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COMMENTARY

Implementing Cognitive-Behavioral Conjoint Therapy for PTSD With the Newest Generation of Veterans and Their Partners

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As the newest generation of veterans returns home from the fronts in Afghanistan and Iraq, increased attention is being paid to their postdeployment mental health adjustment as well as the interpersonal sequelae of posttraumatic stress disorder (PTSD) and other mental health conditions. The Department of Defense has begun to invest in relationship-enhancement programs to ease the burden on both service members and their families across the deployment cycle. However, when there is the presence of PTSD, a disorder-specific conjoint treatment may be needed to address both PTSD and associated relationship difficulties. Cognitive-behavioral conjoint therapy (CBCT) for PTSD is a disorder-specific, manualized conjoint therapy designed to simultaneously improve PTSD symptoms and intimate relationship functioning. This article reviews knowledge on the association between PTSD and relationship problems in recently returned veterans and provides an overview of CBCT for PTSD. We then present a case study to illustrate the application of CBCT for PTSD to an Operation Iraqi Freedom (OIF) veteran and his wife and conclude with recommendations for how mental health providers can apply the treatment to recently returned veterans and their loved ones.

As the newest veterans return home from the fronts in Afghanistan and Iraq, increasing attention has been paid to their mental health adjustment, as well as the intimate relationships in which they exist. Families of deployed individuals must make a number of instrumental and emotional adjustments across the deployment cycle (Pincus, House, Christenson, & Adler, 2001), and the challenges associated with these sacrifices can be exacerbated by a veteran's PTSD and other mental health conditions. To assist veterans and their loved ones, who may be struggling with the sequelae of PTSD, interventions that address both PTSD and its associated relationship difficulties are urgently needed.

In this article, we provide a brief overview of research on the associations between PTSD symptoms and intimate relationship difficulties among Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) veterans, highlighting important clinical issues to consider when working with couples. We then describe a disorder-specific conjoint therapy for PTSD, cognitive-behavioral conjoint therapy for PTSD (Monson & Fredman, in press), and its application to an OIF veteran and his wife. Following this case study, we conclude with recommendations for future work to help clinicians assist veterans with PTSD and their loved ones.

PTSD Symptoms and Relationship Problems in Recently Returned Veterans

Research on previous cohorts of veterans, primarily Vietnam veterans, has consistently documented an association between PTSD and intimate relationship problems, including relationship distress, physical aggression, and problems with emotional and physical intimacy (for a review, see Monson & Taft, 2005). Emerging research on OEF/OIF veterans suggests that there is an association between PTSD symptoms and intimate relationship functioning in this cohort as well (e.g., Nelson Goff, Crow, Reisbig, & Hamilton, 2007). Given the high and increasing prevalence of mental health problems, such as PTSD, depression, and substance use disorders, among service members (Hoge, Auchterlonie, & Milliken, 2006) and the fact that problems in interpersonal relationships are especially on the rise in this cohort (Milliken, Auchterlonie, & Hoge, 2007), it is perhaps not surprising that OEF/OIF veterans who screen positive for mental health problems such as PTSD or depression are also at greater risk for having at least one family readjustment problem following their deployment (Sayers, Farrow, Ross, & Oslin, 2009).

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Partners' perceptions of veterans' experiences also appear to be an important variable in relationship adjustment. For example, Renshaw, Rodrigues, and Jones (2008) found that wives' marital satisfaction was negatively related to National Guard soldiers' PTSD symptom severity when they perceived that the soldiers had experienced low levels of combat exposure. However, when they perceived that soldiers had experienced high levels of combat exposure, there was no association between wives' relationship satisfaction and soldiers' PTSD symptom severity. These results suggest that spouses' attributions for veterans' thoughts, feelings, and behaviors might play a role in their overall relationship adjustment. Given that family members' attitudes towards patients are associated with treatment outcome for PTSD (Tarrier, Sommerfield, & Pilgrim, 1999), these findings have important clinical implications and highlight the potential benefit of involving significant others in treatment for PTSD.

Cognitive-Behavioral Conjoint Therapy (CBCT) for PTSD

Therapy Overview

CBCT for PTSD (Monson & Fredman, in press) is a disorder-specific conjoint therapy designed to simultaneously improve symptoms of PTSD and enhance intimate relationship functioning. The treatment is manualized and consists of 15 sessions organized into three stages: (a) psychoeducation about the reciprocal influences of PTSD symptoms and relationship adjustment, exercises to promote positivity, and conflict-management skills; (b) behavioral interventions that increase couple-level approach behaviors and improve dyadic communication; and (c) cognitive interventions designed to address maladaptive thinking patterns that maintain both PTSD symptoms and relationship difficulties. The stages are sequenced such that psychoeducation and conflict-management strategies are provided first to increase both partners' buy-in and commitment to the conjoint treatment and to ensure the physical and emotional safety of both members of the couple prior to endeavoring the communication skills training and joint in-vivo approach exposure exercises that characterize Stage 2. The behavioral interventions in Stage 2 precede the dyadic cognitive restructuring in Stage 3 so that couples can rely on their improved ability to communicate and decreased tendency to avoid when asked to do the trauma-focused work that forms the basis of the third stage of treatment.

