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Cognitive-Behavioral Conjoint Therapy for PTSD: Application to an Operation Enduring Freedom Veteran

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There is increasing recognition that combat-related posttraumatic stress disorder (PTSD) affects the service member or veteran who experienced the trauma, his or her partner, and their relationship more broadly. Reactions by partners and other loved ones can also serve as impediments to, or facilitators of, recovery in the wake of trauma exposure. In this article, we highlight research findings related to the association between PTSD symptoms and intimate relationship functioning in service members and veterans from the current conflicts and describe the application of cognitive-behavioral conjoint therapy for PTSD (CBCT for PTSD; Monson & Fredman, 2012), a disorder-specific couple therapy designed to simultaneously decrease PTSD symptoms and enhance intimate relationship functioning, to a veteran with combat-related PTSD and his wife. We conclude by discussing the powerful role that partners can play in helping individuals with combat-related PTSD recover from the disorder through improved communication, decreased couple-level avoidance, and modification of cognitions held by either member of the couple that can maintain PTSD symptoms and/or relationship distress.

Posttraumatic stress disorder (PTSD) is a mental health condition associated with impaired occupational and social functioning (American Psychiatric Association, 2000) and overall quality of life (Kessler, 2000). Due to recent military conflicts, there is a high incidence of PTSD among service members, with approximately 17% of active duty and 25% of reservists screening positive for PTSD at 6 months postdeployment (Milliken, Auchterlonie, & Hoge, 2007).There are well-documented associations between PTSD symptoms and intimate relationship problems (Lambert, Engh, Hasbun and Holzer, 2012; Monson, Taft, & Fredman, 2009; Taft, Watkins, Stafford, Street, & Monson, 2011), such that relationship difficulties may serve as a risk factor for, or consequence of, PTSD. To account for this bidirectional association, cognitive-behavioral conjoint therapy for PTSD (CBCT for PTSD; Monson & Fredman, 2012) was developed to simultaneously treat PTSD and enhance couple functioning. This therapy may be particularly relevant to providers treating service members and veterans with PTSD because relationship difficulties are often a motivating factor for seeking treatment, and these couples often experience distress (Interian, Kline, Callahan, & Losonczy, 2012). In this article, we briefly review the literature examining the relation between PTSD and intimate relationship functioning. We then provide an overview of CBCT for PTSD and illustrate the application of this therapy through a case study of a recently returned veteran with combat-related PTSD and his wife.

The association between PTSD symptoms and couple and family problems is well established in veterans (Monson et al., 2009; also see Taft et al., 2011, for meta-analysis). Research with combat veterans from prior eras, especially Vietnam veterans, provides a window into the chronic and likely reciprocal effects of PTSD and family relationship problems. 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 divorcing multiple times, higher rates of verbal and physical aggression against partners and children, more sexual dysfunction, and more substantial impairments in emotional expressiveness. Partners of veterans with PTSD also report a wide range of mental health problems and difficulties, such as depression, anxiety, and caregiver burden (Beckham, Lytle, & Feldman, 1996; Calhoun, Beckham, & Bosworth, 2002).

Research on service members returning from Iraq and Afghanistan also documents an association between PTSD and relationship problems. In addition to the high and

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rising prevalence of mental health problems among these service members, one of the most notable areas of difficulty is in interpersonal relationships. For example, one study (N = 88,235) documented a four-fold increase in interpersonal problems in U.S. soldiers between the time they returned home from Iraq and 6 months postdeployment (Milliken et al., 2007). Furthermore, more than three-quarters of partnered veterans who screen positive for mental health problems (i.e., PTSD and major depression) report difficulties with their significant other and/or children (Sayers, Farrow, Ross, & Oslin, 2009). Self-reported PTSD symptom severity, particularly in the areas of sleep problems, dissociation, and sexual problems, has been shown to be associated with marital dissatisfaction for both male service members and their female partners (Nelson Goff et al., 2007). These findings underscore the importance of treating not only PTSD in the service member or veteran but also relationship difficulties that may be related to PTSD.

