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ADVANCING SCIENCE AND PROMOTING UNDERSTANDING OF TRAUMATIC STRESS
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PTSD 101 Course

Transcript for: Couples and PTSD

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There are three primary objectives of this presentation. First is to review the research that has documented a very strong association between PTSD and intimate relationship problems. And this is across different types of survivor groups and of different kinds of problems. And it shows that essentially PTSD is one of the mental health conditions most related to these kinds of problems.

The second objective is to discuss how we can include partners and loved ones in the assessment of PTSD and relationship functioning, which is really important in terms of appreciating the full picture of PTSD and assessing especially those parts or symptoms of PTSD that are difficult to get only from the person who has PTSD, and for us to more fully appreciate the different effects of PTSD on the person's life.

And finally, this presentation is geared towards looking at various methods of incorporating significant others in PTSD treatment. So while we have treatments that work for PTSD, there is certainly room to expand the efficacy of these treatments and including these loved ones in treatment is an important way of making these therapies that work, work better.

There has been some epidemiological research establishing the association between PTSD and intimate relationship problems. And this research has shown that the association between PTSD and relationship problems is actually one of the mental health conditions most associated with these problems. So as you can see in this slide, the odds of divorce are about 1.6 times greater in those couples where at least one member of the couple has a mental health condition (has PTSD) compared with couples in which neither partner has a mental health condition. And the odds of marital distress if the relationship has remained intact are almost four times greater in the case of those couples in which one of the members has PTSD. Intimate Relationship Problems & PTSD Compared to couples in which neither partner has a mental health diagnosis, couples in which PTSD is present have: 1.6 times greater odds of divorce (Kessler et al., 1998) 3.8 times greater odds of marital distress (Whisman et al., 1999) Strength of associations on par with or stronger than other diagnoses.

Some really interesting research has come out of work on natural disasters. And in particular, one of the earlier findings was that marriage, or having a marital status as married, was a protective factor for men but actually a risk factor for women. And, this finding actually parallels other research where we have found that marriage is a risk factor for women, whereas a protective factor for men.

Other research has shown that consistent with this prior finding about marriage, that husbands' symptoms of PTSD seem to be more strongly predictive of the wives' symptoms than vice versa, suggesting that women may be more susceptible to the symptoms of their loved one than vice versa.

In more recent research, there has been an emphasis on looking at how husbands' and wives' beliefs or cognitions about the world that are related to being traumatized can actually influence one another. In a particular study that my colleagues and I conducted, when the wives and husbands both had world assumptions or beliefs that were more negative, it actually predicted even more severe symptoms on the part of the wives; suggesting that our loved one's views about the world post trauma can have an important impact on symptoms.

The other finding from that similar study was that women's relationship functioning at that time of a flood (in this case) actually helped to account for the association between the exposure and their symptoms. More specifically, when women were in happier, more satisfied relationships, it decreased the likelihood of them having PTSD symptoms as a result of that flood; suggesting that our intimate relationship functioning may be an important protective factor in the wake of a natural disaster.

There has been a significant amount of research about the association between PTSD and intimate relationship problems that has come from research with combat Veterans from prior eras. This research has generally compared Veterans who have the diagnosis of PTSD to Veterans who have been exposed to combat trauma but didn’t have PTSD as a result of that exposure. The research from these Veterans suggests that those with PTSD have more divorce, they also have more intimate relationship problems, they are less self-disclosing and intimate in their relationships, and have less parenting satisfaction in that role. An important clinical observation is that those with PTSD were also more likely to perpetrate acts of domestic aggression in their relationship.

Research from the National Vietnam Veterans Readjustment Study suggests that the rates of PTSD in the past year were about twice that in Veterans who had the diagnosis of PTSD compared with those Veterans who had been exposed but didn’t have the disorder. And the number of acts in the past year of physical aggression were about four times that in those who had PTSD compared to those who did not have PTSD. So an important clinical take-home message is that it seems that it is something about the disorder and the symptoms of the disorder that place people at risk for having intimate relationship problems rather than the trauma exposure per se.