Sessions of CBCT for PTSD are 75 minutes each and conclude with out-of-session assignments designed to promote the couple's skill use in their everyday lives. The treatment is trauma-focused but not imaginal exposure-based. That is, events are discussed in enough detail for those involved in the therapy to have a shared sense of what happened so that dyadic cognitive restructuring can be done. Explicit renditions of the events are discouraged. This is in contrast to more traditional, individually delivered exposure-based therapies for PTSD (e.g., prolonged exposure; Foa, Hembree, & Rothbaum, 2007), in which patients are encouraged to repeatedly review events in exquisite detail until habituation or extinction of anxiety related to feared memories occurs. We have found that the strategy of discussing the trauma(s) in "broad brush strokes" rather than in "nitty gritty" detail works well to facilitate shifts in thinking about the event and its consequences, while decreasing the likelihood that patients and their partners might become unduly emotionally distressed in response to patients' sharing trauma-related material.

In the first session of CBCT for PTSD, the therapist provides the couple with a rationale for treatment and psychoeducation about PTSD and its symptoms, an explanation of how avoidance and problematic thoughts maintain PTSD, and ways that PTSD can contribute to and maintain relationship problems. The second session of this stage focuses on enhancing physical and emotional safety in the relationship for both partners. Couples are provided with psychoeducation about the role of PTSD in relationship functioning as it relates to dysregulation in the autonomic nervous system and are taught primary (e.g., slowed breathing) and secondary prevention strategies (e.g., time-out) for managing conflict.

In Stage 2 (Sessions 3 through 7), the focus is simultaneously on enhancing relationship satisfaction and decreasing behavioral and experiential avoidance. Enhanced couple communication is used as an antidote to PTSD-related emotional numbing and avoidance and a means of increasing emotional intimacy. 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. The couple then uses these communication skills to discuss PTSD-related content and to problem-solve how they will "shrink" the role of PTSD in their relationship by collaboratively addressing PTSD-related behavioral and experiential avoidance. It is this couple-level avoidance of places, situations, people, and emotions that is believed to contribute to and maintain both PTSD and relationship difficulties. To address it, the couple develops a list of avoided people, places, situations, and feelings, and with the therapist's guidance, increasingly challenging approach activities are assigned. In contrast to traditional individually delivered in-vivo exposure assignments, SUDS ratings are not collected, and the couple's relationship is the unit of intervention. In this way, both members of the couple participate in the in-vivo exposure

approach activity rather than the partner serving as a "coach" for the PTSD-identified client. One couple we worked with had stopped going to restaurants because crowded venues served as PTSD-related triggers for the veteran. In the course of an in-session communication exercise, the couple identified and shared their feelings about the fact that PTSD had interfered with their ability to do fun things together and then discussed how they felt when they imagined "making PTSD smaller" so that they could engage in these shared, rewarding activities again. As an initial assignment, they went to their favorite restaurant in the middle of the afternoon, when it was less crowded, and then went back over the course of several weeks at later times, when it was more crowded. To ensure that the activity was maximally beneficial, the veteran was instructed to sit in the middle of the restaurant with his back to the door. Within several weeks, the couple commented that, as they continued to "shrink" the presence of PTSD in their relationship, they felt closer.

With a foundation of increased satisfaction, improved communication, and decreased behavioral and experiential avoidance, Stage 3 of CBCT for PTSD targets trauma-related cognitions. The therapist teaches the couple a dyadic cognitive restructuring process that they use together to challenge cognitions that maintain PTSD and associated relationship problems. The process is summarized in the acronym UNSTUCK:

- ***U***nified and curious as a couple as they join together in collaborative empiricism
- ***N***otice and share thoughts and feelings
- (Brain)***S***torm alternative thoughts or interpretations, even if they seem implausible
- ***T***est the thoughts (i.e., consider the evidence for each alternative thought)
- ***U***se the most balanced thought(s)
- ***C***hanges in emotions and behaviors that ensue as a result of the new thought(s)
- ***K***eep practicing (i.e., recognition that it requires effort to change one's mind when there have been entrenched patterns of thinking)

We sequence the cognitions targeted in this stage with an initial focus on historical cognitions specific to the traumatic event(s) and then address interpersonally oriented beliefs disrupted by the trauma. This sequence is chosen because changes in the ways in which a traumatized person makes sense of the specifics of his/her trauma(s) can have cascading effects on beliefs operating in the here-and-now. For instance, a person who blames himself for a traumatic event may have trouble trusting his judgment in the here-and-now. If, however, the person is able to reconstrue the event based on a more accurate view of the contextual factors beyond his control at the time, he may develop different views of his judgment and ability to trust himself in the present.

Treatment culminates with a session on the potential for benefit-finding and posttraumatic growth and how they can continue to grow as individuals and as a couple by using the skills learned during the therapy. The final session is designed to help the couple consolidate gains and anticipate fluctuations in their individual and relationship functioning over time. Results from an uncontrolled pilot study of an earlier, more present-centered version of the therapy with Vietnam veterans and their wives (Monson, Schnurr, Stevens, & Guthrie, 2004; Monson, Stevens, & Schnurr, 2005) revealed statistically significant improvements in the veterans' PTSD symptoms according to clinician interview and wives' self-report. The veterans reported more modest improvements in their PTSD symptoms but large improvements in depression, anxiety, and social functioning. Wives reported large improvements in relationship satisfaction, as well as their general anxiety and social functioning. Results of the current version of the therapy with veterans and non-veterans diagnosed with PTSD and their intimate partners suggest that the revised, more trauma-focused version of the therapy also appears to hold promise for both members of the couple (Monson et al., 2009).

