Couple Treatment for Posttraumatic Stress Disorder

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Posttraumatic stress disorder (PTSD) affects not only the people suffering from the disorder but also those surrounding them. PTSD is one of the mental health difficulties most strongly associated with relationship distress (Whisman et al. 2000); it has a strong association with a range of family problems, including mental health difficulties in partners and children (Monson et al. 2009; Renshaw et al. 2011; Taft et al. 2011). PTSD can elicit responses from friends and family that are well-meaning but may maintain the symptoms of PTSD, such as helping the individual with PTSD avoid reminders of the trauma, which may over time erode these relationships and place increased burden on family members, leading to negative mental health outcomes (Caska and Renshaw 2011). These accommodative behaviors may also reinforce avoidance associated with PTSD (Figley 1989). Consistent with research documenting that negative social interactions in the wake of trauma are among the most robust risk factors for PTSD (e.g., see Wagner et al. under review for a review), negative family interactions have been linked to poorer individual cognitive-behavioral therapy outcomes (Monson et al. 2005; Tarrier et al. 1999). Moreover, individual evidence-based treatments for PTSD do not consistently improve relational functioning (e.g., Galovski et al. 2005; Monson et al. 2012c; Lunney and Schnurr 2007). Consequently, there have been efforts to develop and test dyadic treatments that improve relational functioning and PTSD and, in some

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cases, also improve the health and well-being of partners. The current chapter describes different ways to conceptualize couple treatment in the case of PTSD and reviews the efficacy of these interventions.

24.1 Conceptualizing Partner Involvement in Treatment

When making the decision to involve loved ones in the treatment of PTSD, it is necessary to establish the treatment targets. More specifically, it is important to establish whether the desired outcomes of treatment are reduction in PTSD symptoms, improved relationship functioning and satisfaction, or both. A heuristic has been developed to describe and categorize the different types of couple treatments for PTSD based on their intended focus – improving PTSD and/or relationship functioning (Monson et al. 2012b). This heuristic builds upon work in both couple and family therapy by expanding the description of couples to include other loved ones (Baucom et al. 1998). This also builds upon work in the substance abuse literature by including interventions that are used to enhance treatment delivery (Miller et al. 1999).

Dyadic interventions for PTSD can be categorized into four general types of intervention:

1. Disorder-specific couple therapy
2. Partner-assisted interventions
3. Generic couple therapy
4. Education and family-facilitated engagement

First, disorder-specific couple therapies are interventions explicitly designed to target both PTSD symptoms and relationship functioning and satisfaction. Loved ones are integrated into these therapies to simultaneously improve both of these targets. Interventions are typically developed to target mechanisms of action that contribute to both treatment targets.

Second, partner-assisted interventions involve loved ones in therapy by having them act as a "coach" to the individual with PTSD, and the treatment target is reduction of PTSD symptoms. The loved one is used to enhance the treatment for the individual with PTSD, and treatment is often delivered in an individual format. Relationship functioning or satisfaction is not the target of these interventions. Rather, the interventions educate loved ones about how to assist the individual with PTSD successfully complete a trauma-focused intervention.

Third, generic couple therapy refers to interventions designed to target relationship functioning. These interventions do not explicitly target PTSD symptoms but may improve PTSD symptoms and the psychological health and well-being of the loved one by improving interpersonal interactions. These treatments do not specifically target the mechanisms maintaining PTSD symptoms, however.

Fourth, interventions may use loved ones to help engage the individual in PTSD treatment and/or to provide psychoeducation about PTSD and evidence-based treatments. The target of these interventions is not PTSD symptom reduction specifically but, rather, engagement in treatment and/or education.

24.2 Evidence Supporting Couple Treatments for PTSD

The following section reviews the evidence for each type of intervention for PTSD, organized according to the heuristic described above (see Table 24.1 for an overview). The review begins with those interventions with the strongest evidence and dual treatment targets.

