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Post-Traumatic Stress Disorders (K Chard and T Geracioti, Section Editors)

Couple Therapy for PTSD

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Opinion statement

Research has consistently documented a bidirectional association between posttraumatic stress disorder (PTSD) symptoms and intimate relationship functioning. PTSD symptoms are associated with greater relationship distress, higher likelihood of divorce, decreased emotional intimacy, and increased sexual dysfunction. Conversely, specific relational factors and interaction patterns (e.g., hostility, partner accommodation of PTSD symptoms) can serve to maintain or exacerbate PTSD symptoms. Given this reciprocal relationship, several couple therapies for PTSD have been created and empirically examined. Therapies that have been empirically studied include behavioral family therapy, emotionally focused couple therapy, strategic approach therapy, and cognitive-behavioral conjoint therapy for PTSD (CBCT for PTSD). To date, CBCT for PTSD has accumulated the most supporting evidence in the most diverse samples. Collectively, these empirical studies suggest that CBCT for PTSD is associated with improvements in PTSD, comorbid mental health symptoms, some partners' mental health symptoms, and relationship satisfaction. CBCT for PTSD is a 15-session, trauma-focused PTSD treatment that occurs within a conjoint context. The therapy includes three phases: (1) psychoeducation and safety building, (2) communication skills and dyadic approach tasks to undermine avoidance, and (3) cognitive change regarding historical trauma appraisals and here-and-now maladaptive cognitions that maintain PTSD symptoms and/or relationship problems. Given the evidence supporting conjoint therapies for PTSD, clinicians should consider systematically involving partners in PTSD treatments to facilitate treatment by targeting both individual and relationship

factors maintaining PTSD symptoms, as well as cultivate the strength within the couple's relationship to encourage them to confront PTSD as a team.

Introduction

Posttraumatic stress disorder (PTSD) is associated with a range of negative consequences, including physical, psychosocial, and quality of life concerns [1]. Research has consistently documented the adverse impact of PTSD on intimate relationships (see [2] for a meta-analysis). More specifically, individuals with PTSD are more likely to experience relationship difficulties, to divorce and divorce multiple times, to perpetrate verbal and physical aggression against partners, to suffer sexual dysfunction, and to experience substantial impairments in emotional expressiveness (for a review, see [3]). Partners of individuals with PTSD also report an increased rate of mental health difficulties, such as depression, anxiety, and caregiver burden [4].

Studies using the former diagnostic system's (DSM-IV-TR) [5] definition of PTSD suggest that the avoidance/emotional numbing cluster of symptoms is primarily responsible for intimate relationship dysfunction and impaired intimacy (e.g., [6]). Avoidance may interfere with partners engaging in pleasant activities together, whereas emotional numbing may lead to difficulty experiencing and sharing emotions [7]. Emotional numbing may also cause a lack of interest in or aversion to emotional or physical closeness with another person. When partners are emotionally and physically distant from one another, relationship satisfaction and intimacy diminish. Additionally, partners generally report finding the emotional numbing symptoms of PTSD most distressing [8].

In addition to decreased emotional intimacy, individuals with PTSD are at greater risk of intimate partner aggression. As severity of symptoms increases, individuals with PTSD become more likely to perpetrate aggression [2]. Studies suggest that the hyperarousal symptom cluster, which is linked to difficulty managing anger, may be most responsible for increased aggression [9, 10]. Additionally, comorbidities, such as alcohol use, play a role in the relationship between PTSD and aggression. Savarese and colleagues [9] found that quantity of alcohol consumption in US Vietnam veterans moderated the association between PTSD hyperarousal symptoms and partner aggression. Higher quantities of alcohol use led to greater violence, even at lower levels of hyperarousal; however, frequent, low-quantity alcohol use appeared to mitigate the relationship between hyperarousal and aggression. Using the same sample, Taft and colleagues [11] found that male veterans with PTSD who engaged in partner aggression reported more symptoms of depression and drug abuse or dependence and lower marital satisfaction compared with non-aggressive veterans with PTSD.