Assessment and Clinical Considerations

In our research and clinical practice working with couples in which one member has PTSD, we routinely assess PTSD symptoms and relationship satisfaction over the course of therapy using the PTSD Checklist (PCL; Weathers, Litz, Herman, Huska, & Keane, 1993) and the Dyadic Adjustment Scale (DAS; Spanier, 1976), respectively. We also frequently use the Beck Depression Inventory–II (BDI-II; Beck, Steer, & Brown, 1996) as a measure of depression symptom severity given the comorbidity between PTSD and major depression (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). We administer the PCL and a single question about general relationship happiness every other session to track progress and use the full DAS to assess relationship adjustment before and after treatment. We have found it helpful to assess the partner's perceptions of the veteran's PTSD symptoms and functional impairments as well because it is our experience that veterans from the current conflicts tend to underreport symptoms and associated impairment compared with clinician evaluation and partner report. Accordingly, we have created a partner version of the PCL (PCL-P) that asks intimate others to rate their perception of the veteran's PTSD symptoms. We have also observed that recently returned veterans tend to underreport the extent to which they use alcohol and other substances as a method of managing PTSD symptoms. In light of this tendency, partners often

serve as reliable multimodal sources of this important clinical information.

Additionally, in the course of treatment planning, we assess for and inquire about partner behaviors and cognitions that might serve to inadvertently reinforce veterans' PTSD symptoms. Common ways that partners accommodate, and thereby help to maintain, PTSD symptoms include "running interference" with other family members by making excuses for veterans' irritability or absence from events, requesting that others modify their behaviors to minimize veterans' feeling triggered (e.g., telling children to be quiet so that the veteran is not exposed to sudden, loud noises), taking over veterans' roles and responsibilities to minimize their being exposed to anxiety-provoking situations (e.g., doing all of the grocery shopping or driving), or even explicitly encouraging veterans to avoid anxiety-provoking situations by isolating themselves or using alcohol. When asked why they engage in such behaviors, partners typically share their belief that exposure to even mildly stressful situations will exacerbate veterans' symptoms. Because their intention is to help the veteran feel better in the moment, they think that the most effective way to help is to buffer the veteran from stress. A conjoint approach to the treatment of PTSD can, therefore, be ideal in addressing and modifying these behaviors and cognitions to maximize the likelihood that the new skills and behaviors veterans learn in treatment will generalize to settings outside of the therapist's office.

Lastly, we have found it helpful to be as flexible as possible when scheduling appointments for couples. Unlike Vietnam-era couples, who may be retired or unemployed and, thus, easily able to attend regularly scheduled daytime appointments, many of the OEF/OIF couples we have treated work, go to school, and/or have young children. When possible, offering evening appointments and the option to schedule appointments around work, school, or childcare responsibilities can assist in navigating potential barriers to treatment utilization.

There are some couples for whom it may be contraindicated to pursue conjoint therapy for PTSD. For instance, couples in which one or both partners express a minimal commitment to their relationship or to the notion of participating in a disorder-specific couple therapy would not be considered appropriate for CBCT for PTSD and would likely be referred for individual treatment of PTSD or more generic couple therapy to address relationship difficulties. Couples in which one member is actively substance dependent, as medical stability may be compromised, and those in which there is current severe violence are also not appropriate for CBCT for PTSD. To assess for the presence of severe physical aggression, we recommend using the Conflict Tactics Scale–Revised (CTS-R; Straus, Hamby, McCoy, & Sugarman, 1996). Other contraindications for current treatment include unmanaged major psychosis or bipolar disorder, or significant cognitive impairments. If the couple's circumstances change and these issues improve, it may be appropriate to provide the treatment at that time.

Case Study

Martin's Presentation

"Martin" was a 27-year-old Iraq War veteran referred for treatment for PTSD following a compensation and pension evaluation at a Department of Veterans' Affairs Medical Center. Martin denied any mental health problems prior to his service in Iraq but did endorse a family history of substance use problems. Following his evaluation, he was referred to the PTSD clinic, where he met with a staff psychologist for two sessions but then dropped out of therapy without explanation. He subsequently returned to the clinic and met with a second staff psychologist. Martin's primary presenting complaint at that point was uncontrolled anger and irritability, which was directed primarily at his wife, "Sue," as a result of her having spent his paychecks sent home while he was in Iraq. He denied being physically aggressive toward her but stated that he was controlling and "mean" to her and was concerned that she would eventually leave him as a result of this behavior. Martin expressed a high level of motivation to improve his marriage and was referred to our research study evaluating the efficacy of CBCT for PTSD. Martin quickly contacted the study project director and scheduled a meeting to begin the process of determining the couple's eligibility for the study.

