# CHAPTER 1

# An Introduction to Cognitive-Behavioral Conjoint Therapy for PTSD



Approximately 75% of North Americans will be exposed to a traumatic event at some point in their lifetime that could lead to posttraumatic stress disorder (PTSD; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Of these individuals, about 8% will be diagnosed with PTSD in their lifetime, and many more will have symptoms of the disorder. Symptoms of PTSD include reexperiencing (i.e., reliving the event through intrusive memories, nightmares, flashbacks, distress at reminders), avoidance (i.e., active avoidance of reminders in the environment), emotional numbing (i.e., difficulty feeling a range of positive and negative emotions), and hyperarousal (i.e., sleep disturbances, anger/irritability, exaggerated startle, hypervigilance, concentration difficulties). Left untreated, these symptoms most often have a chronic and pernicious course associated with substantial individual and societal costs (Greenberg et al., 1999; Kessler, 2000).

Most theories, empirical research, and treatments to date have focused on the intrapersonal facets of PTSD. For example, individual psychophysiology, brain structure and functioning, personality traits, and cognitive styles are frequent topics of study. Current treatments identified in guidelines for the effective treatment of PTSD are delivered individually (Foa, Keane, & Friedman, 2009; Institute of Medicine, 2007; Veterans Health Administration, U.S. Department of Defense, 2004). With this text, we offer a new approach to the treatment of PTSD—cognitive-behavioral conjoint therapy (CBCT) for PTSD—that capitalizes on our growing recognition of the interpersonal nature and consequences of trauma and the potential power of intimate relationships to ameliorate PTSD. This is especially timely, given the rising rates of violence, the ongoing threat and realities of man-made and natural disasters, and the continued military involvement around the world that can have broad and devastating effects on individuals and their loved ones (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2011; Norris, Friedman, & Watson, 2002; Norris, Friedman, Watson, Byrne, et al., 2002; North, Kawasaki, Spitznagel, & Hong, 2004).

CBCT for PTSD is a time-limited, manualized, disorder-specific conjoint therapy with the simultaneous goals of improving PTSD and enhancing intimate relationship functioning. We have evidence that this therapy also improves co-occurring conditions and the mental health and well-being of close others who participate in the therapy with a loved one with posttraumatic stress problems (see Chapter 2 for a review). CBCT for PTSD is designed to be a stand-alone treatment for PTSD; that is, it is not intended to be delivered as an adjunctive therapy to individual PTSD treatment. It is also not a conjoint therapy to be provided after a course of individual PTSD therapy unless individual PTSD treatment did not result in intended improvements.

CBCT for PTSD is designed for couples with a range of relationship satisfaction levels, and not only for distressed couples. In other words, couples do not need to have clinical levels of relationship distress to profit from the treatment. In the majority of couples presenting for treatment, at least some relationship distress will be the norm, and they may have already discussed the possibility of dissolving the relationship or may be ambivalent about remaining together. In these cases, the benefit of a conjoint treatment to address PTSD is readily apparent. Nonetheless, it is our experience that even highly satisfied couples in which at least one partner has PTSD are in need of a conjoint treatment format, because the structure and the function of their relationship maintain the individual mental health problems. Family relationship systems that have rigid rules and expectations about how partners will function in the relationship can be less receptive to individual change in therapy. Referred to by some as *symptom–system fit* (Baucom, Stanton, & Epstein, 2003; Rohrbaugh, Shoham, Spungen, & Steinglass, 1985), individual changes may be resisted by the couple or family system. For example, a spouse may discourage her partner with PTSD from facing trauma reminders, and thereby improving, because she is gratified by the notion of being the caregiver of an "ill" spouse. Conjoint treatments such as CBCT for PTSD are able to address the relational system that may contribute to or maintain individual psychopathology.

The clients whom we and others have treated with CBCT for PTSD have suffered a range of traumatic events, from childhood and adult sexual and physical assault to military combat and peacekeeping missions to the witnessing of genocide to the loss of loved ones by sudden death as well as a combination of events. We have used CBCT for PTSD with many dyads in which both individuals have experienced trauma and in which both individuals were diagnosed with PTSD. We also have conducted the therapy with different types of dyads: heterosexual and gay couples, cohabitating and noncohabitating couples, and even nonromantic dyads, such as siblings and close friends. We have treated couples who have dated for only months to couples who have been married more than 25 years. At the outset, we titled the therapy a "conjoint" versus "couple" therapy because we envisioned its application to a range of traumatized individuals and the loved ones whom they considered closest to them. In Chapter 2 we discuss implementation of the protocol with these different types of dyads and the issues that they can bring, which are a point of focus for the therapy.

Although originally developed and tested as a treatment for PTSD, we have since found this therapy to lead to improvements in a range of mental health problems that arise after traumatization, including depression, substance use, guilt, anger, dissociation, and other anxiety symptoms (panic, general anxiety). The range of traumatic stress problems also needs to be conceptualized and addressed in treatment to optimize outcomes. For example, if there is comorbid substance abuse or dissociation, these symptoms need to be assessed, monitored, and addressed throughout the therapy. We discuss conceptualization of these problems within the therapy and comment on their intervention throughout the protocol.

It is important to note that CBCT for PTSD is a trauma-focused treatment, but it does not include imaginal exposure-based interventions (i.e., repeatedly imagining the traumatic event until anxiety surrounding the memory subsides). When discussing the trauma memory in the final phase of treatment, couples are discouraged from discussing nitty-gritty or explicit renditions of traumatic events. In keeping with a cognitive approach to processing the trauma, we and others have found that discussing the traumas as if from a "10,000-foot view" provides enough detail to facilitate shifts in the ways patients and their significant others think about the event and its consequences (Resick, Monson, & Chard, 2008). In this way, clients are able to process the memory by properly contextualizing the event and correcting any misappraisals about it—the goal of CBCT for PTSD. Patients are encouraged to engage in traditionally described *in vivo* exposure exercises (e.g., Foa, Hembree, & Rothbaum, 2007), which we describe as approach assignments that are either completed as a couple or conceptualized within an interpersonal framework (e.g., sometimes partners serve as safety signals, and the approach assignments involve removing the partner from certain places and situations). These assignments are designed to create new learning about current situations, places, people, and feelings that are reminiscent of the traumatic event but are, in fact, safe.

## Benefits of Conjoint Therapy for PTSD

Given the available choices for the treatment of traumatic stress-related problems, why have clinicians and clients alike chosen to pursue CBCT for PTSD? Why might you deliver this therapy to your clients?

There are a number of benefits of conjoint therapy for PTSD, all derived from its focus on the importance of interpersonal factors in PTSD, based on evidence regarding intimate relationships and individual PTSD treatment, the role of loved ones in PTSD treatment engagement and retention, and the efficacy of CBCT for PTSD (see Chapter 2).

### *The Importance of Interpersonal Factors in PTSD*

The majority of traumatic experiences that lead to PTSD occur at the hands of others. In fact, the two types of traumatic events most likely to lead to PTSD are man-made: rape and combat exposure (Kessler et al., 1995). Other human-induced traumatic experiences can also precipitate PTSD, including, for example, physical aggression, motor vehicle accidents, and witnessing violence (e.g., assault, witnessing murder). By their nature, these experiences can lead to a range of interpersonal disruptions. In a related vein, Freyd and colleagues (e.g., Freyd, 1996) have written extensively about the specific sequelae of "betrayal traumas," or traumas that involve betrayal by persons or institutions that one depends on for survival. This class of traumas has been shown to be particularly deleterious to individual and interpersonal functioning (e.g., Birrell & Freyd, 2006).