In addition to the robust relationship between PTSD and intimate relationship difficulties, research has also documented relationship factors that may contribute to the development or maintenance of PTSD symptoms. Lack of positive social support following trauma exposure may increase the likelihood of a diagnosis of PTSD [12, 13]. Additionally, specific interaction patterns between intimate partners may serve to maintain or exacerbate PTSD symptoms [14]. Poor communication and relationship conflict, together with PTSD-related avoidance, may limit disclosure in relationships. Disclosure of trauma-related material in close relationships has been found to mediate the relationship between partner support and PTSD symptoms, and disclosure is negatively related to relationship distress [15]. Even if high conflict is not experienced within a relationship, partners of those with PTSD may engage in accommodative behaviors in an effort to avoid triggering their partners' PTSD symptoms or relationship conflict [16]. For example, partners may take over tasks or chores, run interference with family members, or disengage from social activities in an effort to support the person with PTSD. Fredman and colleagues hypothesized that partner accommodation is a contributing factor to the maintenance of PTSD symptoms through continued avoidance, and they found that partner accommodation is linked to higher PTSD and depressive symptoms, greater trait anger, greater partner depressive and state anger severity, lower patient and partner relationship satisfaction, and less perceived social support received from their partners with PTSD [16]. Despite partners' good intentions, they may be unwittingly helping to maintain their loved one's PTSD symptoms. However, participation in couple-based treatment for PTSD appears to mitigate the effect of partner accommodation of PTSD symptoms on patient's treatment outcomes, including PTSD and depressive symptom severity and

patient-rated relationship satisfaction [17]. Furthermore, even when individuals receive evidence-based individual treatment for PTSD, low positive social support and high negativity in family environments attenuate treatment gains and impede recovery [18, 19].

Empirical evidence for couple-based therapies for PTSD

Given the bidirectional nature of the relationship between PTSD symptoms and intimate relationships, greater family involvement in treatment is often desirable. Several couple-based interventions for PTSD have been created to simultaneously address PTSD symptoms and relationship functioning. Below, we review published, empirical studies testing the efficacy of couple interventions for PTSD. In addition to the studies reviewed below, additional couple-based interventions have been theoretically proposed (e.g., Critical Action Theory for combat-related PTSD [20], Reaching out to Educate and Assist Caring, Healthy Families [21]), but not empirically evaluated, while others have been evaluated within a trauma-exposed, rather than a PTSD-positive, sample (e.g., family systems therapy [22], Koach [23, 24], Operation Restoration [25]). Following the review of empirical studies, we describe in detail one of the interventions with the most established evidence to date, cognitive-behavioral conjoint therapy for PTSD (CBCT for PTSD) [26•].

In one of the earliest published studies to test the efficacy of couple/family therapy for PTSD, Glynn and colleagues [27] evaluated whether behavioral family therapy following individually directed therapeutic exposure would facilitate positive outcomes. Forty-two Vietnam veterans diagnosed with PTSD and a close family member (89 % romantic partners) were assigned to one of three conditions: (1) directed therapeutic exposure alone; (2) directed therapeutic exposure followed by behavioral family therapy, which included communication and problem-solving skills training; and (3) waitlist. Results revealed that both active treatment groups experienced a decrease in the positive symptoms of PTSD (i.e., re-experiencing, hyperarousal) as compared with waitlist; however, there was no statistically significant difference between treatment groups, though the authors reported that the behavioral family therapy group experienced twice as large a decrease in positive symptoms as the exposure-only group. The group receiving behavioral family therapy did report a significant increase in problem-solving skills as compared with the exposure only and waitlist conditions.