To begin to understand why it is that intimate relationship problems are associated with PTSD, several studies have looked at the different symptoms of PTSD and their association with relationship problems. In this research, people have often separated out the emotional numbing symptoms of PTSD from the behavioral avoidance symptoms of PTSD. Because there seems to be a specific association between the emotional numbing symptoms of PTSD and relationship satisfaction which myself and others have argued is because emotional expression in intimate relationships is really important to the satisfaction, cohesion, and intimacy of those relationships.

And as you might expect the hyperarousal symptoms such as irritability, anger, and psycho-physiological arousal more generally is what has been most associated with the perpetration of intimate aggression in those relationships.

It’s exciting to see that more recent research has focused on intimate relationship problems of the Veterans who are returning from Iraq and Afghanistan. One of the interesting studies has been a follow-up assessment to the very large Land Combat Study that was of over 1000 Marines and Soldiers who have served in Iraq and Afghanistan.

Approximately 12 months after their deployment when they assessed these Veterans, what they found was a fourfold increase in their interpersonal relationship problems, which in fact was higher than the

increase in individual mental health symptoms. It was outpacing those individual problems in terms of their interpersonal problems. The authors of this article called for increased family services for these Veterans because of these interpersonal effects of their combat deployment.

Another fascinating study that has come from Veterans who served in Iraq has been done by Renshaw and colleagues. In this case, this study points to the importance of wives' attributions or thoughts in their own mental health and the mental health of their loved ones. This study was conducted with 49 male soldiers in a National Guard unit that was deployed to Iraq for 12 months and both the wives and the soldiers completed the questionnaires three months after returning from the deployment.

The wives were found to have the greatest individual distress when they perceived substantial problems in the soldier but the soldier failed to recognize such problems; pointing to the soldier appreciating those symptoms or problems in the wives' own mental health functioning.

The other important clinical implication of this study was that the wives' marital satisfaction was dependent on the match between her sense of combat exposure and the match between the husband's PTSD symptoms. So in these cases when the wives thought that the Veteran had had much combat exposure and had high symptoms, they were more satisfied. Whereas if they thought that the Veteran had had minimal exposure but had lots of symptoms, that mismatch led to less satisfaction.

Clinically, this suggests that some level of disclosure about the combat exposure helps for loved ones to make sense of why is this person having these symptoms in the context of having had this particular exposure.

A fair question to be asked is, "Do Veterans actually want their families included in their PTSD treatment?" There has been one study that has spoken to this issue conducted by Sonia Batten and her colleagues. In this case they assessed Veterans who were receiving treatment within a PTSD program in the United States VA. And in this case, 86% of the Veterans viewed PTSD as a source of stress in their families and nearly 80% of them desired greater family involvement in their treatment. Relevant to most of the evidence-based treatments for relationship problems, about two-thirds of them requested tips on how to communicate more effectively with their families.

There are a number of reasons to think about including significant others in assessment and treatment for PTSD. The top ten reasons from my perspective are:

10. All traumatization occurs in an interpersonal context. And what I mean by that is that many of the traumatic events that lead to PTSD are perpetrated at the hands of another person. If they are not perpetrated by another person or manmade, they are usually simultaneously experienced, like in the case of a natural disaster or technological disaster.

9. Social support is one of the most robust protective factors after traumatization and this comes from several meta analyses that have been done on the topic looking at a variety of individual and interpersonal risk factors for PTSD. And of all those factors, the social support received in the wake of trauma is one of the most important protective factors for an individual not having PTSD after they have been exposed to a traumatic event.

8. Significant others of those with PTSD often have significant caregiver burden and mental health problems related to living with someone who has PTSD. So it's important to attend to those particular problems that can arise from living with someone who has this mental health condition.

