asked John about what got in the way of the other days, and he responded, "I just forgot to write them down, but I did notice." In a low-key manner, the therapist addressed John's partial success with the assignment. The therapist was aware that early adherence with practice assignments was very important to ongoing practice, and thus wanted to maximize adherence as much, and as quickly, as possible, while minimizing any shaming of the couple.

The other notable aspect of session two for John and Jennifer was the discussion about safety as it related to trauma disclosure. In the course of exploring both of their thoughts and feelings about hearing about John's experiences in Iraq, John indicated that he was surprised that Jennifer wanted to hear about what happened. Jennifer stated, "Obviously something happened. You're a changed person. I want to know why you're so changed. I can handle it." In response, John said, "I'm not sure that you'd still be saying that after you heard it. Hell, I don't want to think about it. Why would you want to think about it?" Jennifer remained steadfast in her desire to know some of the details. The therapist reminded the couple that the therapy would not include explicit retellings, but that there would need to be enough information for the two of them to make better sense of what happened and remove the barriers to recovery. The therapist also inserted that experience and research suggests that it is the *sharing* of thoughts and feelings in a relationship, and not the *valence* of thoughts and feelings, that improves the relationship, and that disclosure after traumatic exposure appears to be protective against PTSD.

John and Jennifer completed most of their out-of-session assignments, including each of them calling a time-out, when they arrived at the third session. They remarked that they seemed to be arguing less since they started the therapy. John attributed it, in part, to being more aware of his anger, understanding where it came from, and to his decreased alcohol use. The therapist reinforced prior psychoeducation about the role of avoidance and numbing in John's PTSD and relationship problems as part of her introduction to the communication skills paramount to Stage 2. She indicated that more and better communication was one important antidote to avoidance. In each of the sessions in this stage, the therapist introduced the skills and then had John and Jennifer turn their chairs to face each other and practice the given skill in the session with PTSD-related content. For example, in Session 3, they practiced listening/paraphrasing skills in response to the question, "As a couple, what kinds of things does PTSD make us avoid?," while the therapist coached the couple in using the skills and recorded the things that the couple described avoiding. At the end of the practice, John commented, "I cannot imagine using this in our life. It's so weird to repeat back everything." The therapist validated this observation saying, "Of course it feels artificial and weird. You guys have some habits—some of them not so good—in the way that you talk with each other. One of

your habits is to assume that you heard what the other person said. We've talked before about how that has caused problems. One of the benefits of this way of communicating, especially about a more stressful topic, is that it slows things down and you can make sure that you don't misunderstand one another. Let's adopt a wait-and-see attitude about the listening skills after you've practiced them for at least a week." Each of them agreed to listen/paraphrase at least once per day prior to the next session. The therapist also began assigning the in vivo approach exercises to "shrink" the role of PTSD in their relationship.

In this stage of therapy, John had a difficult time identifying and expressing his emotions. The therapist needed to prompt John on several occasions to share his *feelings* versus his *thoughts* with Jennifer saying, "Can you give her a single word that describes your gut's reaction?" This seemed to improve with practice and after the session focused on thoughts because thoughts could be more fully contrasted with feelings. The therapist was heartened when John pointed out that Jennifer had shared a thought versus a feeling in response to the therapist's inquiry about Jennifer's feeling.

The therapist administered the DAS; both John and Jennifer's scores were approaching the nondistressed range. Although John's PCL scores had improved, he was still in the mild to moderate range of severity, and it was noteworthy to the therapist that the couple was still in conflict about John's time spent with Tim. The therapist hypothesized that Tim was serving as a trauma-related reminder.

The most notable progress with the couple was made in Sessions 8 and 9, in which they focused on greater acceptance of the event that John witnessed and his related self-blame. John remained very reluctant to share details of the event with Jennifer, but with Jennifer's urging that John was "stuck" because of not sharing, he initiated sharing in session. The psychotherapist had determined from the initial questions that each had completed about the effects of PTSD, and in listening to John's rendition of the event, that a primary thought interfering with his recovery was that he believed he should have been able to protect the boy from the improvised explosive device (IED). The therapist urged the couple to use the UNSTUCK process to externalize the thought that John should have been able to change the outcome. Jennifer did a fantastic job of being curious with John about the context of the event to develop alternative thoughts or ways of making sense of the event.

Therapist: Let's put that thought "I should have prevented the boy's death" on the table to make sure that it is a good way of making sense of what happened. Let's use the UNSTUCK process. You're...we're...united (U) in this process and the thought has been noticed (N) and shared (S). Let's take it out and test it (T). Jennifer, anything you're curious about?