When a trauma is not man-made but results from a natural or technological disaster, it is simultaneously experienced with others, and the circumstances that follow in the wake of trauma are interpersonally situated. Hurricane Katrina is a salient example. Individuals and families sought refuge together as the levees broke and water surged, and they worked together (or not) to survive until the water receded. Many people expressed dismay and betrayal at the response of the U.S. federal and state agencies to provide safe water, food, and temporary

housing for people affected by the storm, believing that this disaster could have been prevented outright or at least mitigated once it occurred. Because these and other traumatic experiences occur in an interpersonal context, it is important to take into account interpersonally contextualized behaviors, emotions, and beliefs linked to traumatization in order to treat the sequelae of traumatic experiences most effectively.

Consistent with the inherently interpersonal nature of traumatization, posttrauma social support has consistently emerged as one of the most potent factors associated with PTSD and other trauma-related mental health disorders. By now, there have been several meta-analyses of factors associated with PTSD after exposure to traumatic events. Brewin, Andrews, and Valentine (2000) found that the pretrauma factors of female sex, social, educational, intellectual disadvantage, and psychiatric history were associated with PTSD. However, trauma intensity and posttrauma factors had larger effects on the risk for later PTSD than did pretrauma variables. Trauma severity, lack of social support, and additional life stress were especially strongly associated with PTSD, with lack of social support being the greatest.

Ozer, Best, Lipsey, and Weiss (2003), in their meta-analysis of factors associated with PTSD in adults, investigated seven predictors: (1) prior trauma, (2) prior psychological problems, (3) family history of psychopathology, (4) perceived life threat during the trauma, (5) posttrauma social support, (6) peritraumatic emotional responses, and (7) peritraumatic dissociation. They found that all of the variables were significantly associated with PTSD: Peritraumatic dissociation and social support had the strongest associations and, consistent with Brewin and colleagues (2000), family history, prior trauma, and prior adjustment had the weakest. Interestingly, Ozer et al. also found that the association between poor social support and PTSD symptomatology was *stronger* with greater lapse of time after traumatization, suggesting that the buffering effects of social support may be cumulative over time or that the symptoms of chronic PTSD may, in fact, erode social support.

The notion that symptoms of PTSD and its comorbidities may erode social support has been validated by several studies of war veterans and disaster victims. For example, cross-sectional studies of Vietnam War (Keane, Scott, Chavoya, Lamparski, & Fairbank, 1985; King, King, Fairbank, Keane, & Adams, 1998) and Persian Gulf War (King, Taft, King, Hammond, & Stone, 2006) veterans have shown that chronic PTSD symptoms erode social support more than vice versa. Another study examined the association between social support and PTSD over time in the more acute phases of disaster recovery (Kaniasty & Norris, 2008). The researchers interviewed survivors of a flood that devastated a number of communities in Mexico in 1999. They found that familial social support predicted PTSD symptoms between 6 and 12 months posttrauma but that this was reversed between 18 and 24 months posttrauma. Between 12 and 18 months posttrauma, a bidirectional association between social support and PTSD symptoms emerged. Regardless of directionality, there is a strong association between poor social support and PTSD symptoms, possibly more so than any other variable.



### *The Role of Family Functioning in Individual PTSD Treatment and Vice Versa*

Conventional clinical wisdom holds that individual PTSD treatment will result in cascading improvements in interpersonal functioning. With this line of thinking, treatment planning often involves providing couple/family therapy after the individual PTSD treatment if it is needed.

Empirical data, however, have not supported the notion that individual PTSD treatment will necessarily ameliorate couple/family problems. Monson and colleagues' (2006) trial of individual cognitive processing therapy for military-related PTSD did not reveal significant improvements in many areas of psychosocial functioning, including close relationship functioning, as a result of treatment. Thus, in order for interpersonal relationships to improve, it does not seem sufficient to focus solely on treating PTSD symptoms.

If individual PTSD treatment does not generally improve relationship functioning, does relationship functioning influence individual PTSD treatment? The answer seems to be "yes." Two studies have examined the role of couple or family functioning in individual PTSD treatment outcomes. In their study of individual imaginal exposure and cognitive therapy for PTSD, Tarrier, Sommerfield, and Pilgram (1999) found that patients whose relatives displayed high levels of criticism and/or hostility (i.e., high expressed emotion) exhibited significantly less improvement in PTSD symptoms, depressive symptoms, and general anxiety following treatment than did those with relatives who expressed low levels of these behaviors.

Similarly, Monson, Rodriguez, and Warner (2005) studied the role of interpersonal relationship variables in two forms of group CBT for veterans with PTSD: trauma focused (i.e., exposure to trauma memories and cognitive restructuring of trauma-related beliefs) and skills focused (i.e., symptom management skills without focus on traumatic memories and reminders). Although there were no differences in the PTSD outcomes for the two forms of treatment, pretreatment intimate relationship functioning was more strongly associated with treatment outcomes in the trauma- versus skills-focused therapy. In the trauma-focused group, there was a stronger association between pretreatment intimate relationship functioning and intimate violence perpetration outcomes. Greater intimate relationship adjustment at pretreatment was associated with lower levels of intimate violence perpetration at follow-up for veterans who received trauma-focused versus skills-focused treatment. These studies suggest that there are benefits to enhancing the interpersonal milieu of those who are endeavoring PTSD treatment, particularly trauma-focused treatment.

### *Benefits for Treatment Engagement and Retention*

Despite years of public health campaigns to decrease the stigma surrounding mental health problems, there is still significant evidence of its effects in preventing people from seeking sorely needed services. Nowhere is this more apparent than among active-duty service members and veterans of the Iraq and Afghanistan Wars. Several academic articles have been written about the need to overcome the stigma among service members and veterans about seeking mental health services (Dickstein, Vogt, Handa, & Litz, 2010; Hoge, Castro, & Messer, 2004). Military policies have even been revised to help overcome this stigma and protect service members' careers when they seek mental health services. Yet it is our experience that, for a variety of reasons, military and community members alike are loathe to admit to individual problems and to seek treatment.

Individuals presenting for our therapy have appreciated the option of being able to say they are seeking couple or family therapy rather than individual therapy for a mental health disorder. Patients have expressed that it has been less stigmatizing for them to engage in this mode of therapy. One police officer who completed the treatment with his wife commented, "If this would have been individual counseling, I would have never gotten help. I would have

never shown up." From the time people seek assessment and treatment, we present traumatic stress-related problems as existing in an interpersonal context, and not within either of them, in order to overcome stigma, increase buy-in, and decrease the mutual blame that often exists in these dyads. We believe couple/family therapies are often overlooked as an important conduit to treatment for many people who are reluctant to seek services for individually defined problems.

When individuals seek treatment for PTSD, a relative minority present because of the symptoms of PTSD per se. In most cases, individuals with mental health problems, including PTSD, depression, and substance use disorders, ultimately seek treatment because of psychosocial impairments associated with these disorders: for example, marital dysfunction leading to threats of divorce, struggles in their interaction with their children, employment-related trouble, or legal problems. It is often these functional impairments that get people to treatment and may, in the longer term, keep them in treatment. We believe that meeting clients "where it hurts" in their daily life is more likely to lead to treatment engagement and motivation to improve the psychopathology driving those impairments. Interpersonal problems are a significant source of "where it hurts" for clients with trauma-related symptoms and their loved ones.

Decades of research have validated the association between traumatic stress-related problems and intimate relationship functioning. For example, these studies indicate that those diagnosed with PTSD are three to six times more likely to divorce than those without PTSD (Davidson, Hughes, Blazer, & George, 1991; Kessler, Walters, & Forthofer, 1998). An epidemiological study of nearly 5,000 spouses in Ontario, Canada, investigated the association between nine mental health diagnoses and marital distress (Whisman, Sheldon, & Goering, 2000). The authors found that clinical levels of marital distress were 3.8 times more likely among couples with a partner diagnosed with PTSD, a rate second only to that for a diagnosis of dysthmia (5.7 times). A number of cross-sectional studies with clinical samples reveal that the severity of PTSD symptoms is associated with the number and severity of relationship problems, level of self-disclosure and expressiveness between partners, and degree of anxiety related to intimacy (Carroll, Rueger, Foy, & Donahoe, 1985; Riggs, Byrne, Weathers, & Litz, 1998). In a recent longitudinal cohort study of Iraq/Afghanistan war veterans, interpersonal relationship problems outpaced the occurrence of individual mental health problems by at least twice the rate (Milliken, Auchterlonie, & Hoge, 2007).