7. Treatment seeking often occurs around functional problems. So while some people with PTSD will present because they are having nightmares or flashbacks, most people come for treatment when they are having functional problems. So they are having trouble at work, their wives have told them they are

going to divorce them if they don't get help, they don't like how they are interacting with their children. It's those things that really drive most people into treatment. And it's important for us to be able to meet them where they're at in their desires for improvements in those areas.

6. Loved ones/significant others can be an important gateway to treatment and may be helpful to overcoming the stigma of presenting for individual mental health treatment. So in a number of individuals that I've treated, it was much more palatable for them to come for couples counseling or family therapy than it was to present for an individual mental health problem.

5. While we have some excellent individually based PTSD treatment, dropout rates have run as high as 50 percent in some samples and run on average about 25-30 percent in clinical trials. If a person is able to complete the treatment, there still is a significant proportion of those individuals who have a partial response or don't respond to the available treatments. And so it's important for us to develop treatments that can improve the number of people or enhance the number of people who can profit from the therapies for PTSD.

4. Now another fair question is, "If we treat the individual PTSD symptoms, does it have a cascading effect downstream in terms of their interpersonal and intimate relationship functioning?"

In fact, the existing data suggests that treating PTSD symptoms alone does not necessarily improve intimate relationship problems. So it's important for us to think about providing treatments that can help in this particular sphere of a person's functioning.

3. At least one study that shows if an individual receives PTSD treatment on an individual basis, the environment in which they are existing plays an important role in the outcomes. So if an individual is existing in a highly negative family environment, they don't profit from the individual treatment as much as they do if they were in a more supportive and positive family environment.

2. Loved ones are often important motivators for change; it's the reasons that we change sometimes when we can't change for ourselves. They can also be important proponents of the therapy; encouraging people to do treatments that are very difficult, or very difficult for some to do, but lead to important positive outcomes.

1. We do have some evidence to indicate that including significant others in treatment can lead to improvements not only in the PTSD symptoms but also improvements in the relationship functioning and in the individual functioning of the partner who is included in that treatment. So in this way, we are essentially getting a "three for one" in providing these therapies for PTSD.

Relevant to the inclusion of significant others in assessment, with regard to PTSD, significant others can often give us a window into a person's functioning in ways that we couldn't get from the patient alone. So in our clinical practice in my clinic, we actually include a PTSD checklist measure that is reported on by the significant other about the person with PTSD so we can get a multi-modal perspective on the person's PTSD symptoms.

There also are co-morbid conditions that go along with PTSD that it may be very helpful to have significant others weigh in on. For example, substance use disorders is an area where sometimes relying on the person presenting for treatment alone can be problematic. So having loved ones report on substance use can be an important addition piece of information.

Dissociation is another example of a condition where it may be difficult for the person who has these symptoms to report on them. And loved ones can then provide important information about the occurrence of dissociation they observed in the person's day-to-day life.

With regard to relationship functioning, it's important to assess satisfaction in areas of conflict that are occurring in the relationship and one measure that is often used in this vein is the Dyadic Adjustment Scale. It is also important to do an assessment of violence and safety in the relationship because approximately 60% of couples who are seeking couple therapy report some act of physical aggression in their relationship in the past year if you ask them.

So a commonly used measure in this area is the Conflict Tactic Scale Revised, that can be used in combination with a discussion about safety with each member of a couple. It's also important to ask about intimacy and emotional expression because that is an important part of what drives relationship satisfaction as well as having a candid discussion about sexual functioning. This is an area—even among couples therapists—that is sometimes difficult to ask about but is an important part of healthy intimate relationships.

If a couple therapy is going to be pursued, it may be very helpful to also screen partners for their own individual mental health problems because oftentimes people with PTSD can partner with other people who have PTSD or some other mental health condition or may have mental health conditions from living with someone who has the disorder.

Finally, we recommend that if you are going to try some form of couple therapy to also do a communications sample. And this involves asking the dyad to turn, face each other, and have a conversation about a moderately distressing topic while you as the therapist watch on and observe that communication. This gives an important window into how that particular dyad typically communicates about an issue in their relationship and can help you form a basis of what their strengths are but also what are the areas you are probably going to need to intervene to help them improve their relationship.