Initial assessment using the Clinician-Administered PTSD Scale (CAPS; Blake et al., 1990) was consistent with results from prior assessments that Martin was experiencing PTSD secondary to his combat experiences in Iraq. As noted in Table 1, his pretreatment score on the CAPS was in the moderate range of severity; however, his total PCL score was suggestive of more mild symptoms. Sue's ratings of Martin's symptoms on the PCL-P were more consistent with the clinician assessor's ratings on the CAPS. Neither Martin nor Sue met criteria for major depression according to the Structured Clinical Interview for DSM-IV (SCID; First, Gibbon, Spitzer, & Williams, 1996) and their scores on the BDI-II were in the nondepressed range. Though Martin's pretreatment DAS score was in the nondistressed range, Sue's score indicated the presence of a clinical level of relationship distress on her part.

Regarding Martin's combat experiences, he served two tours in Iraq, during which he worked as a Special Forces communications sergeant. During the first tour, he saw a number of dead bodies, was shot at by missiles, and a fellow soldier was shot in the head but survived. Symptoms

Table 1
Patient and Partner Pre- and Posttreatment Assessment Results

	Measure		Patient	
	Pretreatment	Posttreatment	Pretreatment	Posttreatment
Clinician-Administered				
PTSD Scale	58	20	0	–
PTSD Checklist	36	21	66	32
Beck Depression Inventory-II	9	2	0	0
Dyadic Adjustment Scale	107	112	90	108
State Trait Anger Expression Inventory				
State Anger	10	10	10	10
Trait Anger	29	13	10	10
State Trait Anxiety Inventory				
State Anxiety	20	20	20	20
Trait Anxiety	24	20	20	21
Social Adjustment Scale – Overall	1.67	1.73	1.23	1.25

Note. PTSD = posttraumatic stress disorder. To confirm that the partner did not have current PTSD at the time of study entry, she was administered the Clinician Administered PTSD Scale at the pretreatment assessment but not at the posttreatment assessment. Across all measures, lower scores indicate lower severity of problems in the given domain with the exception of the Dyadic Adjustment Scale, for which higher scores indicate better functioning.

of PTSD emerged shortly after completing his first tour and returning home. At the time, Martin had been dating Sue for several years. He was subsequently redeployed to Iraq for a second tour and felt certain that he would be killed in action. To ensure that Sue would be taken care of financially in the event that he was killed, Martin married Sue shortly before he returned to Iraq. He described the second tour as more traumatic than the first. During the 9 months of his second tour, he and other Special Forces troops worked with Iraqis who assisted the American military in learning where improvised explosive devices (IEDs) were being made. He described the situation as "crazy" because the Iraqis with whom they made contact were often tortured and killed as retaliation for cooperating with the Americans. Martin also reported that he frequently pulled dead and mutilated bodies out of the Tigris River and had witnessed several car bombings. According to Martin, one of the most disturbing events of his combat experience involved finding the mutilated body of a 12-year-old boy who had been tortured and killed because his father had collaborated with the Americans against the insurgents.

When Martin returned after his second tour, he experienced a number of PTSD symptoms, including intrusive thoughts, nightmares, disturbed sleep, exaggerated startle response, anger/irritability, avoidance of trauma-related stimuli, social withdrawal, and emotional numbing. Both he and Sue were particularly disturbed about the numbing because Martin had no desire to be emotionally or physically intimate with her. Sue made numerous attempts to engage with him, and he rebuffed her. At the time that the couple presented for conjoint treatment, there had been no physical intimacy (i.e., sexual intimacy or physical affection) between them since Martin had returned from Iraq more than 18 months before. The couple reported that Martin frequently berated Sue, calling her "fat," "ugly," and "stupid." Martin stated that he felt guilty about this but felt helpless to change it. He was also drinking a 12-pack of beer each weekend day during this time. He denied driving while intoxicated or being unable to fulfill obligations as a result of being hung over but did report that his sister, a nurse, was concerned about his drinking and had encouraged him to decrease his alcohol consumption. Despite PTSD symptoms and substance use, Martin was enrolled full-time at a local university and was performing well.

Course of Treatment

Stage 1: Treatment Rationale and Psychoeducation About PTSD Symptoms and Relationship Difficulties

When the couple arrived for their first session of CBCT for PTSD, Martin appeared guarded, with affect that alternated between flat and irritable, and Sue seemed anxious. The therapist sought to quickly establish rapport with the couple and reinforced them for their commitment to work on their relationship during the therapy. She noted that she would be talking more than usual in this session and provided an overview of what they would be discussing in the session and over the course of treatment. The couple participated actively during the first session, which included a description of PTSD and a discussion of the symptoms Martin was currently experiencing. To engage both members of the couple and to begin shifting the couple's tendency for Martin to speak for both of them, the therapist made an effort to engage Sue as well, soliciting her observations of how the

traumatic experiences had affected Martin. The end of the first session culminated with the couple articulating treatment goals with respect to both the relationship and Martin's PTSD symptoms. Relationship goals included (a) better communication, characterized by more "two-way" conversations and less name-calling; (b) more intimacy, as evidenced by physical affection and emotional closeness; and (c) more shared rewarding activities, such as hiking and walking. Treatment goals for Martin's PTSD symptoms centered on decreased irritability and emotional numbing, improved sleep, increased comfort in crowds, and more going out in public. At the end of the session, the couple was asked to read a handout describing the dynamic interplay between PTSD and relationship difficulties, to "catch" each other doing nice things, and to provide written responses to questions about how Martin's trauma had affected each of them and their relationship, why each believed the traumas had happened to Martin, and what they each thought in the areas of control, trust, and physical and emotional intimacy on a form referred to as the Trauma Impact Questionnaire (TIQ).