The health of intimate relationships plays a role not only as a presenting problem but also as a factor in treatment engagement. Recent research with service members returning from Iraq and Afghanistan suggests that strong intimate relationships are associated with higher rates of treatment engagement. In their large longitudinal study of male National Guard soldiers and their intimate female partners, Meis, Barry, Kehle, Erbes, and Polusny (2010) found that soldiers with the most satisfied intimate relationships were the most likely to engage in individual mental health treatment.

An important question to ask is whether individuals with traumatic stress-related problems want their loved ones involved in their therapy. At least one study indicates they do. Batten and colleagues (2009) found that more than 80% of the veterans in their outpatient U.S. Department of Veterans Affairs (VA) PTSD program desired their family members to be more involved in their treatment. They also found that 66% of the veterans wanted help to improve their communication skills with family members, which is a major focus of CBCT for PTSD. In addition, there have been consistent referrals to treatment programs situated in different settings offering

CBCT for PTSD. Clinicians practicing CBCT for PTSD have informed us of their ample referrals when they started offering the therapy.

Once engaged in therapy, retention and adherence to the interventions are crucial. Existing individual evidence-based psychotherapies for PTSD, such as prolonged exposure (Foa et al., 2007) and cognitive processing therapy (Resick et al., 2008), with their focus on direct confrontation of traumatic material, are potent therapies. However, there are a number of clients who do not complete them or only partially respond to treatment. A meta-analysis of randomized controlled psychotherapy trials for PTSD found that the average dropout rate from trauma-focused treatment is greater than 25% (Hembree et al., 2003); dropout rates from these therapies in clinical settings are generally higher (Pitman et al., 1996). The current dropout rate for CBCT for PTSD in our trials is about 15%, which we attribute to patients' having more social support while undertaking trauma-focused treatment, loved ones' knowledge and support of the treatment rationale, and diminished stress in the patients' interpersonal environments while participating in the therapy.

Individuals who complete an existing evidence-based psychotherapy for PTSD are likely to have symptom improvements. Randomized clinical trials demonstrate a remission rate of approximately 66% treatment completers (see, e.g., Bradley, Greene, Russ, Dutra, & Westen, 2005). These are impressive results compared with those for many other mental health conditions. However, this means that 33% of participants, who are sufficiently motivated to enter these trials and complete treatment, nevertheless still have a PTSD diagnosis at treatment end. There is clearly room for innovative therapies that can bridge this gap in success, increasing the number of patients who experience remission in their PTSD diagnosis upon completion of treatment. Incorporating significant others into PTSD treatment is one such innovation.

When armed with proper psychoeducation and skills, loved ones can be champions for the therapy and for interventions that are often the antithesis of what an individual with traumatic stress-related problems wants to do (i.e., to avoid). However, in the absence of understanding of how avoidance maintains PTSD and intimate relationship problems, for example, loved ones may unwittingly reinforce symptoms. Current evidence-based interventions for PTSD involve facing memories or current-day reminders of traumatic events. As we discuss in Chapter 2 regarding conceptualizing PTSD in a dyadic relationship, many loved ones "protect" the person with traumatic stress-related symptoms from the distress caused by facing these triggers. On the basis of our experience, we believe that these individuals, although usually well meaning, functionally collude in their loved one's cognitive, behavioral, and emotional avoidance, on which posttraumatic stress problems thrive. We have labeled these types of behaviors as "accommodation" to the symptoms because they serve to maintain the individual problems and make space in the relationship for the symptoms to exist. With the skills and education that CBCT for PTSD offers, couples work together to overcome this avoidance, which maintains or even increases the posttraumatic problems, and this sense of togetherness can then serve as an important motivator for patients engage in the hard work of therapy. As one of our clients stated, "What I won't do for myself, I'll do for my family."

We have also had cases in which loved ones were not privy to the rationale for individual trauma-focused CBT for PTSD and were upset by the interventions. Some even encouraged behaviors that ran in opposition to the interventions. In one case a wife called to ask, "Why, Dr. Monson, after all of these years of me helping to 'button him up,' are you trying to unhinge him?" In another case, a client reported in session that her partner had offered her a glass of

wine before she was to listen to an audiotaped account of her trauma memory at home, stating, "He thought it would chill me out, and it did." Again, we presume that most significant others are acting with the best of intentions, albeit misguided. Including significant others in the treatment of clients' posttraumatic problems can be beneficial not only in improving symptom-level outcomes but, as we discuss next, also for the loved ones themselves and their relationships.

### *Efficacy of CBCT for PTSD: Getting Three-for-One Benefits*

Perhaps the most important reason for considering conjoint therapy for PTSD is that you can simultaneously achieve benefits for (1) the person diagnosed with PTSD, (2) his or her loved one, and (3) their relationship. Our initial test of the therapy showing this three-for-one benefit was with romantic couples, including seven male Vietnam War veterans with PTSD and their wives (Monson, Schnurr, Stevens, & Guthrie, 2004). We found significant and large effect size improvements in clinicians' and partners' ratings of veterans' PTSD symptoms from pre- to posttreatment. The veterans reported moderate improvements in PTSD and statistically significant, large improvements in depression, anxiety, and social functioning. Wives reported large effect size improvements in relationship satisfaction, general anxiety, and social functioning (Monson, Stevens, & Schnurr, 2005).

We have since applied the therapy to a range of couples and trauma survivors diagnosed with PTSD. A recent uncontrolled study (Monson et al., 2011) revealed clinically significant improvements in clinicians', patients', and partners' ratings of patients' PTSD symptoms, and five of the six patients who completed treatment no longer carried a PTSD diagnosis by the end of the therapy. Three of the four couples who presented as distressed before treatment were satisfied after treatment, and partners reported significant improvements in their relationship satisfaction. In addition, patients reported large effect size improvements in depression and state anger symptoms, and partners reported large and significant improvements in their ability to express anger.

We are currently completing a randomized controlled trial of the therapy compared with treatment as usual in a diverse sample of couples and with survivors of different types of trauma. The available results from this trial show even stronger outcomes than those previously found. These results have been replicated in several cases outside of our research clinics as well (Schumm, Fredman, Monson, & Chard, 2012).



## Cognitive-Behavioral Interpersonal Theory Underlying CBCT for PTSD

Understanding the theoretical model upon which CBCT for PTSD was built is critical to case conceptualization and the successful implementation of this protocol-driven intervention. The more you understand the cognitive, behavioral, and emotional factors that interact to maintain traumatic stress-related problems and relationship difficulties, the better able you will be to think broadly and flexibly about how to implement the treatment with a given dyad while staying true to the treatment protocol. Here we discuss traumatic stress-related symptoms and associated relationship problems and describe how the different components of CBCT for PTSD target these difficulties. The descriptions are not exhaustive but rather illustrative examples;

the vast range of symptom presentations and complex manifestations within different intimate relationships preclude description here.

The art of delivering this manualized treatment relies on the ability to deliver the essential ingredients of the therapy as prescribed while simultaneously considering how a variety of thoughts, feelings, and behaviors on the part of each partner interact to maintain the problems and associated relationship difficulties and then addressing them in the context of the particular couple. For instance, we assert that there are as many ways for individuals and couples to avoid trauma-related material as there are people struggling with posttraumatic sequelae. Your ability to conceptualize these behaviors within an interpersonal, cognitive-behavioral framework and then translate this understanding into a curious and nonjudgmental inquiry about the potential function of these behaviors will ultimately facilitate clients' recovery from PTSD and relationship problems.