An important development that is occurring in the world's largest PTSD treatment providing organization is the inclusion of Veterans marriage and family counseling services. And this was enacted with public law 110-387, the Veterans' Mental Health and Other Care Improvement Act. It adds these services to the continuum of services offered to Veterans and all Veterans eligible through VA care can be provided these services. It rescinds the prior stipulation that limited these kinds of services for Veterans receiving non-service connected treatment. It also provides for the hiring of marriage and family therapists within the year following the enactment of this particular law.

In actually implementing this particular public law, United States VA has focused on providing a continuum of family services. From being a family-friendly agency that includes family members in medical health care decisions and treatment planning, to providing more basic family education, to more in-depth family consultation, and finally at the end of that spectrum, to providing what is called family psycho-education or family treatment.

As a clinician, it's important to think about how is it that one might include significant others in treatment and what are the types of conjoined or couple therapies that one might provide for someone with PTSD. One method of including loved ones and doing couple therapy is to do what we term generic couple therapy where the focus really is on improving the intimate relationship and using skills to develop improvements in those areas.

The other strategies that one might consider include the loved one in the intervention to really focus specifically on the symptoms of PTSD. At the lowest level, loved ones can be included in basic education about the disorder; they can also be included in individually based treatments where the partner is serving as a surrogate therapist or facilitating and assisting in the provision of that individual therapy; and at the highest level of involvement may be involved in what we term a disorder specific couple therapy; which is basically shorthand for saying it is a couple therapy that's developed specifically for the treatment of the PTSD symptoms as well as improvements in the intimate relationship functioning.

And in the following slides, I am going to provide some examples of each of these different ways of including a significant other in the treatment of PTSD.

There are several interventions that have been considered to be evidence-based couple interventions. Perhaps the earliest interventions that were provided for couples' distress were the group of interventions called Behavioral Couple Therapy where the focus was really on skill development, communication skills, and promoting positive exchanges between the couple.

The next set of interventions that grew from the behavioral couple therapies is termed the Cognitive Behavioral Couple Therapy. And in this case, there was an additional emphasis on the thoughts and assumptions and standards that each person in the relationship might have toward the relationship or the other person, in addition to a focus on improving the behaviors within the couple's relationship.

A recent innovation in the cognitive behavioral therapy world is the introduction of integrative behavioral couple therapy. And this particular form of therapy really introduced the idea of acceptance; that there is not only an attempt to change couple behavior but also promoting acceptance of each other and their relationship in addition to trying to change it.

Two therapies that have some evidence of improvements in relationship functioning are Emotion Focused Couple Therapy where the focus is really on improving the emotional expression in the relationship and focused on trying to alter particular patterns of interacting in the couple that are problematic in their relationship. And also Insight Oriented Couple Therapy which is focused on gaining for the couple insight into their couple interactions and their own motivations on how they interact with one another.

So in the case of these generic interventions, they could be added on to other interventions for PTSD treatment. There has been one trial that has actually tested this method of including significant others in treatment. This is a study by Shirley Glynn in which they compared an exposure therapy called directed exposure therapy to that exposure therapy plus behavioral family therapy that was provided after the individual Veteran received the exposure therapy and there is a third condition that consisted of a waiting list.

There were 18 sessions initially of the directed exposure therapy and for those Veterans who were randomized to get the additional behavioral family therapy, they had 16 subsequent sessions of that particular form of therapy.

The conditions that included the exposure therapy: they found a reduction in positive symptoms at the end of treatment and they also found that the gains in the PTSD symptoms were maintained at the six-month follow up.

Interestingly, there was not an additional benefit of including the behavioral family therapy at the end of the directed exposure therapy. So it did not lead to significant decreases in the PTSD symptoms above and beyond the directed exposure therapy. There was some evidence that there was some clinical improvements in the positive symptoms of PTSD and some improvements in overall social adjustment to do the family therapy as it related to PTSD symptoms. But consistent with the focus being on the improvements on the relationship, there were some improvements in social problems solving in those Veterans and family members who participated in the treatment.