Table 24.1 Intervention descriptions and key outcomes

Intervention	Description	Key outcomes
Disorder-specific couple therapy		
Cognitive-Behavioral Conjoint Therapy for PTSD (CBCT for PTSD)	15-session dyadic intervention targeting relationship satisfaction and PTSD symptoms. Composed of three phases: (1) psychoeducation and safety building; (2) dyadic skill-building, including communication and in vivo-graded exposures; and (3) trauma-focused cognitive interventions	Three uncontrolled studies and a wait-list controlled trial have demonstrated significant improvement in PTSD symptoms and increased relationship satisfaction (Monson et al. 2004, 2011, 2012a, c; Schumm et al. 2013)
Strategic Approach Therapy (SAT)	10-session couple therapy consisting of three phases: (1) motivational enhancement and psychoeducation, (2) relationship enhancement, and (3) partner-assisted exposures	A sample of six couples found improvement in avoidance and numbing symptoms of PTSD. Relationship adjustment outcomes not reported (Sautter et al. 2009)
Emotionally Focused Couple Therapy for PTSD (EFCT for PTSD)	12–20 session couple therapy focusing on identifying and understanding trauma-associated emotions. Composed of three phases: (1) identifying negative interactions, (2) dyadic skill-building including acceptance and communication, and (3) interactional and coping strategies	Two case studies and one case study replication with 10 couples have found improvements in relationship satisfaction and PTSD symptoms (Greenman and Johnson 2012; Johnson 2002; MacIntosh and Johnson 2008). Several cases of increased emotional abuse were noted, however, in couples where abuse was already present (MacIntosh and Johnson 2008)
Partner-assisted interventions		
Lifestyle Management Course	Five-day group residential program for Australian veterans and partners. Wide range of topics covered, including psychoeducation, self-care, problem-solving, and stress management	Gains in veterans' PTSD symptoms at post-intervention were not maintained at 6-month follow-up. Sustained reductions in depression, anxiety, and stress. No improvement in relationship satisfaction (Devilly 2002)

(continued)

Table 24.1 (continued)

Intervention	Description	Key outcomes
Generic couple therapy		
Behavioral Couple/ Family Therapy (BC/FT)	Behavioral interventions used to improve communication skills and problem-solving	In a randomized controlled trial with BFT following individual exposure therapy versus individual exposure therapy alone revealed greater improvement in problem-solving with BFT. No additional gains in PTSD symptoms with BFT (Glynn et al. 1999). Likewise, uncontrolled trials reveal some improvement in relationship functioning but not PTSD symptoms (Cahoon 1984; Sweany 1987)
K'oach program	Month-long intensive treatment program for Israeli veterans with PTSD. Some spousal involvement. Program includes psychoeducation, communication skills, and problem-solving	Reported improvements in relationship satisfaction. No change reported in PTSD symptoms (Rabin and Nardi 1991; Solomon et al. 1992)
Education and family facilitated engagement		
Support and Family Education program (SAFE)	14-session educational program for family members of veterans with mental health difficulties. Workshop sessions include topics such as psychoeducation, skills training, problem-solving, and stress reduction	Few outcomes reported. Program evaluation noted very high participant satisfaction, and participation led to better understanding of mental health difficulties, awareness of resources, and engagement in self-care (Sherman 2003)
Reaching Out to Educate and Assist Caring, Healthy Families program (REACH)	16-session psychoeducation program for veterans and family members. Three phases included goal-setting and rapport building, psychoeducation, and maintenance of gains	Few outcomes reported. Program evaluation noted high program retention and high participant satisfaction ratings (Sherman et al. 2011)
Coaching into Care program	A telephone intervention available to family members of US veterans providing guidance to encourage veterans to access mental health services	Reports indicate some increase in veteran health-care service use after family members have used the program (Sayers et al. 2011)

24.2.1 Disorder-Specific Couple Therapy

Three types of disorder-specific couple therapy for PTSD have been examined thus far in the literature.

24.2.1.1 Cognitive-Behavioral Conjoint Therapy for PTSD

Cognitive-Behavioral Conjoint Therapy for PTSD (CBCT for PTSD) is a 15-session conjoint therapy designed to reduce PTSD symptoms and enhance

relationship satisfaction. The therapy consists of three phases: (1) psychoeducation about PTSD and safety building; (2) dyadic skill-building, specifically focusing on communication skills and graded in vivo approach assignments to reduce avoidance and increase mutually satisfying activities for the dyads; and (3) trauma-specific cognitive interventions to address problematic trauma appraisals and beliefs maintaining PTSD and relationship problems. CBCT for PTSD has been tested in three uncontrolled studies with Vietnam veterans, Iraq/Afghanistan veterans, and community members, as well as a wait-list controlled trial (Monson et al. 2004, 2011, 2012a; Schumm et al. 2013). All four studies have revealed significant improvements in PTSD symptoms as well as increased relationship satisfaction, even when couples do not begin treatment relationally distressed. In addition, intimate partners participating in CBCT for PTSD showed evidence of improvements in their psychological functioning (Monson et al. 2005; Shnaider et al. 2014).

24.2.1.2 Strategic Approach Therapy

Strategic Approach Therapy (SAT) is a 10-session behavioral couple therapy that specifically targets avoidance and numbing symptoms of PTSD. The treatment consists of three phases: (1) motivational enhancement and psychoeducation about PTSD (focusing on avoidance symptoms in particular), (2) relationship enhancement and increased emotional intimacy, and (3) partner-assisted graded exposures for anxiety reduction. One study presenting findings from six couples (all heterosexual couples with male military veteran partners with PTSD) noted significant improvements in overall PTSD symptoms by patient, partner, and clinician ratings, but no reductions in reexperiencing or hyperarousal symptoms, except for patient ratings of reexperiencing. Relationship adjustment outcomes have not been reported (Sautter et al. 2009).