## *PTSD as a Disorder of Impeded Recovery*

CBCT for PTSD is based on a recovery model of traumatic stress-related problems. In this approach to PTSD, symptoms are not considered as developing over time, like many other mental health conditions that have early warning signs or a prodromal phase (e.g., depression, schizophrenia). Rather, prospective studies indicate that, in the acute aftermath of exposure to a traumatic event, most individuals will have an assortment of symptoms later identified as PTSD symptoms if they have lasted the 1 month required by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). With time, most people will experience abatement in their symptoms, and they will naturally "recover" without intervention (Ehlers, Mayou, & Bryant, 1998; Riggs, Rothbaum, & Foa, 1995; Rothbaum, Foa, Riggs, & Murdock, 1992). The evidence suggests that delayed-onset cases of PTSD are most generally characterized by subthreshold diagnoses at prior evaluations (Bryant & Harvey, 2002; Buckley, Blanchard, & Hickling, 1996; Ehlers et al., 1998).

Epidemiological data regarding trauma exposure and subsequent PTSD diagnosis also illustrate this point regarding natural recovery. As mentioned, approximately 75% of North Americans will be exposed to traumatic stressors (Kessler et al., 1995; Van Ameringen, Mancini, Patterson, & Boyle, 2008). However, only about 5% of men and 10% of women will be diagnosed with PTSD in their lifetime, indicating that a substantial majority have natural remission of their symptoms after exposure. When implementing CBCT for PTSD, you should think about what got in the way, or impeded, that natural recovery process.

The notion of impeded recovery is integral to the rationale for CBCT for PTSD and, as such, is built into the description of the therapy course for therapists and clients alike. More specifically, we chose the acronym R.E.S.U.M.E. Living to characterize the three phases of the therapy (discussed later) and convey its recovery orientation and to imbue hope for improvements in traumatic stress symptoms, relationship problems, and quality of life more broadly.

In prior work, we have outlined a cognitive-behavioral interpersonal theory of PTSD (Monson, Fredman, & Dekel, 2010; Monson, Fredman, Dekel, & Macdonald, in press). Translating this theory into the interventions that make up CBCT for PTSD, traumatic stress-related problems are postulated to result from behavioral, cognitive, and emotional factors that interact within each individual and also between members of a couple. These interacting systems simultaneously create a shared relationship milieu that, in turn, feeds back on the individuals

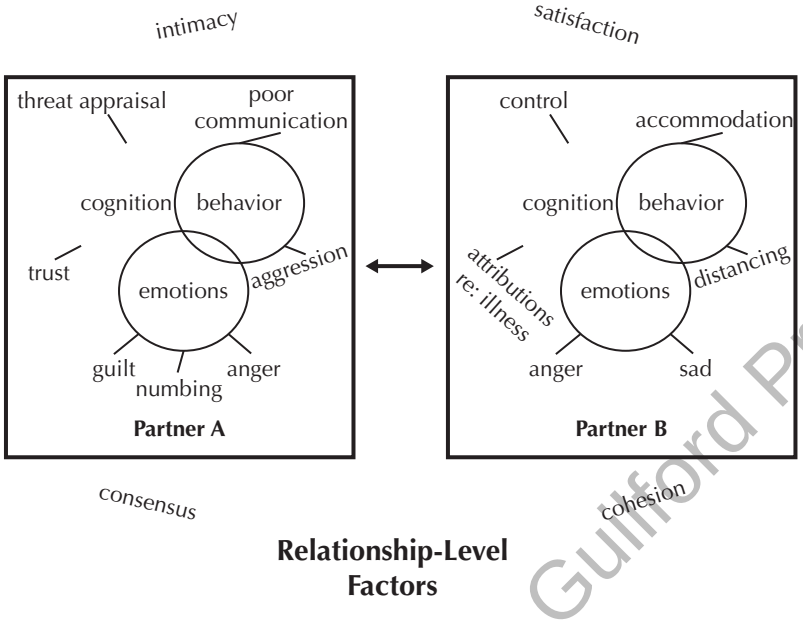


**FIGURE 1.** Example of interacting cognitive, behavioral, and emotional factors within and between partners and the influence on and by relationship factors (Monson et al., 2010).

existing within that milieu (see Figure 1 for examples of factors). These factors are postulated to impede the natural trajectory toward recovery. Implicated behavioral mechanisms include communication deficits and various types of avoidance. Cognitive mechanisms involve problematic appraisals of the event and related conclusions drawn in the here and now that emanate from those appraisals. Emotional mechanisms include disturbances in a range of emotions and in the processes that govern these emotions (i.e., identifying, experiencing, sharing).

## *Behavioral Mechanisms*

In behavioral models of PTSD, classical conditioning accounts for the associations between certain stimuli and physiological and psychological distress when confronted with the stimuli. For example, we have had cases in which fireworks provoked arousal for combat veterans because the sights and loud, unexpected noises reminded them of war zone explosions to which they were exposed. In another case, the sight of an automated teller machine (ATM) provoked distress in a client who was robbed at knifepoint during an ATM transaction. For a rape victim whom we treated, the smell of spearmint gum was a source of distress because her attacker was chewing that flavor of gum at the time of the assault. In these cases, a previously neutral stimulus (e.g., loud noise, ATM, spearmint gum) took on distressing properties because it was paired in time with the traumatic event.

Operant conditioning, and specifically the negatively reinforcing value of avoiding distressing internal and external reminders, accounts for the maintenance of the distress response

when confronted with traumatic material (Mowrer, 1960). That is, when traumatized individuals avoid people, places, situations, or other stimuli that remind them of the traumatic event(s), they feel less distressed or uncomfortable in the moment and, therefore, are more likely to keep avoiding over time. As a result, they are denied the opportunity for new associations to develop and to learn that they are, in fact, safe in the present. Through these processes, avoidance provides short-term relief but paradoxical long-term maintenance, or even exacerbation, of the distress.

When conceptualizing avoidance within CBCT for PTSD, it is important to consider a broad range of behaviors that can strengthen the association between trauma stimuli and distress. These include the classic behavioral avoidance and emotional numbing symptoms. However, there are behaviors beyond these traditional symptoms that can serve an avoidance function. Some of these behaviors are more active in nature, while others are more indirect or passive. Examples of active avoidance include alcohol or other substance use, angry outbursts to dissuade others from discussing particular topics, self-harm, workaholism, electronic gaming, sex, safety behaviors (e.g., scanning/patrolling areas), pornography, nonattendance at sessions, and noncompletion of out-of-session assignments. Other, more passive behaviors that can serve an avoidance function include dissociation, social withdrawal, somatic complaints, skirting difficult topics, and sleeping. Any behavior that serves to minimize exposure to trauma reminders or memories may be avoidance. One question to consider in monitoring for avoidance is "If not for the traumatic event, would the person be engaging in (or not engaging in) the behavior?"

At the dyadic level, significant others' well-intended caretaking or "accommodation" behaviors—efforts to assuage the distress of affected family members by minimizing their loved one's exposure to stimuli that he or she finds aversive—can also serve to promote or maintain avoidant behavior. For example, family members of a motor vehicle accident survivor may drive him everywhere because of his anxiety at the mere thought of driving a car. Likewise, a combat veteran and his partner may avoid crowded venues, such as restaurants, theaters, or concerts, because, as targets of bombings during his deployment, they serve as trauma-related triggers. Rape survivors and their loved ones might avoid sexual intimacy in general or particular sexual positions or behaviors because they are reminiscent of the assault. Loved ones can also accommodate the symptoms of PTSD by colluding in safety behaviors and by serving as safety signals in distressing situations. For example, partners may participate in excessively checking door and window locks, carry weapons at their partner's insistence, avoid certain highways when they drive, or agree to around-the-clock cell phone accessibility so that their PTSD+ loved one can call for safety reassurance. We have also had cases in which the presence of partners and children was used to manage distress in stressful environments (e.g., grocery stores, malls) by serving either as a form of reassurance or distraction.