Emotionally focused couple therapy (EFCT) [28] focuses on the role of emotion within rigid interaction patterns and emphasizes the importance of affect in therapeutic change. Only one published study has investigated the efficacy of EFCT within a PTSD population. MacIntosh and Johnson [29] examined the effects of EFCT in a small sample ($N = 10$) of childhood sexual abuse survivors. Following an average of 19 sessions, half of the couples reported clinically significant improvements in PTSD symptoms and relationship satisfaction. All individuals with PTSD experienced clinically significant improvements in clinician-rated PTSD symptoms. However, three couples experienced increases in emotional abuse or verbal aggression and terminated their relationship during the course of therapy. A second study investigated the

effects of EFCT [30] in a sample of women exposed to childhood sexual abuse and their partners; however, a diagnosis of PTSD was not necessary for inclusion in the study. Results revealed an improvement in relationship distress, but not trauma-related symptoms.

Structured approach therapy (SAT; originally known as strategic approach therapy) is a couple-based therapy designed specifically to reduce PTSD-related avoidance symptoms, including both effortful avoidance and emotional numbing [31]. SAT involves providing the couple with psychoeducation about PTSD, using stress-inoculation strategies to build emotion regulation skills, and conducting partner-assisted exposure and trauma disclosure. SAT was developed using two small pilot studies, one of male Vietnam veterans and their wives [31] and one of male Iraq War veterans and their wives [32]. These studies found that SAT led to significant reductions in overall, avoidance, and emotional numbing PTSD symptoms, partner depression and anxiety, and significant improvements in relationship satisfaction in the majority of patients and partners. Recently, SAT was examined in a randomized clinical trial of Iraq and Afghanistan veterans and their partners [33•]. Fifty-seven couples were assigned to SAT or PTSD family education (PFE). PTSD symptoms decreased in both groups, but SAT produced significantly greater improvement. Patient, but not partner, relationship satisfaction and attachment-related avoidance improved in the SAT group as compared with PFE. Additionally, partner attachment anxiety decreased in the SAT group as compared with PFE.

CBCT for PTSD [26•] is the couple-based intervention for PTSD with the most supporting empirical evidence in the widest variety of populations to date. The therapy was initially examined in three, small uncontrolled trials with male Vietnam veterans and their wives [34], male Iraq and Afghanistan veterans and their wives [35], and individuals from the community and their intimate partners [36]. Results indicate improvements in both PTSD symptoms and relationship satisfaction across a range of baseline relationship distress levels. Additionally, some partners experienced improvements in their individual mental health symptoms [37].

The efficacy of CBCT for PTSD has also been tested in a randomized controlled trial comparing CBCT for PTSD with a waitlist condition [38•]. Forty individuals with a range of traumatic events (e.g., combat, childhood physical and sexual abuse, physical and sexual assault, motor vehicle accident) were included in the trial, as well as a variety of intimate couples (i.e., married, cohabitating, noncohabitating, same sex). Results from the trial demonstrated improvements in PTSD and comorbid mental health symptoms in the CBCT for PTSD group compared with waitlist, and the effect sizes of these improvements were comparable to those found for individual trauma-focused therapies. Patient reports of relationship satisfaction also significantly improved, and these increases were maintained at 3-month follow-up; partner-rated relationship satisfaction did not change, likely because the majority of partners were relationally satisfied at baseline (65 % scored in the "satisfied" range at initial assessment). Additionally, partners reporting clinical levels of depression and anxiety symptoms at pretreatment evidenced significant improvements in psychological functioning at posttreatment [39].