One of the standard interventions of the cognitive behavioral generic couple therapy is to introduce and practice paraphrasing skills also known as listener speakers' skills or reflective listening.

In the following clip, you are going to see a Veteran and his spouse practicing the paraphrasing skill in session with a therapist.

Dr. Monson
We're going to start with listening skills because really that's the foundation of all very good communication, is that a message sent is actually a message heard. So, I'm curious in your relationship can you think of a time where one of you was trying to convey something and the other person misunderstood what it is that you were trying to say?

Wife
I feel like that's all the time.

Dr. Monson
Yeah. So, in order to actually practice good listening, one of the major ways you can do that is to paraphrase. So, what that means is one of you makes a statement the other person says back what they thought they heard. So, you can make sure that you're actually talking and communicating about the same thing before the person who received the message says the next statement. So, it's kind of like passing a baton. Going between each other and really slowing down the communication long enough to make sure that you really heard what the other has said. The other thing that you can do to really communicate well, listen well to each other, is to try and speak in bullet points instead of long paragraphs. So, if you want to really communicate effectively with each other, you can try to shorten the message sent so that the other person can really hear. And that is really important to someone who has PTSD or depression because attention and concentration can get in the way. So, I'm going to go ahead and have you turn your chairs to face each other if you would. Okay. So, the question I would like you guys to practice your best paraphrasing listening skills is, "What has PTSD made us avoid?".

Wife
I think PTSD made us avoid the Bon Jovi concert I wanted to go to. And, we got the tickets and wanted to go. And, then you just decided at the last minute you wouldn't go and didn't care enough to know how important it was to me.

Husband
That's not true.

Dr. Monson
Jeff, I'm going to stop you. Sorry. I'm wondering if you could paraphrase back what you heard her say, even if you don't agree with it, can you make sure that what she was saying is what you received as the message.

Husband
Okay. So basically, you are saying that PTSD made us avoid going to the concert. Is that right?

Wife
Yeah.

Dr. Monson
Is there anything else you were conveying or did Jeff get it?

Wife
Yeah, the big part is I feel like it's because you didn't care that it was important to me.

Husband
Okay. So, you're saying that the reason we didn't go is because I don't care. Is that it?

Wife

Yes.

Dr. Monson
So, Jeff anything you would like to say in response? And, Amy is going to use her best listening skills.

Husband
You know I can't stand being around crowds. And, I don't think I can handle going to a concert like that.

Wife
We didn't go to the concert because you don't like being in crowds. And, it wasn't because you don't care.

Husband
Yeah. That's pretty much it. Yeah.

Dr. Monson
Okay. Do you want to send a message about that?

Wife
When we talked about it that night, he got really angry with me, when I wanted to know why. And I felt really just shut out and put down.

Husband
So, you're saying that we talked about it that night that I was angry and, what was the last part?

Wife
That I felt put down, like you put me down when you were talking to me.

Husband
And you felt like I was putting you down.

Wife
Yeah.

Husband
Is that it?

Wife
Yeah, I think you got it.

Dr. Monson
Good job. And then do you have a message you want to make sure she hears in response.

Husband
I guess PTSD has made us avoid talking about this stuff. Because, you know, it's just kind of hard. It's hard for me to really talk about when I feel upset about stuff. I'd rather just kind of push it away.

Wife
Okay. So, it's hard for you to talk about how you feel, because PTSD gets in the way. Is that it?

Husband
Maybe… It makes me want to just push stuff away, and not…I'd rather not deal with it.

Wife
So, you'd rather not deal with problems that come up because PTSD, because of your PTSD.

Husband
Yeah, that's it.

Dr. Monson
I'm actually going to stop this there for just a second. You guys are doing really great at this. I'm really curious how it feels.

Wife
Awkward.

Husband
Different.

Dr. Monson
Of course, it's a new way you're interacting. I doubt you do this at home.

Wife
No.