One key assumption of CBCT for PTSD is that the association between PTSD and intimate relationship distress is complex and bidirectional. PTSD symptoms are thought to contribute to couple distress which, in turn, exacerbates and reinforces PTSD symptoms. A stressful or otherwise unsupportive interpersonal environment can also impede recovery from PTSD by reinforcing the traumatized individual's perception that he or she is under chronic threat (Monson, Fredman, & Dekel, 2010). The processes underlying this relationship are hypothesized to include behavioral and experiential avoidance (e.g., disengaging from couple's activities, not sharing thoughts or feelings with partner), conflict management and communication deficits, and partners' maladaptive thought processes related to the trauma(s) (e.g.,"I cannot trust others"; "I have no self-control"; "My partner is damaged"; "We cannot get better"). Partners can also unwittingly interfere with recovery from PTSD by altering their own behaviors in response to PTSD symptom in an attempt to minimize patient distress or conflict related to PTSD symptoms (e.g., the partner does not express his or her own thoughts and feelings for fear that the patient will become anxious or angry or the partner takes over tasks or chores that serve as a PTSD-related trigger), a phenomenon that we have labeled "partner accommodation to PTSD symptoms" (Fredman, Vorstenbosch, Wagner, Macdonald, & Monson, 2014). Notably, behaviors that help maintain PTSD symptoms can occur in both satisfied and distressed couples (e.g., wife, either happily or resentfully, may do all of the shopping because her husband is anxious in crowds).

CBCT for PTSD has the simultaneous goals of improving PTSD and the couple's intimate relationship functioning. Unlike a partner-coaching model in which one person is the identified patient, the couple's relationship with respect to PTSD is the unit of treatment. CBCT for PTSD is a three-phase, 15-session treatment consisting of (a) treatment orientation, psychoeducation about PTSD and associated intimate relationship problems, and safety building; (b) behavioral interventions that combat behavioral and experiential avoidance, increase dyadic 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 designed to be 75 minutes each and end with assignments designed to facilitate skill acquisition through practice outside of sessions.

Three uncontrolled studies with Vietnam veterans (Monson, Schnurr, Stevens, & Guthrie, 2004), Iraq and Afghanistan veterans (Schumm, Fredman, Monson, & Chard, 2013), and community members (Monson et al., 2011) and their intimate partners have been conducted. The results from these studies indicate statistically significant and clinically meaningful improvements in PTSD symptoms (d = 1.51 to1.60). Improvements in relationship functioning in couples with a wide range of baseline relationship satisfaction (i.e., from very satisfied to dissatisfied) were noted as well, although the level of improvement did not reach statistical significant in all three studies. Improvements in partners' mental health symptoms following therapy have also been found (Monson et al., 2005).

A wait-list controlled trial of CBCT for PTSD with a diverse sample (i.e., individuals with a range of traumatic events, different types of intimate couples including married, cohabitating, noncohabitating, same sex) was recently published (Monson et al., 2012). This trial found significant improvements in PTSD and comorbid symptoms among patients in CBCT for PTSD compared with those on the waiting list, with large effect sizes for PTSD (Hedge's g = 1.13), depression (Hedge's g = 0.83), and anxiety (Hedge's g = 0.85). Notably, these treatment effect sizes are similar to those found in psychotherapies for PTSD (e.g., g = 1.63; Watts et al., 2013). There was also a significant improvement in patient reports of relationship satisfaction, which was maintained at 3-month follow-up. Consistent with prior research (Monson et al., 2005), there were also improvements in partners' mental health symptoms among those with clinical levels of distress (Shnaider, Pukay-Martin, Fredman, Macdonald, & Monson, 2014). Given the accumulating evidence of the efficacy of CBCT for PTSD in treating PTSD, enhancing relationship functioning, and improving partners' mental health, it may be considered a stand-alone treatment for PTSD for a wide range of couples.There are no published data comparing CBCT for PTSD with an