Over time, avoidance leads to the unfortunate consequence of diminished relationship satisfaction because of less engagement in shared rewarding activities and restraints on partners' behaviors, feelings, and communication. Connecting around mutually satisfying events and experiences represents an important way for couples to nurture and invest in their relationships and to buffer against the effects of the inevitable ups and downs that characterize even healthy relationships. However, when couples are deprived of opportunities to connect as a result of behavioral avoidance, their relationships can become distressed because of the absence of positive interactions. These couples also become more attentive to their negative interactions, which contributes to relationship dissatisfaction (Epstein & Baucom, 2002).

Other behavioral mechanisms implicated in the cognitive-behavioral interpersonal theory of PTSD are poor communication and conflict management skills. Individuals with PTSD display communication skills deficits (Nezu & Carnevale, 1987), which may be a risk factor or consequence of the disorder. Hyperarousal symptoms such as anger/irritability, hypervigilance, and sleeplessness fuel these deficits and contribute to negative interpersonal interactions, which can be characterized by verbal and physical aggression (Taft, Vogt, Marshall, Panuzio, & Niles, 2007; Taft et al., 2009). Problematic communication is characteristic of unhappy couples, and communication problems are one of the most commonly reported reasons why couples seek therapy (Geiss & O'Leary, 1981). Deficits in communication skills, coupled with behavioral constriction, avoidance, and emotional numbing, can also lead to problems with emotional intimacy. Deficits in communication skills and diminished emotional intimacy can also decrease the likelihood of trauma disclosure. As discussed shortly, trauma disclosure in an encouraging and supportive environment can lead to the development of a more cogent trauma narrative and emotional processing of traumatic memories.

### *Cognitive Mechanisms*

There are related cognitive thematic content and processes that are theorized to account for the association between individual posttraumatic stress and close relationship problems. A primary barrier to trauma recovery is maladaptive appraisals about the traumatic event(s). There are a variety of different ways in which individuals and significant others can maladaptively appraise traumatic events that lead to posttraumatic symptomatology and intimate relationship problems. These barriers include a variety of social-cognitive constructs, including hindsight bias and its derivatives (e.g., "undoing" the event by thinking about alternative actions that may have prevented the event; "happily-ever-after" thinking that an alternative action would have led to a positive outcome), just-world thinking (the belief that good things happen to good people and bad things happen to bad people), and actor–observer biases (i.e., not fully appreciating the situational variables that affect behavior; making characterological attributions about situationally influenced behavior). Examples of these misappraisals include the rape victim who believes she should have fought back because it would have prevented the rape and the combat medic who believes he failed to prevent his comrade's death despite a lack of knowledge and tools to perform surgery on the battlefield. Significant others, including therapists, can also fall prey to these appraisal errors and thereby influence trauma survivors' appraisals about trauma events. Examples of maladaptive attributions sometimes held by loved ones include victim-blaming attributions (e.g., "You shouldn't have worn that outfit," "If you hadn't have drunk alcohol . . . ," and "You drove unsafe") and characterological attributions about those involved in traumatic events (e.g., describing combat veterans as "baby killers" and sexual assault victims as "sluts" or "provocative"). These appraisal barriers to recovery are described in more depth in Sessions 8 and 9. In general, these barriers can be conceptualized as efforts to exert predictability and control over the events by clients, loved ones, and therapists. Yet they leave the traumatized person with unprocessed traumatic material and the related symptoms.

Problematic appraisals about traumatic events can lead to overgeneralized maladaptive beliefs about the self, others, and the world after traumatization. Borrowing from earlier work by McCann and Pearlman (1990), and consistent with content found in cognitive processing therapy (Resick et al., 2008), beliefs about trust, power, and intimacy are affected by traumatization.

For example, prior positive beliefs in these areas may be challenged by traumatization (e.g., "I thought I could trust my judgment and the person who assaulted me") or prior negative beliefs could be seemingly confirmed (e.g., "I knew men could not be trusted"). These beliefs are extremely pertinent to close relationship functioning. Consider an incest survivor who believes she will be betrayed again if she were to become emotionally vulnerable with another person. As a consequence of her belief, she avoids emotional intimacy with her partner and lashes out preemptively in an effort to protect herself before she can be hurt again. Other couples we have worked with have been characterized by overly controlling behaviors on the part of the traumatized individual as a result of the belief that the world in general was an unsafe place. For example, some combat veterans have demanded to know where their partners and children were at all times with the belief that they could protect them from perceived harm by untrustworthy others.

In addition to cognitive content that is disturbed with traumatization, there are cognitive process disturbances associated with PTSD, including attention/concentration deficits and selective attention to negativity (Vasterling & Brewin, 2005). Not uncommonly, selective attention to threat extends to the perceptions of the partner's behaviors, such as the suspicion that the partner's intentions toward the traumatized individual are negative. For instance, when asked by his wife where he was earlier in the day, the traumatized individual could construe this as an accusation that he was having an extramarital affair. Selective attention to negative relationship behaviors, negative attributions for each other's behaviors, and negative assumptions and expectancies about each other also characterize couples experiencing relationship distress more generally (Epstein & Baucom, 2002). Thus, the tendency among couples in which at least one partner has PTSD to view each other as a source of threat is similar to that observed in other distressed couples and tends to be amplified in the presence of PTSD.

In addition to those who have been directly traumatized, significant others can hold maladaptive beliefs that interfere with therapy and, consequently, trauma recovery. For instance, a combat veteran client was dissuaded by his wife from approaching safe places and situations that caused him anxiety (e.g., the mall, grocery store) because of her belief that even mild stress would cause her husband to suffer a heart attack. Because of his wife's maladaptive cognition and related protective behavior, the veteran had not had the opportunity to place himself in anxiety-provoking situations and learn that he was actually safe. With cognitive interventions, however, the wife was able to facilitate her husband's approach of these safe situations, with the realization that he might be more at risk for cardiovascular problems resulting from chronic PTSD than with prescribed and planned approaches to trauma-related stimuli like a crowded mall.



### *Emotional Mechanisms*

Although PTSD has been defined as an anxiety disorder within the current DSM classification system, research has shown that the emotional disturbances associated with traumatization extend beyond anxiety. For instance, there is strong evidence that individuals with PTSD experience disruption in a range of emotions in addition to fear, such as guilt, shame, anger, grief, and sadness (e.g., Kubany & Watson, 2002; Novaco & Chemtob, 2002). Moreover, avoidance can generalize to the experience and expression of emotions more generally in PTSD (Boeschen, Koss, Figueredo, & Coan, 2001; Morina, Stangier, & Risch, 2008). Emotional process

disturbances such as alexithymia and difficulty identifying and expressing emotions have also been associated with PTSD (Price, Monson, Callahan, & Rodriguez, 2006).

These emotional content and process disturbances are suspected to contribute to emotional communication deficits and their related relationship impairments, such as an inability to relate on an emotionally intimate level. As we discuss in Session 4, emotions are the "glue" that hold couples together. With the exception of hostility, the expression of emotions enhances emotional intimacy regardless of the valence of the emotion that is shared (i.e., whether the emotion is positive or negative). Alexithymia and other difficulties labeling emotions interfere with traumatized individuals' ability to name and share their emotions with others and can be especially deleterious to relationship satisfaction. Indeed, research has shown that it is the emotional numbing symptoms of PTSD that are most strongly associated with lower relationship satisfaction (Riggs et al., 1998) and are not as responsive to existing individual evidence-based therapies for PTSD (Asmundson, Stapleton, & Taylor, 2004).