Husband
Never.

Dr Monson
Anything good, you think that comes from communicating like this, just making sure you really hear what the other person is saying?

Wife
Like the second and third time, it helped me think about 'how is he going to hear this? So can I say it slower?'.

Dr. Monson
Okay. Yeah. Okay. How about for you?

Husband
I think it kind of feels like it made us understand each other a little bit better. Because most of the time what happens is we just try to get across our point. We don't listen too well.

Dr. Monson
Yeah. My sense is that you felt like you heard better what Amy was saying. And you heard what Jeff was trying to say about it. And as I was sitting here, I was thinking there was at least once where if you hadn't said back what you heard, you could have been off to the races, and really derailed the way that you communicate. It was something about the fact you felt that he might not have cared about you, and that's why he didn't want to go to the concert. And by clarifying, you have the opportunity to really understand what is being said before you make a lot of assumptions and mind-read what the other person is thinking. And then end up in an argument because you are responding to something that really wasn't the message that was being sent. So great job…

Another method of including significant others in PTSD treatment more specifically is to do educational interventions. And in this example, I am going to highlight the S.A.F.E. program as an example of an educational intervention.

S.A.F.E., or Support And Family Education, Mental Health Facts for Families, is a program that was developed by Dr. Michelle Sherman at the Oklahoma City VA Medical Center and the Oklahoma University Health Sciences Center. It's a series of ongoing, free, confidential workshops for families and friends of individuals living with PTSD and/or some other serious mental illness. It's a series of 18 sessions with each of those sessions having a specific topic. So some examples of those topics include: What causes mental illness?, How can I take care of myself as a caregiver?, What can I do when he/she might be angry or violent?, Schizophrenia and its impact on the family, PTSD and its impact on the family.

This particular program allows for rolling admissions meaning that individuals can come and go into the program as it seems appropriate. And there is also time that's allotted for group discussion and social support exchange as well as an opportunity to ask a psychiatrist questions about medications for these mental health conditions.

Another method of including significant others more directly into PTSD treatment is to do partner-assisted interventions. And in this case, I'm going to showcase Strategic Approach Therapy.

Strategic Approach Therapy was developed by Fred Sautter at the New Orleans VA Medical Center. It is a 10-session manualized behavioral couple therapy intervention. It is designed to specifically target the PTSD symptoms of behavioral avoidance and emotional numbing. And it is based upon the idea of including partners to reduce anxiety in the person who has PTSD. It also is designed to improve the relationship quality or tone between the two individuals by using behavioral exchange techniques.

So creating caring days and the idea of increasing the pleasing behaviors between the two individuals. It also builds from stress inoculation training which includes a focus on having the couple or dyad increase their exposures to anxiety producing situations and to increase the positive emotional experiences that they have between the two of them. So this might include going out for dinner in a restaurant that is anxiety provoking but it's also a part of what individuals who are in happy satisfied couples do in their relationship.

Sautter and colleagues have published some uncontrolled outcome data with six male Vietnam-era combat Veterans showing significant improvements in the behavioral avoidance and emotional numbing symptoms that the intervention specifically targets. They also found non-significant improvements in the hyperarousal and re-experiencing symptoms which may be related to having a smaller number of individuals in the sample.

At this point the effects on the relationship satisfaction are unknown and we look forward to hearing more about the more global effects, not just on the PTSD symptoms but also on the relationship factors.

A final way of including couple therapy as a part of the interventions for PTSD is to do a disorder-specific intervention, which is a couple intervention that has a specific focus on a given disorder—PTSD in this case. And the example that I provide for this type of intervention is Cognitive Behavioral Conjoint Therapy for PTSD.