24.2.1.3 Emotionally Focused Couple Therapy for Trauma

Emotionally Focused Couple Therapy for Trauma (EFCT for Trauma) is a 12–20 session experiential couple therapy that focuses on identifying and understanding trauma-associated emotions. The therapy aims to determine how these emotions affect relationships, attachment, and communication. The intervention has three components: (1) identification of negative relational interactions, (2) dyadic skill-building through acceptance and communication, and (3) development and consolidation of positive patterns of interaction and coping strategies. Single-case and case replication studies report outcomes from the therapy (Greenman and Johnson 2012; Johnson 2002; MacIntosh and Johnson 2008). In the case study replication of ten couples, half of the participants reported improvements in relationship satisfaction at posttreatment and all participants with PTSD demonstrated clinically significant reductions in PTSD symptoms. Three couples in the study demonstrated an increase in emotional abuse and decreased relationship satisfaction over the course of the treatment. The authors caution that EFCT for Trauma may not be indicated for couples with ongoing emotional abuse (MacIntosh and Johnson 2008).

24.2.2 Partner-Assisted Interventions

24.2.2.1 Lifestyle Management Course

A 5-day, residential Lifestyle Management Course was developed for Australian military veterans and their partners to address quality of life and psychological symptoms (Devilly 2002). The course was delivered in a group format, and various topics were discussed throughout the week, including diet and nutrition, relaxation, communication, PTSD psychoeducation, self-care, stress management, medications, alcohol use, anger management, self-esteem, problem-solving, and goal-setting. Although there were reductions in PTSD symptoms following the program, by 6-month follow-up the effects were minimal. Reductions in veterans' depression, anxiety, and stress were sustained at 6-month follow-up. The partners of the veterans noted larger improvements on all measures except for anger. No improvements in relationship satisfaction were found.

24.2.3 Generic Couple Therapy

24.2.3.1 Behavioral Couple/Family Therapy

Behavioral Couple/Family Therapy (BC/FT) generally involves improving interactions among family members or partners and enhancing communication. A randomized controlled trial tested BFT following individual exposure treatment for PTSD with veterans (Glynn et al. 1999). Individuals who received BFT subsequent to individual exposure therapy had greater improvements in interpersonal problem-solving compared with those who did not. No additional improvements were seen in PTSD symptoms following BFT. Several uncontrolled studies of group BCT with veterans with PTSD and their female partners have yielded improvements in relationship functioning but not PTSD symptoms (e.g., Cahoon 1984; Sweany 1987).

24.2.3.2 K'oach Program

The K'oach program is a month-long intensive treatment program for Israeli military veterans with PTSD (Rabin and Nardi 1991; Solomon et al. 1992). The program provides PTSD psychoeducation, communication, and problem-solving skills. The program incorporates spouses at several times over the course of treatment to learn cognitive, communication, and behavioral reinforcement skills. Minimal empirical research has been conducted on the efficacy of the K'oach program, although participants reported improved relationship satisfaction. No change was found in PTSD symptoms (Solomon et al. 1992).

24.2.4 Education and Family Facilitated Engagement

24.2.4.1 Support and Family Education Program

The Support and Family Education (SAFE) program is a 14-session educational program for the loved ones of veterans with mental illness (Sherman 2003). The

program is delivered in a monthly workshop format. It is designed for a range of mental health difficulties (e.g., PTSD, schizophrenia, depression) and for any family member to attend. The program includes psychoeducation about mental health difficulties, as well as four sessions of skills training, problem-solving, and stress reduction. Although no assessment of the impact of the SAFE program on PTSD symptoms and/or relationship functioning for the individual with PTSD or their loved ones has been conducted, 3- and 5-year program evaluations report very high participant satisfaction (Sherman 2003, 2006). Findings suggest that program participation led to increased understanding of mental health difficulties, awareness of resources, and increased ability to engage in self-care activities. Fewer attended sessions were associated with higher distress in loved ones (Sherman 2003).

24.2.4.2 Reaching Out to Educate and Assist Caring, Healthy Families Program

The Reaching Out to Educate and Assist Caring, Healthy Families (REACH) program is a 16-session psychoeducation program for veterans with mental health difficulties and their family members (Sherman et al. 2009b). The program consists of three phases. The first phase is a 4-week session conducted with the veteran and his or her family. This phase focuses on goal-setting and rapport building. The second phase is a 6-week session of diagnosis-specific psychoeducation for a group of four to six veterans and their families. The third phase is 6-month group session to support ongoing education and maintain gains. A preprogram motivational interviewing strategy was also used to engage veterans with the REACH program (Sherman et al. 2009a). Participants with PTSD had a relatively high rate of retention across phases I and II of the program (of those who began phase I, 90 % completed that phase, and 97 % who began phase II completed that phase), although there was 25 % attrition between phases I and II (Sherman et al. 2011). Data was not reported for phase III. Participants reported high satisfaction with the program (Sherman et al. 2011). No data regarding PTSD symptom change or relationship satisfaction was reported.