## Specific Mechanisms of PTSD and Relationship Problems Targeted in CBCT for PTSD

To address the interacting behavioral, cognitive, and emotional processes postulated to underlie PTSD and associated relationship problems, CBCT for PTSD consists of 15 sessions organized into three phases that build upon one another. The acronym R.E.S.U.M.E. Living was chosen to reflect these sequential phases and the recovery-focused nature of the therapy for therapists and clients alike:

| | |
|---|---|
| R = *Rationale* for Treatment<br>E = *Education* about PTSD and Relationships | Phase 1 |
| S = *Satisfaction* Enhancement<br>U = *Undermining* Avoidance | Phase 2 |
| M = *Making Meaning* of the Trauma(s)<br>E = *End* of Therapy—commitment to ongoing betterment | Phase 3 |
| Living | |

Table 1 presents an overview of the sessions of CBCT for PTSD.

### *Phase 1. Rationale for Treatment and Education about PTSD and Relationships (Sessions 1–2)*

In this phase, couples receive a rationale for treatment, an overview of the protocol, and psychoeducation about the reciprocal influences of PTSD symptoms and relationship adjustment, including an explanation of how avoidance, emotional numbing, and maladaptive thinking maintain both PTSD and relationship difficulties. At the end of Session 1, they are asked (1) to catch each other doing nice things in order to promote positivity in their relationship and decrease selective attention to negative relationship behaviors and (2) to read a psychoeducational handout on the association between PTSD symptoms and relationship behaviors. Both

**TABLE 1. Overview of CBCT for PTSD**

**R.E.S.U.M.E. Living**

**Phase 1. Rationale for Treatment and Education about PTSD and Relationships**

Session 1. Introduction to Treatment

Session 2. Safety Building

**Phase 2. Satisfaction Enhancement and Undermining 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 U.N.S.T.U.C.K.

Session 7. Problem Solving to Shrink PTSD

**Phase 3. Making Meaning of the Trauma(s) and End of Therapy**

Session 8. Acceptance

Session 9. Blame

Session 10. Trust

Session 11. Control

Session 12. Emotional Closeness

Session 13. Physical Closeness

Session 14. Posttraumatic Growth

Session 15. Review and Reinforcement of Treatment Gains



partners are also asked to complete the Trauma Impact Questions-I (TIQ-I); see Part II, Session 1, Handout 1.5), which is designed to elicit their thoughts about how PTSD has affected their relationship and the perceived causes of the traumatic event(s) as well as their thoughts about themselves, each other, and the world in general in the areas of trust, control, emotional closeness, and physical closeness. These are then shared and read aloud at the next session. In Session 2, in addition to reviewing the partners' responses on the TIQ-I, the couple is educated about how PTSD contributes to a range of aggressive behaviors because of dysregulation in the fight–flight–freeze system, and they learn strategies to facilitate a shared sense of safety, such as recognizing early warning signs of anger, slowed breathing, and time-out conflict management strategies. To increase the likelihood of skill use outside of the session, the couple has the opportunity to practice slowed breathing and the time-out technique during the session.

## *Phase 2. Satisfaction Enhancement and Undermining Avoidance (Sessions 3–7)*

In Phase 2, couples learn about the insidious role of avoidance in maintaining both PTSD and relationship problems and are taught communication skills to address both. Enhanced dyadic communication is used as an antidote to PTSD-related emotional numbing and avoidance and as a means of increasing emotional intimacy. In Session 3, couples use the communication skill

of reflective listening to begin generating a list of people, places, situations, and feelings that they have avoided as a couple as a result of PTSD. Starting in Session 4 and continuing through the rest of the therapy, this "avoidance" list becomes their "approach" list, and ideographically programmed, trauma-relevant *in vivo* approach assignments from the approach list are completed after each session in a graduated manner. Special attention is paid to the selection of *in vivo* approach activities that will address behavioral and experiential avoidance and concurrently double as shared rewarding activities. For example, a couple who has avoided restaurants because crowded places serve as a trigger for the PTSD-identified partner would first be asked to go the restaurant during the week in the early afternoon when it is unlikely to be crowded, then go on a weeknight evening, and ultimately to go on a Saturday night while the patient sits with his or her back against the wall in order to decrease PTSD-related hypervigilance. These exercises are similar to *in vivo* exposures completed in the context of prolonged exposure (Foa et al., 2007). However, they differ in that no formal SUDS (Subjective Units of Distress Scale) ratings are made, as is typically done in the treatment of anxiety disorders. In addition, the couple's relationship is the unit of intervention rather than the patient and his or her disorder only. Consequently, both partners participate in the exercise instead of the non-PTSD partner serving as a surrogate therapist or coach.

Communication skills presented and practiced in each session build 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. For example, in Session 4, couples learn the skill of channel checking to differentiate between conversations focused on sharing thoughts and feelings versus trying to solve a problem or make a decision. They then use reflective listening skills to discuss the feelings they each have about the role of PTSD in their relationship (e.g., angry, sad) and, in Session 5, use the reflective listening skills to identify and share thoughts and related feelings that they have as a result of PTSD (e.g., "PTSD makes me think that I can't trust anybody, and that makes me feel sad and angry"). In Session 6, the couple learns a dyadic cognitive intervention process that they use together to increase flexibility in thinking and to challenge cognitions that maintain both PTSD and relationship problems (e.g., "If I go to the movies with Jake, I will be attacked"). Consistent with the notion that the couple is together identifying and modifying these maladaptive thoughts, or "stuck points," related to traumatization, the steps of the process are summarized in the acronym U.N.S.T.U.C.K.:

- Unified and curious as a couple as you join together in collaborative empiricism.
- Notice and share thoughts (e.g., "If I go to the movies with Jake, I will be attacked," with a corresponding feeling of fear).
- (Brain)Storm alternative thoughts or interpretations, no matter how implausible they might seem initially (e.g., "Although it's possible that something bad could happen, it's extremely unlikely," "My PTSD makes me exaggerate the risk that we could be hurt at the movies").
- Test the thoughts (i.e., consider the evidence for and against each alternative thought generated; e.g., "I used to go the movies, and nothing bad ever happened," "I don't know anyone who's ever been attacked at a movie," "There will be a lot of people around, so it's unlikely that someone could actually hurt us if someone did something dangerous")
- Use the most balanced or reasonable thought(s) (e.g., "Although it's possible that something bad could happen, it's extremely unlikely").

- Changes in emotions and behaviors that result from the new thought(s) (e.g., less scared, less avoidant of going to crowded places).
- Keep practicing by generating specific behavior(s) that will reinforce this new way of thinking (e.g., schedule a date on Saturday night and go to the movie theater for a matinee).

In Session 7, the couple learns the skill of problem solving to decide how they will continue to "shrink" the role of PTSD in their relationship by collaboratively addressing PTSD-related avoidance, and they practice this skill in session by determining their next *in vivo* approach activity. For example, in the case described previously, the couple might use their problem-solving skills to decide which theater they will go to, when they will go, what movie they will see, and what they will do if one or both of them feels anxious before or during the exercise.