Several variations of the CBCT for PTSD protocol have been created and examined. Pukay-Martin and colleagues [40] designed a present-focused version of CBCT for PTSD, which includes pleasant relationship activities in lieu of

in vivo approach exercises and cognitive challenging of here-and-now cognitions rather than historical, trauma-focused cognitions. Results from a small sample of community members and their partners revealed improvements in PTSD symptoms and relationship satisfaction; however, the decreases in PTSD symptoms were not as large as those found with the original, trauma-focused CBCT for PTSD. More research is needed to determine the relative efficacy of present-focused CBCT for PTSD. CBCT for PTSD is currently being tested with various types of dyads (e.g., couples in which both partners have a diagnosis of PTSD, sibling dyads, adult child-parent dyads), and the relative efficacy of CBCT for PTSD as compared with prolonged exposure is being tested in a randomized controlled trial with active-duty service members and their partners. In addition, the CBCT for PTSD protocol has been adapted to incorporate a mindfulness-based component and the first half of treatment has been modified for delivery in a workshop format [41]. Given the growing empirical evidence for CBCT for PTSD, the intervention is described in depth below.

A description of CBCT for PTSD

CBCT for PTSD [26•] is a treatment designed to target PTSD symptoms in a conjoint format and is appropriate for couples at all levels of relationship satisfaction (i.e., relationally distressed or satisfied). CBCT for PTSD assumes that PTSD exists within the couple's relationship and that partners can join together to "shrink" the presence of PTSD in their relationship. Therefore, the couple and their relationship is considered to be "the patient," rather than the individual with PTSD, as in individual therapies. Goals for treatment include decreasing PTSD symptoms, increasing relationship satisfaction, and addressing related mental health problems in the partner. CBCT for PTSD consists of 15, 75-minute sessions that are organized into three phases of treatment: (1) psychoeducation about PTSD and relationships and building relationship safety, (2) communication skills and approach tasks designed to decrease avoidance behaviors and increase satisfaction, and (3) dyadic cognitive interventions to promote change regarding the meaning of the trauma and problematic beliefs that maintain PTSD and/or relationship distress. Out-of-session assignments are designed to assist the couple in reinforcing skills learned in session.

Time in session is generally allocated according to the following guidelines: 30 minutes devoted to out-of-session assignment review, 10 minutes to introduce new skill or session content, 25 minutes for in-session practice and discussion, 5 minutes to assign the new out-of-session assignment, and 5 minutes for check-out. Prior to each session, the individual with PTSD completes a self-report measure of weekly PTSD symptoms, the partner provides a collateral report of weekly PTSD symptoms, and both partners complete a one-item measure of weekly relationship happiness. The therapist uses a graphical visual aid to present the couple with their weekly scores at the beginning of each session so that progress can easily be recognized, reasons for fluctuations in symptoms can be identified, and the relationship between PTSD symptoms and relationship satisfaction can be discussed.

In the first session of phase 1, the therapist provides a rationale for treatment, explaining the reciprocal nature of PTSD and relationship difficulties and factors that are thought to maintain PTSD symptoms (i.e., emotional numbing,

behavioral avoidance, and maladaptive cognitions). The therapist introduces a conjoint model of PTSD symptoms and leads the couple in a discussion of their experience of PTSD. In this early phase of treatment, the therapist assists the couple in viewing PTSD as an entity outside of their relationship (as opposed to being integral to the character of the individual with PTSD) and encouraging the partners to join together to decrease (or "shrink") PTSD. Following psychoeducation, the couple and therapist collaboratively set behaviorally-specific goals for treatment, including goals for improvements in PTSD symptoms, as well as the relationship. At the end of session, the therapist introduces the first out-of-session assignment. Between sessions, the couple is instructed to notice and record at least one positive behavior his/her partner engages in each day, which is designed to increase the positivity of the relationship milieu. Each partner is also asked to respond to several questions about the cause of the trauma and the impact of PTSD on their relationship and on their thoughts about themselves, each other, and the world. The couple is also assigned psychoeducational readings to reinforce the information provided in session.