When the couple returned for their second session, Sue had completed all parts of the assignment. Martin had completed the assignment to "catch" Sue doing nice things but had not completed the TIQ. Using a nonjudgmental tone, the therapist gently inquired about what had gotten in the way of his completing this portion. Martin said that he had been busy with school during the previous week and had forgotten. The therapist problem-solved with the couple about things they could do to increase the odds that assignments would be completed, and she reassigned the practice. Further, so as not to reinforce Martin's avoidance, she asked him to verbally provide answers to the questions on the TIQ. As requested, Martin answered the questions verbally and was amenable to completing the assignment out of session prior to the next session. As agreed, he returned the following session with the completed TIQ in hand.

Stage 2: Communication Skills Training and Couple-Level in-Vivo Exposure Approach Activities to Enhance Positivity and Decrease Avoidance

By the third session, the couple reported finding the "catch your partner" exercise quite helpful in noticing positive behaviors by the other one, instead of focusing primarily on each other's negative behaviors. Martin, in particular, reported that he had previously not been aware of how many nice things Sue did for him on a daily basis and that he wanted to be better about expressing his appreciation. Sue reported that she enjoyed the shift in Martin's behavior and that she was more inclined to continue engaging in positive behaviors toward him as a result of being noticed for this. In Session 3, communication skills training was introduced as a way of increasing approach over avoidance behavior. During the session, the couple used reflective listening skills to generate a list of places, situations, feelings, and people that they jointly avoided as a result of the PTSD. They identified that, as a result of PTSD, they avoided physical intimacy, seeing friends, and socializing with people from Martin's unit in Iraq.

The couple's adherence to out-of-session assignments continued to improve and, by the fourth session, both said they felt happier in the relationship as a result of better communication and increased shared positive activities. Emotional identification and sharing was introduced to decrease emotional numbness and enhance intimacy. During the session, the couple demonstrated considerable skill in using a range of emotion words to describe how they felt about the effect of PTSD on their relationship and how they each imagined feeling as they continued to "shrink" the role of the PTSD. Martin's affect appeared much softer in general, and he displayed tenderness toward Sue during the session by wiping away her tears with his hands. Both partners also reported feeling more emotionally intimate after the conversation compared to before. To assist the couple in reconnecting physically, they were asked to start engaging in physically, though not necessarily sexually, intimate behaviors such as holding hands as their out-of-session in-vivo exposure approach activity.

By Session 5, the couple reported experiencing increasing physical and emotional intimacy and improvements in Martin's PTSD symptoms. The couple reported that they were also socializing more with friends. Self-report measures of Martin's symptoms and each partner's relationship happiness were consistent with the couple's subjective report of improvements in both PTSD and relationship adjustment (see Figs. 1 and 2). In-session communication skills training focused on the relation of thoughts to feelings and behaviors, with instruction to

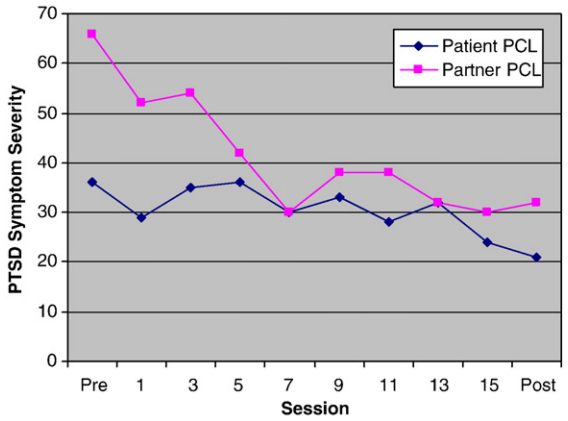

Figure 1. Patient and partner ratings of patient's PTSD symptom severity, according to PTSD Checklist (PCL). Higher scores on the PCL indicate greater PTSD symptom severity.

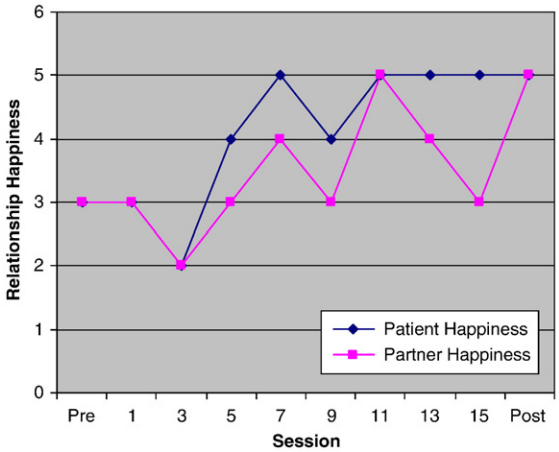

Figure 2. Patient and partner ratings of their relationship happiness. Higher scores indicate greater relationship happiness. Patient and partner ratings were identical pretreatment and at Session 1.