### *Phase 3. Making Meaning of the Trauma(s) and End of Therapy (Sessions 8–14)*

The final phase of therapy capitalizes on the couple's improved communication skills and their new tendency to approach rather than avoid by examining trauma-related beliefs that they may each hold that contribute to PTSD symptoms and relationship problems. Discussions focus directly on the resolution of problematic appraisals of the trauma and then proceed to specific problematic core beliefs that have been impacted by the event and maintain PTSD and relationship difficulties. These domains include trust, control, emotional closeness, and physical intimacy. Sessions are sequenced in Phase 3 with a focus on appraisals specific to the trauma first because more accurate appraisal of the traumatic event(s) should have robust and cascading effects on present- and future-oriented beliefs that have been affected by (mis-)appraisals of traumatic events. When progressing to the core areas, the therapist guides the couple to investigate how the traumatic event has influenced thoughts in each core area and to challenge any appraisals that influence current-day individual and relationship functioning. For instance, we have worked with many rape survivors who have had the thought "I should have known that he was going to rape me and could have prevented this" or "I should have fought back harder." As a result, they harbored current-day beliefs that they could not trust their own judgment in the here and now and consequently relied on their partners to make all decisions for fear that any decision they made would result in danger, which, in turn, contributed to their partners feeling burdened and frustrated. We have seen many cases in which the couple successfully used the U.N.S.T.U.C.K. process to notice and challenge these thoughts by taking more a contextualized view of the event and considered alternatives to PTSD-related cognitions, such as "The rapist had the element of surprise on his side, and I had no way of predicting that this would happen" or "If I had fought back, I might have gotten hurt worse or been killed." Once the survivor learned to accurately place blame with the rapist rather than herself, the thinking frequently shifted from presently believing that she could not trust her own judgment to believing that she could rely on her ability to make good decisions to keep herself safe in many, but not all, situations. We have seen similar shifts in thinking with combat veterans. With the help of their partner's being curious and asking questions, they were able to challenge historical misappraisals of traumatic events (e.g., "I should have known an IED [improvised explosive device] was about to go off" to "There's no way that I could have known there was an IED. They were deliberately

placed so that we would be unable to predict the explosions"). The veterans experienced corresponding shifts in current-day thinking (e.g., "I have to try to control everything to prevent bad things from happening to me or my partner" to "I can control some, but not all, things in my life, and it is ultimately better for my relationship for me to share control with my partner than to try to control all aspects of our relationship in an attempt to keep us safe"). Treatment culminates with a discussion of the potential for benefit finding and posttraumatic growth and ends with a review of gains made in therapy and challenges expected in the future.

We have found processing appraisals and the consequent meaning of traumatic events in an interpersonal context to be very powerful in terms of not only accelerated healing and reduction of symptoms but also increasing closeness and deepening close relationships. Significant others often provide alternative explanations for traumatic events, support the survivor in confronting the trauma memory to do the reappraisal work, and help the survivor practice new ways of making sense of the traumatic experiences and the consequences of those experiences in the interpersonal interactions. Consistent with the literature on self-disclosure about traumatic events and relationship functioning (Koenen, Stellman, Stellman, & Sommer, 2003; Solomon, Dekel, & Zerach, 2008), it is our experience that this type of work increases intimacy in the couple beyond that achieved with more traditional couple therapy techniques and enhances understanding and empathy in the couple's relationship.

### *Important Therapeutic Assumptions*

CBCT for PTSD is based on several assumptions. First, and consistent with a family systems perspective, the nature of the problem is the way that the couple relates around the posttrauma sequelae and not something inherently pathological in the partner diagnosed with PTSD. Accordingly, the treatment is disorder specific, meaning that the targets of intervention are the interactions within the couple; and the patient, in this case, is the couple's relationship vis-à-vis the PTSD. This is in contrast to partner-assisted models of couple/family-based treatments for individual psychopathology in which the partner functions as a coach or surrogate therapist (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). Second, we presume that individuals with PTSD will have significant others with their own mental health issues, whether by virtue of assortative mating (Merikangas, 1982; i.e., the tendency to partner with someone similar to oneself) or as a consequence of living with someone with untreated PTSD. The third assumption is that PTSD and relationship problems are reciprocally related. That is, we do not presume that PTSD necessarily causes relationship problems or that relationship problems cause PTSD. Rather, there is a bidirectional association in which each influences the other, which is why an intervention that addresses both concurrently is indicated. Last, following a manualized treatment such as CBCT for PTSD does not replace the need for good nonspecific therapy skills, such as warmth and empathy. Many of the patients and significant others whom we see have been struggling with PTSD and its effects for years and come to us feeling discouraged and demoralized, both about the possibility of recovery from PTSD and the thought of improving the relationship. Providing a compelling rationale for treatment and skill use in the context of an encouraging and collaborative therapeutic relationship can be a powerful motivator for change, especially given that we are asking both members of the couples to try a new way of relating to each other specifically and to others more generally.

## Therapist Preparation

Any provider sanctioned to provide psychotherapy, or in training and supervised by someone who is sanctioned to provide psychotherapy, is eligible to deliver CBCT for PTSD. With regard to preferable clinical experience, we have found that most clinicians do not have experience providing conjoint therapy for specific mental health conditions. The providers who we train often either have experience providing generic couple/family therapy or individual/group therapy for PTSD, and those therapies may or may not be evidence based. Because we have created a treatment that capitalizes on evidence-based interventions in each area, clinicians with experience in CBT for either couple distress or PTSD tend to find ease in transitioning to provide CBCT for PTSD. For example, those practitioners using couple behavioral therapy will find the communication skills training familiar; those using exposure-based therapies for PTSD will recognize the use of *in vivo* exposure exercises; and those practicing cognitive therapies for PTSD and/or relationship distress can draw on their Socratic dialogue skills. To facilitate confidence and competence in delivering the interventions, we provide a detailed set of session-by-session instructions later in this volume. In addition, we have a program that offers a variety of supports to providers to facilitate their delivery of the therapy. These supports include workshop training, group teleconsultation, and expert review of audio-recorded therapy sessions for fidelity to the model. Clinicians have the option of achieving certification in CBCT for PTSD. More information regarding our training program can be found at *www.couplestherapyforptsd.com*.

Successful implementation of a manualized therapy involves the clinician's employing the essential but nonspecific ingredients of any efficacious psychotherapy. These ingredients include building a solid working alliance with the couple based on empathy, genuineness, warmth, and support. Consistent with our attention to these key ingredients, we evaluate the presence of them and therapist competence in delivering them when we rate clinicians' adherence and competence in delivering CBCT for PTSD.



## Considerations in Implementing CBCT for PTSD

### *Piecemeal versus Protocol Implementation*

CBCT for PTSD has been designed and tested to be 15 sessions of 75 minutes. It may be tempting to treat the protocol as a guide for conducting treatment with couples in which at least one partner has been traumatized, picking and choosing interventions or allowing the treatment to expand to an undetermined number of sessions. We caution against the use of the protocol in this way. First, the interventions were developed to be sequentially delivered. Even in couples with no significant relationship distress (likely the exception rather than the rule given the research on relationship distress and PTSD; Taft, Watkins, Stafford, Street, & Monson, 2011), the interventions designed to enhance relationship functioning in Phases 1 and 2 can improve the dyadic milieu in which the individuals exist. Perhaps more importantly, distressed and nondistressed couples alike can interact in ways that advertently and inadvertently contribute to avoidance. Second, because of trauma-related distress and the related avoidance hallmark to PTSD, most people who have it will procrastinate to change. Thus, we believe that an active ingredient of the therapy is its time-limited and structured nature. We support contracting to conduct the

therapy as designed, evaluating the progress of the individuals and couples throughout and especially at the end, and then recontracting for an episode of goal-driven therapy at the conclusion of the therapy if necessary. Related to this last point, we encourage therapists to give the couple or each individual in the couple a break from therapy that is at least 1 month long (preferably longer) to determine whether further changes occur or are maintained before immediately pursuing another episode of care. Follow-up assessments from PTSD treatment studies, including CBCT for PTSD, suggest maintained gains or even further improvements in symptoms and functioning (e.g., Resick, Williams, Suvak, Monson, & Gradus, 2012). Thus, therapists are urged to allow for a break or "holiday" from treatment to determine the longer term effects of therapy and whether additional sessions are indicated.