24.2.4.3 Coaching into Care Program

A program has been developed whereby loved ones of veterans who are suspected to have PTSD and other trauma-related symptoms can call a telephone support service to receive guidance on how to facilitate engagement of their loved one in treatment. The program provides information about available treatment options, allowing loved ones to assist the veteran in accessing care in a non-coercive manner. Initial program evaluation has demonstrated some increase in veteran engagement in mental health services after use of the program (Sayers et al. 2011).

24.3 Discussion

The mental health field is beginning to recognize the permeating effects of trauma and PTSD on interpersonal relationships and the role of these relationships in improving the lives and well-being of those with PTSD. There are a variety of ways in which

partners might be incorporated into treatment, including disorder-specific couple therapy, partner-assisted interventions, general couple therapy, and education and engagement interventions. The class of disorder-specific couple therapy for PTSD has the strongest empirical support in terms of achieving multiple outcomes (i.e., reductions in PTSD, improvements in relational functioning, improvements in partners' psychological functioning). Because PTSD has systemic-level implications for relationships with loved ones, targeting both the individual with PTSD and their partner in treatment seems to have greater effects across both symptom and relational domains. If the client and the partner are both willing to participate in a dyadic intervention for PTSD, disorder-specific couple therapy is recommended, regardless of level of relationship distress, because these interventions have been tested with couples across the spectrum of relationship satisfaction. Caution should be heeded, however, if the couple has ongoing emotional abuse for interventions focused explicitly on emotions.

Depending on the desired focus of treatment and client preference, however, other types of treatment described in the aforementioned heuristic may be most appropriate. For example, should the client be engaged in individual PTSD treatment and/or not want their partner to participate in trauma treatment with them but are experiencing relationship distress, also engaging in generic couple therapy may be helpful. Decreasing stress in social relationships may help the client participate more fully in individual treatment and can help improve treatment outcomes (e.g., Price et al. 2013).

Evidence-based individual, couple, and group interventions for PTSD only matter if individuals with PTSD engage in them. Thus, using partners and other loved ones to facilitate engagement in assessment and treatment represents an important innovation in the traumatic stress field. Moreover, partner-assisted interventions may be beneficial if additional assistance is needed to implement individual interventions that have been shown to ameliorate PTSD. However, we recommend that partner-assisted interventions be chosen and implemented with caution and may be contraindicated if the couple is experiencing significant distress based on prior research on partner-assisted interventions for clients with agoraphobia (Barlow et al. 1981).

Given the importance of social variables in the onset of PTSD and other traumatic stress-related disorders, we argue that early intervention strategies for preventing acute stress disorder and PTSD incorporate significant others. There have been some efforts to include significant others in these interventions (Billette et al. 2008; Guay et al. 2004), but no full protocol has been developed and no randomized controlled trial has been conducted to date. Several have offered suggestions about the types of interpersonal interventions that might be used to reduce mental health problems in the early period after traumatization (e.g., Guay et al. 2006, 2011; Litz et al. 2002; Wagner et al. under review).

In addition to considering the inclusion of significant others in the early intervention and treatment of PTSD, couple therapy for PTSD may be particularly important for cases of "complex PTSD (C-PTSD)," which has been put forth by a number of authors (e.g., Cloitre et al. 2012), and is considered for inclusion in the upcoming version of the International Classification of Disorders (Maercker et al. 2012). One of the symptoms of C-PTSD put forth is disturbances in interpersonal relationships. Thus, interventions that simultaneously target interpersonal relationship

functioning should address these symptoms postulated to comprise C-PTSD and may potentiate treatment for C-PTSD. Likewise, couple therapy may be particularly well suited for "complicated/protracted/prolonged grief" (Boelen and Prigerson 2013), especially when the loss is shared by the couple.

Couple interventions for PTSD, with its range of possible modes of delivery, present compelling preliminary data in terms of treatment outcomes. This area of research is still in its infancy, however, and additional research is warranted to further establish the long-term effectiveness of the interventions and to extend findings into community samples, as the vast majority of the work thus far has been done within the veteran population. Couple-oriented interventions for PTSD address the systemic nature of PTSD and provide hope for not only improvements in the client's PTSD symptoms but also the partner's functioning and improved relationship satisfaction.

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