"catch" (i.e., paraphrase) each other's thoughts and associated feelings. For their out-of-session approach activity, the couple agreed to broaden their new repertoire of physically intimate behaviors to include daily hugging and snuggling on the couch.

The couple returned for their sixth session reporting that they had been sexually intimate several times during the previous week and that Martin had initiated, much to Sue's happiness. Content during the session focused on how the couple could begin to test out their thoughts with the idea that they could "change their minds." The couple very skillfully used the cognitive restructuring process to examine their jointly held belief that Sue could not be trusted with money as a result of her having spent most of their money during Martin's second deployment. Externalizing the thought and reviewing the contextual factors at play during Martin's deployment revealed that Martin had actually encouraged Sue to spend their money fixing up their apartment and doing other things that she enjoyed so that she would be less lonely and sad while he was in Iraq. Martin told Sue, "It's not your fault. Looking back now, it's very understandable how the money got spent. I remember telling you to spend some of the money." He reported an associated shift in his emotions from anger to relief. Session 7 focused on problem-solving to take action based on the more balanced beliefs.

Stage 3: Dyadic Cognitive Restructuring of Trauma-Related Beliefs Maintaining PTSD and Relationship Difficulties

The couple was introduced to the third phase of treatment, dyadic cognitive restructuring about traumatic experiences, in Session 8. Barriers to acceptance of traumatic events were reviewed, including "just world" thinking. The couple was instructed that this construct refers to the tendency to believe that "good things happen to good people and bad things happen to bad people." When this standard is violated, such as in war, it can be difficult to reconcile one's previously held views with current events, thus driving reexperiencing symptoms of PTSD and concomitant hyperarousal, avoidance, and emotional numbing. Other barriers to acceptance of events include hindsight bias, the tendency to assume that one had the knowledge at the time of the event that one has now; undoing, the tendency to play out the event with alternative courses of actions that could have prevented it (e.g., "If only I would have…"); and situational neglect, the tendency to overestimate one's own influence at the time of the event and to underestimate the situational forces that affected one's and other's choices and behaviors.

Both partners reported a slight increase in Martin's symptoms at the beginning of Session 9, which the therapist normalized in light of the more historical focus of the therapy at that point. Use of Socratic dialogue revealed the presence of "just world" thinking in maintaining Martin's PTSD symptoms. In particular, he had considerable difficulty reconciling how an innocent child could have been tortured and killed, even in war. The following represents an excerpt from the session in which the therapist engaged the couple with the dyadic cognitive restructuring process to help Martin's thinking become more complex and nuanced. A more contextualized understanding of the nature of war was thought to be the path for Martin to reconcile the event with his previously held standards for warfare, thereby facilitating his recovery from PTSD. To assist Martin and Sue in this process, the therapist encouraged them to discuss possible motivations for the insurgents' behavior to help Martin begin to consider alternative thoughts beyond just, "They shouldn't have done this." The therapist was also careful to encourage this increased flexibility in thinking without necessarily condoning the insurgents' actions.

> THERAPIST: Let's try something out with this UNSTUCK process. It sounds like what you're saying is, "They shouldn't have done this because that violated these rules of humanity that you had going into Iraq: That there are rules of humanity that, even in a war, there are certain things that you don't do, even if you're trying to win..." So, I'm going to ask you guys to do this together. I'm going to be asking some questions, but Sue, I would like you to, as you can, chime in with curious thoughts as we start looking at this thought, putting it on the table to look at the idea that they shouldn't have done this [N — Notice the thought]…We could also turn it on its head and say, "Why shouldn't they have done this?" That's the thought that you've noticed, as you've taken this unified and curious approach [U] …What are some alternatives — I know that this might seem kind of

crazy or radical, but — What are some alternatives to "They shouldn't have done this?" that you guys have come up with? [S —(Brain)Storming Alternatives]

MARTIN: It's not that they shouldn't have done it. It's "How could they do it?" It's that…

THERAPIST: It sounds like there's the idea that they shouldn't have tortured and killed an innocent child.

MARTIN: Yeah, I mean, definitely not… yeah… I think, I just remember, after it happened, I just couldn't comprehend how they could do it. I don't know.

THERAPIST: So, the work is to get you to be able to comprehend that. Not to say it's okay to kill and torture children, but to be able to comprehend how they could do that, because truly I think that's what's keeping you stuck...You said, "I can't make sense of it," and I think that's what's driving the PTSD and the anger and the irritability.

SUE: Is there the possibility that they did it to protect their people, kind of the same way you were trying to protect your people by trying to get information from the father?

MARTIN: Yeah, it could be. Definitely.

THERAPIST: That's a great question. Could you elaborate [on] that and talk about that a little more?

SUE: Sure… I guess, do you think that, I mean they were…

MARTIN: Yeah, to look at it from the other side.

SUE: Right.

MARTIN: Yeah, definitely. Yeah…I don't know. Alright, I'm sorry, killing people is alright, well, it's not alright, but there are humane ways to do things… They were doing it, not out of spite, but just to create a bigger impact, a bigger problem than just to torture this kid. They were trying to run the neighborhood.

SUE: Right, but in their minds, what they were doing was probably right.