In session 2, the couple shares their responses to the questions assigned, and the therapist highlights similarities and differences in their responses to promote an open dialogue regarding trauma and PTSD in their relationship. The remainder of the session focuses on psychoeducation regarding anger, identification of early warning signs related to anger, preventative strategies such as slowed breathing, and a dyadic intervention strategy (i.e., negotiated time out). The time-out strategy can be applicable for both high- and low-conflict couples. For high-conflict couples, time out serves as a method of de-escalating arguments so as to minimize the impact of negative behaviors (e.g., name calling, swearing, threats to end the relationship) on their relationship. For low-conflict couples, time in, which is the final step of the time-out skill, is emphasized as a vital part of time out. Many low-conflict couples are highly avoidant, and the time in serves to assist the partners in re-engaging with each other around distressing topics in an effort to better understand and potentially solve the underlying issue. The time-out strategy builds emotional and physical safety in their relationship and the couple's confidence to tackle more difficult issues later in therapy.

In phase 2, a variety of communication skills are introduced to the couple in the service of enhancing relationship satisfaction and approaching topics related to PTSD. Communication skills are described not only as a method of increasing intimacy and relationship satisfaction but also as a means of decreasing avoidance of internal emotional experience and emotional closeness. The skills build sequentially over this phase of therapy, and the couple practices use of each new skill in session on topics related to PTSD. Session 3 focuses on the importance of listening skills and paraphrasing, session 4 on sharing feelings, and session 5 on sharing thoughts and related feelings. Through these skills, the couple learns to identify and share emotions, observe the impact of their thinking on their emotions and behaviors, and notice the influence of their own thoughts, emotions, and behaviors on each other. In session 6, the couple learns a dyadic cognitive change process in which the partners identify problematic cognitions, brainstorm alternative thoughts, and choose more balanced beliefs. As part of this process, the partners devise ways to continue practicing the new way of thinking. Finally, session 7 focuses on problem solving and teaching the couple skills to make decisions as a team.

Additionally in phase 2, the couple identifies and engages in customized dyadic approach tasks designed to decrease PTSD-related avoidance. Examples of approach tasks include attending concerts, going to movies, spending time with family or friends, or running errands to crowded stores. Couples are taught to identify subtle avoidance behaviors in an effort to better address this avoidance and shrink PTSD. The importance of planning and repeating approach tasks is emphasized, as well as the necessity of experiencing distress and remaining in a situation until this distress decreases.

Phase 3 of CBCT for PTSD, the trauma-focused phase of the therapy, builds on effective communication skills, decreased avoidance, and the dyadic cognitive change strategy. The couple is taught to apply these skills to identify and challenge beliefs about the trauma, as well as thoughts that serve to maintain PTSD and/or relationship problems. In CBCT for PTSD, trauma is examined from a "10,000-foot view," and discussion focuses on the context of the trauma and the judgments the person with PTSD has made about the trauma rather than specific sights, sounds, smells, and internal sensations experienced at the time of the traumatic event. Trauma disclosure can build intimacy, assist in decreasing PTSD symptoms, and correct potential misattributions that partners have regarding PTSD. Additionally, partners often can provide new and more balanced interpretations of trauma to assist the person with PTSD in considering alternate ways to view the trauma. Processing the trauma dyadically can be a very therapeutic process for couples with PTSD.

Each session in phase 3 consists of psychoeducation regarding the impact of PTSD on a specific theme, identifying problematic thoughts either partner holds in this area, and beginning to challenge one of these thoughts in session. The couple then continues this cognitive challenging process in their out-of-session assignments. Sessions in phase 3 first focus historically on cognitions about the cause of the trauma (non-acceptance, blame) and then proceed to here-and-now topics impacted by trauma (trust, power/control, emotional closeness, physical closeness). In session 14, the couple discusses posttraumatic growth and identifies any cognitions that may impede growth following the trauma. For their out-of-session assignment, the couple again completes questions about the cause and impact of the trauma on their thoughts and relationship. In the fifteenth and final session, the couple and therapist review skills, recognize gains made during the course of therapy, identify areas for continued growth, and brainstorm strategies to continue using skills to maintain progress. The couple's new responses from their impact questions are compared to their responses provided in session 2, and this comparison is used to assist in identifying gains and areas of growth. The likelihood of lapses in PTSD symptoms and relationship satisfaction is discussed, as well as ways to manage these fluctuations in functioning.