### *Pacing Therapy Sessions*

A key to delivering manualized therapies successfully, in general, is pacing the delivery of interventions within each session. After the first session, in which the therapist speaks relatively more compared with future sessions in order to provide psychoeducation about the symptoms of PTSD in an interpersonal context and the rationale for the therapy, the therapist is urged to consider the following suggested time frames in pacing each of the 75-minute therapy sessions (see Figure 2). Approximately 30 minutes should be spent reviewing the couple's out-of-session assignment (OOSA) and/or troubleshooting difficulties in completing the OOSAs. Approximately 10 minutes is then spent teaching new skills or introducing specific content, depending on the session. Consistent with the importance of experiential exercises in couple/family therapies, we suggest that approximately 25 minutes of the session be spent practicing the new skill or focusing the couple on interacting about the new content introduced in the session. The balance of the session is spent introducing the next OOSA to the couple (approximately 5 minutes) and doing a check-out (approximately 5 minutes) from the session. The check-out consists of inquiring of the couple what they took from the session, reinforcing any learning that the therapist observed in the session, and emotionally containing or sending the couple out on a positive note as they leave the session.



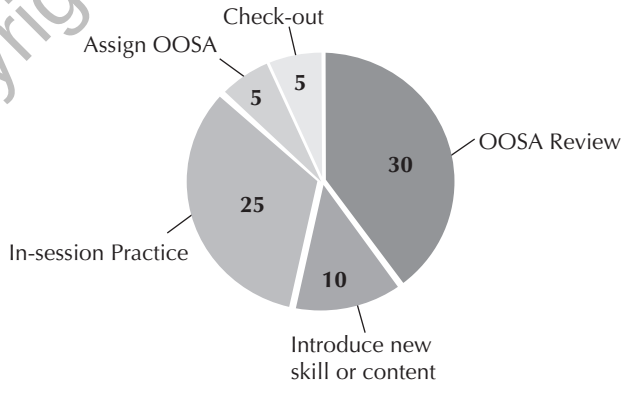


**FIGURE 2.** Pacing of CBCT for PTSD sessions beginning with Session 2 (numbers indicate minutes).

### *Managing Clients' Nonadherence to the Protocol*

One of the most important skills for a psychotherapist delivering skills-focused interventions is the management of clients' nonadherence with prescribed interventions. (Note that we use the term *adherence* rather than *compliance* to convey the shared responsibility between the couple and therapist to increase the likelihood of completing the interventions and choice on the part of the couple to engage in the interventions.) We recommend preempting nonadherence whenever possible, and this begins at the point of treatment contracting. As discussed further in Chapter 2, we recommend reviewing couples' prior experiences with psychotherapy to determine the number and types that they have pursued to improve their relationship and to assess their experience with therapies that require work outside of session. In contracting for a course of CBCT for PTSD, it is important that both members of the couple are fully informed about the expectation of completing tasks outside of session. We specifically introduce the value of "getting the interventions out of the therapy room and into their lives," noting the documented relationship between homework completion and treatment outcomes (Kazantzis, Deane, & Ronan, 2000; Kazantzis, Whittington, & Dattilio, 2010).

Laying a rationale for the OOSAs assigned at the end of each CBCT for PTSD session is an integral step to maximizing adherence. If a client does not understand the reason for an assignment, he or she is less likely to see it as important and tied to recovery. For example, in CBCT for PTSD, couples are assigned OOSAs related to decreasing avoidance and increasing the occurrence of shared, pleasurable events (i.e., approach assignments). If the couple does not understand the role of avoidance in maintaining PTSD and relationship problems, they are not likely to engage in behaviors that cause distress in the short term for longer term benefits. After assigning an OOSA, it is useful to ask the couple why you are asking them to engage in particular tasks in order to gauge their understanding of the rationale for completion and to assess whether both of them seem to understand and buy into it. This gives you an opportunity to correct any misunderstandings about the assignment or the reasons for asking them to do it. We also let the couple know that we will begin the next session with a review of the work that they have done outside of session.

To promote OOSA adherence and decrease the likelihood of spending too much time on the couple's most recent conflict, the clinician should begin each session with an inquiry about how the OOSAs went. This will help focus the session and reinforce the value placed on OOSA completion. The therapist should be sure to review the couple's written work and praise them for any efforts, even if small in nature, and determine with the couple any areas in need of troubleshooting to improve the efficacy of the interventions.

When nonadherence occurs, we recommend five steps to address it. The first is to determine what got in the way of completing the assignment. For example, did the couple not understand what they were asked to do (knowledge deficit)? Do they believe that PTSD and/or their relationship cannot improve (motivational deficit)? Both partners may have different barriers to completing the assignment, and each of their reasons should be elucidated in order to address adherence maximally. The second step is to inquire why they might choose to do the specific OOSAs. It is our experience that clinicians are prone to telling couples the value of doing the assignments when nonadherence occurs. Consistent with the curious spirit of the cognitive interventions making up CBCT for PTSD, we suggest that you become and remain very inquisitive

with the couple about why they might choose to complete the OOSAs, even suggesting that they treat the assignments as experiments to see what might happen if they were to try them.

The third recommended step in addressing nonadherence is to do some work in session. To increase the likelihood of completion the first time or subsequent times that an assignment is made, it is recommended that the therapist do a bit of the work in session. For example, if the couple did not practice paraphrasing at least 5 minutes per day after Session 3, the therapist could ask the couple to practice the skill briefly in session with the therapist coaching. A key part of this recommendation is that the couple does only some, not all, of the work in session. Otherwise, the couple may rely on session time only to complete assignments.

The fourth step is to anticipate barriers and how to overcome them. When thinking about completing the work, what do the partners anticipate will get in the way? What will they do when that happens? After collecting this information, it is recommended that you get very specific about the "who, what, when, and where" of OOSA completion for the next time—the more concrete the better. The couple should consider who will prompt completion (taking turns is recommended to maintain a good balance of power between partners), what they will complete, when they will complete it, and where they will get it done. A concrete example is difficulty completing the OOSA approach assignment of riding public transportation. In session the therapist helps the couple determine which partner will initiate the actual ride, the form of transportation, the day and time it will happen, and the stop they will get on and off. The therapist reviews at the next session how the assignment went.

The final step in addressing nonadherence is to reassign the OOSA and move on to the next. It is important not only to reassign the OOSA not completed but also to assign the next set of OOSAs. This approach helps you to send a message of expected mastery—you believe that they can do the assignments and, therefore, you do not need to hold them up until they "get it." It also helps you to avoid collusion with any avoidance stemming from the PTSD and relationship problems.

We find that couples will complete assignments if there is expectation that they will do them and the therapist follows the principles just outlined. Realistically, couples do not routinely complete 100% of the OOSAs assigned. We aim for at least 75% adherence, yet we are consistently troubleshooting with the couple how they can further maximize their OOSAs. As we indicate in the session-by-session protocol that follows, if the couple comes to Session 4 and has not achieved at least 75% adherence, we strongly encourage the clinician and clients to revisit their treatment contract. Perhaps it is not the optimal time or circumstance to endeavor CBCT for PTSD. As a therapist, it is crucial to keep in mind the pitfalls of continuing with an evidence-based treatment protocol when your clients are minimally adherent. You run the risk of a partial response or nonresponse to treatment, which can leave the clients feeling hopeless, like a failure, and/or negative about evidence-based treatment. You or the next therapist also has that treatment history to overcome.



## Summary

CBCT for PTSD is built on a theoretical model that facilitates a dyadic conceptualization of posttraumatic mental health and relationship problems. It is time to move beyond individual-centric conceptions of posttraumatic stress problems to appreciate more fully the power of

interpersonal relations in trauma recovery. Significant others play a critical role in engaging the traumatized individual in clinical services, maintaining their commitment to treatment, and promoting their recovery through therapy. This model is a time-limited and manualized therapy option for clinicians who might have minimal experience or confidence either in treating traumatized others or in providing a conjoint therapy to those who have been traumatized. The interventions making up CBCT for PTSD have empirical support in the individual PTSD and couple therapy outcome literatures. Moreover, the specific protocol has scientific and clinical evidence supporting its use in treating traumatic stress-related problems, enhancing the mental health and well-being of the significant others of those with these problems, and improving the relationship problems associated with these problems in order to live a quality life. We turn our attention next to assessment, case conceptualization, and therapy progress monitoring.





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