MARTIN: Yeah, it was. Definitely, it was.

SUE: They probably thought that if the Army, or whoever was getting information…it would affect their life, their lifestyle, and they probably thought a child's life versus a whole community's life or whole area's life, is…worth showing this man, or the more radical action that they took. They thought it might stand out to the community.

THERAPIST: Martin, before you respond, could you paraphrase what Sue said?

MARTIN: That they kind of had the same intentions as we do, to protect the people in the neighborhood, but they just have a different way of doing it. Is that it?

SUE: Right, and they have different views as to what's humane and not because of their [sub]culture. You had said before it's kind of almost like survival of the fittest over there, everyone kind of feeds off everyone else. It's one of those things where [it's] "kill or be killed" sometimes in some situations.

MARTIN: Not in that situation, though.

THERAPIST: I wonder if something similar is — kind of picking up on what you're saying — for better or worse, the decision to drop the atomic bomb on Hiroshima. There were lots of innocent Japanese people who were nonmilitary and children who were killed. We could look back in hindsight and say maybe they shouldn't have, but the idea was that the Japanese looked like they weren't going to surrender and the idea was to drop this bomb because, if they didn't level the country like that, they would keep fighting and [there] would just be a greater loss of American life. They would basically fight to their death.

BOTH: Right.

THERAPIST: And it sounds like maybe what you're saying was that…they saw that to protect themselves… they made an example of this child. What do you think of that, Martin? [T — Testing alternatives]

MARTIN: Yeah, it's definitely the same thing as far as that they're both psychological. The Atomic bomb was dropped to show the world's (Allies') power, and these guys did the same thing to show their power, to show that they're willing to… I guess it is the more extreme you do something, the more people see it or fear it, or whatever it is, and obviously torturing and killing a little kid, that's pretty… crazy.

THERAPIST: So, I have a question that might seem surprising, but if there weren't rules that American soldiers went by, to what extent do you think American soldiers might do something like this, too?

MARTIN: Um…definitely, they would do it.

THERAPIST: So, Sue, could you start writing stuff down as we're talking about this? You asked a really good question, so I want to make sure we get that down and then get this other stuff down, too.

SUE: Sure, so what was my question, paraphrased?

MARTIN: The aspect of the people that did it, that their intentions were the same as ours. [Testing alternatives]

THERAPIST: To protect their community. It was really great that you came up with that.

MARTIN: I mean, there was a guy in the [an Army unit] that was doing something similar like that, but he was psychotic. I think he was put in a mental institute.

SUE: The Abu Ghraib prison — that was kind of the same respect.

MARTIN: Yeah, but I don't think it was to the same degree.

THERAPIST: But maybe Abu Ghraib was sort of on that same continuum...

MARTIN: Yeah, the humanity thing...

THERAPIST: Humanity, yeah.

MARTIN: Yeah, I think it would eventually go to the full blown where we would just be...

THERAPIST: Yeah, where American soldiers would...

SUE: Do you think, too, that because they don't have a governing force these people are radicals? They start off young in these militia camps. They really don't have a government or any set standard, so to them, that may be more humane, what they did, than some of the stuff that they've done, because they're learning in these camps to build bombs and blow up hundreds of people and decapitate people. Because what they're learning in these camps is kind of similar to what the American government teaches, not similar (in actions), but they're kind of instilled, engraved...

THERAPIST: It's their [sub]culture.

SUE: It's their [sub]culture. So, to them, it's probably the same as the rules that you're following.

As the exercise proceeded, Martin and Sue decided that the most balanced and believable thought that they had generated together was that people can value life differently, particularly when there is a context of war and subcultural differences in what it means to live or die (Use the Best). As his thought shifted from, "The insurgents shouldn't have tortured and killed this innocent child [because this violates rules of humanity]" to "The insurgents did this because they believed that they needed to take extreme action to protect themselves," his emotions changed from anger to sadness (C — Changed Emotions). To keep practicing this new thought (K), Martin decided that he would talk to Sue and try to remind himself of the context of the event.

Over the next several sessions, Socratic dialogue and the UNSTUCK process were used to consolidate these cognitive shifts and to reinforce Martin's more contextualized thinking in general. For instance, reminding himself that there are no universally held rules in war and that, if there were, there probably would not be war in the first place facilitated Martin's coming to terms with the event despite his sadness that it had occurred. Martin's PCL scores continued to decrease, although by Session 13 symptoms did not decline to the point expected if Martin had completely resolved the most disturbing aspects of his combat experiences. Similarly, although Sue's ratings of Martin's symptoms had declined considerably since the beginning of treatment, her report of residual hyperarousal and avoidance symptoms indicated a plateau in Martin's improvement. Further inquiry revealed that Martin had actually experienced another traumatic event in Iraq but was reluctant to share the details, saying, "I did things that went against my value system" and "I did things over there that I wouldn't have done over here." Sue repeatedly told him that she wanted to know what had happened and that she would not judge him negatively, even if the event involved his having killed people because she understood that his behaviors had occurred in the context of war. The therapist encouraged Martin to disclose enough aspects of the event so that he could potentially make different meaning of it, but in the end, Martin stated that he was unwilling to disclose the details, even in broad brush strokes.