Jennifer: Yeah, given what you've told us, I'm curious how you could have prevented it.

John: I could have stopped the boy from running toward it.

Jennifer: Wasn't he running toward it when you arrived?

John: Yeah, but I could have stopped him.

Therapist: [wanting to highlight hindsight bias]. I'm curious about something, John.

Do you mind if I ask about something? Did you or your friends know at the time that the boy was running toward an IED?

John: [pause] No...no. But, we should have known it was an IED.

Jennifer: Why should you have known?

John: I don't know. I just should have known (more angrily).

Therapist: OK. Do you mind if I tweak your language a little bit. Is one of the possible alternative thoughts “I *wish* I had known it was an IED, but I didn’t at the time? What do you guys think of that?”

Jennifer: That seems to fit more.

Therapist: [pause] John, what do you think?

John: Yeah. That’s true.

Therapist: I think this is a good example of the Monday morning quarterbacking you mentioned. It seems like at the time you didn’t know that it was an IED. [pause] Do the two of you think that “I *wish* that I/John knew that it was an IED” is a more accurate thought, given the circumstances at the time for John?”

Unison: Yeah.

Therapist: Let’s go through the rest of the steps....

Greater acceptance of the event also came from Jennifer’s question in session, “Do you know what the boy’s name was? You’ve never mentioned it.” John became tearful, and indicated, “His name was Rahim.” He admitted that he avoided saying the boy’s name because it made it “more real.” The therapist encouraged the couple to use Rahim’s name, programming this as part of the couple’s in vivo approach assignments. Later, the couple noted that John could say his name with increasingly less negative affect outside of session.

In the context of the session focused on trust, John admitted that he did not trust himself around Tim because he still “felt” like his involvement with Rahim had somehow led to Rahim’s death. The couple used the UNSTUCK process to come up with the alternative thought that the presence of the IED, and Rahim going after it, was not specifically linked to John or John giving Rahim the Pez dispenser. In a vein of benefit finding, Jennifer raised an interesting alternative, “If *Tim* was in a war zone, wouldn’t you want the other side’s men to be kind and caring to him? It wasn’t YOU who put out that IED. Would you blame the guy who gave Tim candy before the IED’s explosion?” John paused for some time with this alternative, before commenting, “Good point.” Across this stage of therapy, John’s PCL scores steadily decreased, and the therapist pointed this out in session to reinforce the couple’s hard work. Jennifer’s improved mood was also noted.

### *Outcome and Prognosis*

Prior to the final session, John and Jennifer each completed a DAS and PCL. Their scores on the DAS were well within the nondistressed range, and John’s PCL scores revealed marked improvements. His final PCL score was below the cut-off for probable PTSD. John indicated that he could not believe how different his answers to the questions about the effect of trauma on their relationship were compared with his prior answers. The psychotherapist stressed the importance of returning to the materials that they had worked so hard on over the 15 sessions if they found themselves arguing more or “slipping apart,” or if the “PTSD demon” was growing again between them.

### Clinical Issues and Summary

In this time of war, with increasing numbers of service members and their loved ones suffering the aftereffects of military-related traumatic experiences, we are called to innovate and provide the best possible services to them. Although the robust association between PTSD and intimate relationship problems is unfortunate, this

connection also presents an opportunity to capitalize on the healing power of intimate relationships to improve the health of the individuals and their relationship. We believe that within every couple exists the potential for recovery at the level of both the individual and the relationship, such that traumatized persons can resume living and both partners can experience enriched, fulfilling lives.

Although we are currently formally evaluating CBCT for PTSD with couples in which one partner is diagnosed with PTSD, we have been using the treatment with couples in which both partners are diagnosed with PTSD. These couples also benefit from the treatment, but tend to require more than 15 sessions due to the greater potential for interacting negative cognitions between partners and more entrenched avoidance behaviors. As a general rule, we have spent two sessions on each of the themes in the final phase of treatment to allow more time to address each partner's disrupted and interacting beliefs in these areas. Use of this therapy with couples with moderate to severe levels of physical aggression, substance dependence, or uncontrolled severe individual psychopathology is contraindicated. However, if individual and couple-level functioning becomes stable, these couples may well benefit from treatment. We hope that more clinicians take advantage of the conjoint modality of treatment where possible, or, at a minimum, incorporate significant others in individual evidence-based treatment for PTSD to optimize the results.

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