Clinical considerations

To determine whether a particular couple is appropriate for participation in CBCT for PTSD, customary exclusion criteria for PTSD treatment should be used for both partners (i.e., imminent suicidal or homicidal risk, uncontrolled mania or psychotic symptoms, alcohol or substance use disorder requiring medical detoxification). Additionally, the couple's relationship must have a minimal

level of safety (i.e., no severe physical aggression in the past 6 months, commitment to stay in the relationship through 15 sessions of CBCT for PTSD). Because CBCT for PTSD is a stand-alone, trauma-focused therapy, participation in another trauma-focused therapy simultaneously is contraindicated because of the possibility of becoming overwhelmed by the increased "dose" of therapy and the potential to obtain conflicting messages from different clinicians.

The next factor to consider is willingness of both partners to participate in conjoint therapy and to discuss trauma-related material. Theoretically, the phases of CBCT for PTSD are designed to build sequentially; therefore, the therapist may decide to conduct assessment only, deliver phase 1 alone, provide phases 1 and 2, or implement all three phases, depending on the needs of the individuals and couple presenting for treatment. Minimally, a multimodal assessment of individual and relationship factors can be conducted and phase 1 material delivered. The psychoeducation regarding PTSD and conflict management strategies can assist couples in creating a shared understanding of PTSD and eliminating treatment-interfering behaviors (e.g., hostility, criticism, accommodation) for people who may pursue individual treatment for PTSD. Couples in which both partners demonstrate willingness to engage in a conjoint therapy can participate in phases 1 and 2. Some individuals or couples may choose not to participate in trauma-focused therapy or may not wish to discuss trauma-related material in a conjoint format. For these couples, phase 1 and 2 material may be beneficial, and more emphasis can be placed on building communication skills and engaging in repeated approach tasks. The skills to increase effective communication and manage avoidance are consistent with other trauma-focused therapies for PTSD and may provide a beneficial complement to participation in individual medication management and/or trauma-focused therapy. Finally, for couples who are willing to discuss trauma material with each other, the full course of CBCT for PTSD can be delivered as a stand-alone, trauma-focused therapy. Couples are informed that trauma-related materials will be discussed with an emphasis on the beliefs they have about the event, rather than specific sensory details. Both partners should agree to have these conversations before proceeding with phase 3. If a couple chooses to participate in phase 3, concurrently engaging in another trauma-focused therapy is contraindicated.

Conclusion

Due to the bidirectional nature of the association between PTSD and intimate relationship factors, clinicians should consider involving partners and close significant others in assessment and treatment planning for PTSD. At the very least, partners can be educated regarding PTSD symptoms and interpersonal relationships, treatment-interfering partner behaviors can be identified and eliminated, and partner support for treatment can be garnered to increase the likelihood of successful intervention. At the greatest level of partner involvement, couples can join together to use the strength of their relationship to decrease PTSD and increase their relationship satisfaction. Within each couple exists the potential to recover from PTSD and to lead rich and fulfilling lives together. As the evidence supporting couple-based therapies for PTSD accumulates, we hope that more clinicians include partners in treatment to take advantage of the healing power of intimate relationships.

Compliance with Ethical Standards

Conflict of Interest

Nicole Pukay-Martin declares that she has no conflict of interest.
Alexandra Macdonald declares that she has no conflict of interest.
Steffany Fredman and Candice Monson declare that they receive royalties related to the publication of *Cognitive-Behavioral Conjoint Therapy for PTSD: Harnessing the Healing Power of Relationships* (Guilford Press).

Human and Animal Rights and Informed Consent

This article does not contain any studies with human or animal subjects performed by any of the authors.

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