At the end of treatment, Sue reported that, although Martin's symptoms were significantly improved by the end of treatment, she wanted improved communication to be an ongoing goal for them as a couple. To consolidate relationship gains made in therapy, the couple was encouraged to use time-outs, reflective listening, and the UNSTUCK cognitive restructuring process to help address Martin's residual irritability, deescalate negative interactions, and to communicate more productively.

Outcome and Prognosis

As shown in Table 1, posttreatment evaluation indicated that there had been notable gains in Martin's PTSD symptoms and relationship adjustment over the course of therapy. He no longer met diagnostic criteria for PTSD according to clinician evaluation, and his 15-point decrease on the PCL and 30-point decrease on Sue's PCL-P were also consistent with clinically significant improvement in PTSD symptoms. Overall relationship adjustment also improved for both members of the couple, particularly for Sue. Martin's scores on the Trait Anger subscale of the State Trait Anger Expression Inventory (STAXI-I; Spielberger, 1988) indicated improvement in this domain as well. Scores on the Social Adjustment Scale (SAS; Weissman & Bothwell, 1976) and

State Trait Anxiety Inventory (STAI; Spielberger, 1983) were unchanged for both partners, likely due to high levels of functioning and low levels of anxiety at both time points.

A qualitative interview conducted with the couple by an independent assessor after completion of the therapy indicated that both partners had found the treatment beneficial. Martin stated, "Before, there was resentment, and we lived like roommates. Now, it's like we're married again." Sue concurred and said that, prior to therapy, she had grown increasingly resentful toward Martin and had lost respect for him as a result of his behavior. She added that she had more respect for him as a result of his sharing his feelings and appreciating her more. She characterized their current relationship as "more mutual and respectful" as a result of treatment. Both partners also stated that it was helpful to discuss Martin's traumatic experiences during the session, and Sue noted that it helped her better understand why Martin had been so angry. When asked if there were other parts of their lives that had changed as a result of treatment, Martin said that he was a "happier person," was more motivated to do well in school, and was drinking less, and Sue added that she was doing better at work as a result of decreased tension with Martin at home. Martin concluded by saying, "I'm really happy we did this. It saved our marriage." Martin contacted the treating therapist approximately 3 months after the course of therapy to request information about his mental status in order to apply for a job. During the course of this phone call, he indicated that both he and Sue were doing well and were pleased that they had participated in the treatment. He noted that, based on their positive experience with the therapy, they were considering additional couple therapy to further enhance their communication.

Summary and Recommendations

There has been increasing recognition by the Department of Defense that healthy relationships between service members and their loved ones provide the foundation for a strong military. Toward this end, the military has devoted resources to be of assistance to soldiers and their families through the Strong Bonds relationship enrichment program (www.strongbonds.org), and researchers have adapted the Premarital Enhancement Program for military couples (Building Strong and Ready Families; Stanley et al., 2005) with good effects. When PTSD is present, disorder-specific treatment is likely indicated to optimize the chances that PTSD-affected veterans and their significant others can experience the best possible quality of life after deployment. CBCT for PTSD capitalizes on the opportunity to simultaneously improve both PTSD and relationship functioning, and early results are promising.

Evidence suggests that stigma regarding mental health symptoms and underrecognition of symptoms of PTSD may be deterrents to OEF/OIF veterans seeking mental health treatment. To increase buy-in by veterans who stand to benefit from treatment, conjoint interventions may serve as an important conduit to their receiving the care they need. In fact, several OIF veterans that we have worked with in the context of our CBCT for PTSD research have said that the primary reason they participated in treatment was the presence of relationship problems secondary to PTSD and not the individual effects of PTSD on them personally. Eliciting from them how PTSD has affected their loved ones and relationships can motivate for engagement in therapy and behavioral change. Therapists can then capitalize on these higher levels of distress to help the couple learn a more adaptive way of relating before their interactional patterns become entrenched, as is frequently observed with older veterans and their partners. For returning veterans not involved in romantic relationships, the therapy can be adapted to nonromantic significant others, such as parents, siblings, and close friends, who may play an important role in veterans' postdeployment adjustment.

Elsewhere we have discussed a heuristic for thinking about how to involve intimate others in veterans' care using CBCT for PTSD as a platform (Monson, Fredman, & Taft, in press). For example, Stage 1 could be used for veterans with relatives who wish only to receive psychoeducation about PTSD and its effects on relationships. For dyads who would like to address relationship difficulties secondary to PTSD but do not wish to do the trauma-focused work done in Stage 3, therapists could provide just Stages 1 and 2, with the option of extending Stage 2 by adding more present-centered sessions to address here-and-now cognitions that maintain both PTSD symptoms and relationship difficulties. If couples or families are amenable to doing the trauma-focused work of Stage 3, then the entire 15-session protocol could be delivered. In nonromantic dyads, we recommend the use of emotional and physical "closeness" versus "intimacy" when discussing these constructs to avoid surrounding the term "intimacy." Closeness can encompass a range of experiences, such as the proximity of unknown others in a public place to sexual intimacy.

It is imperative that we continue to innovate methods that capitalize on veterans' relationships to increase engagement in mental health treatment and incorporate these loved ones in the treatment provided to improve the well being of all who are touched by the effects of war trauma.

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