Cognitive Behavioral Conjoint Therapy for PTSD, or CBCT for PTSD, is considered to be a first-line treatment for PTSD with the additional goal of enhancing close relationships. It's a trauma-focused intervention, meaning there is a specific focus on having the individual who has PTSD to go back and examine the trauma that they experience but it is not imaginal exposure based. In other words, the idea is not for them to get better based on facing that trauma memory and going over and over and over it until the anxiety habituates or is extinguished. In this case, the intervention that is focused on the trauma is more of a cognitive nature where we are using the couple's relationship to go back and examine what

happened in enough detail to put that experience back in its proper context. To understand all of the situational factors that may have been occurring at that time that led to the traumatic event.

It is systemic in its orientation, meaning the couple is the client. It is not a partner-assisted intervention where the partner is involved in treatment as a coach or surrogate therapist. Rather there is a focus on examining the interactions in terms of the behaviors and also the cognitions that are occurring between the couple in order to more effectively treat PTSD. There is also an emphasis on externalizing the disorder to exist within their relationship. So in other words, taking the PTSD out of the person who has been diagnosed with it and placing it between the couple for the two of them to join together to try to shrink it or address it so that it doesn't bring such an impediment to their relationship. There is a focus on each person's cognitions, their emotions, and their behaviors and how those interacting cognitions, emotions, and behaviors may either improve or exacerbate PTSD symptoms.

It's 15 sessions long and has been manualized; that manual is now under contract to be published. The sessions themselves are designed to be one hour and fifteen minutes, although there is some flexibility depending on the particular setting in which the clinician may be delivering the intervention. We do have some data of its application with non-romantic dyads, meaning whoever the person with PTSD may consider a significant other or family member—so parents, siblings, friends, close friends.

We have also applied two of the stages in multi-dyad groups of individuals who have one member of the dyad with PTSD. We also have some experience applying the intervention via tele-health modalities, specifically in this case video cameras.Overview of CBCT for PTSD 15 sessions, manualized 1.25-hour sessions (but can be flexible) Applied with non-romantic dyads Applied with multi-dyad groups Applied via tele-health Monson & Fredman, under contract

There are three stages to CBCT for PTSD. The first stage is really focused on introducing the treatment and the conjoint format as well as providing psycho-education about the symptoms of PTSD in an interpersonal context. So not only "what are the symptoms of PTSD?" but "how do they play out in that particular interpersonal relationship?"

In session two, there is a focus on building safety in the relationship—both emotional, and in those cases where there is physical aggression, physical safety in those relationships. And we teach some anger management strategies as well as time out procedures for the couple.

In stage two we build upon that psycho-education and safety building to enhance the relationship using some of the behavioral communication training and also begin to have the couple start addressing the avoidance that is diminishing their relationship quality but also is maintaining the symptoms of PTSD.

And finally, with the improvements in their relationship, and less avoidance in their relationship, the couple is taught a specific cognitive restructuring strategy so that they can together work on the specific cognitions that may be keeping the person with PTSD stuck in their recovery. And so the couple joins together in this process to really examine from a cognitive perspective what are the ways of appraising the traumatic event that either of them may be doing that is keeping the person with PTSD from recovering from that trauma exposure.

CBCT for PTSD in its three stages is built on and follows the acronym RESUME Living, with the "RE" of stage one focused on the Rationale and Education about PTSD and relationships. The "SU" of stage two focused on Satisfaction enhancement and Undermining avoidance.

And finally in stage three, making Meaning of the trauma and the End of the therapy but certainly not the end of the use of the skills that are learned in the treatment.

This particular acronym is meant to imbue the hopefulness about the treatment and the idea that the person can be treated and that the relationship has an important part in the treatment of PTSD and that the two of them can continue a life that doesn't include PTSD symptoms as part of it.

To facilitate the in-vivo exposures or in-vivo approaches as they are named in the therapy, the couple early on develops a list of places, situations, people, and feelings that they may be avoiding. And using that list, we systematically program places, situations, people, and feelings that the couple is going to approach.

In the following clip, you will see the therapist reviewing the couple's progress in beginning to approach a particular place that had been previously avoided and the therapist's and couple's attempts to improve the ways in which they approach these places.

Dr. Monson
So, the other part of what I'd like you to do before I see you next week, is an approach assignment. So, you guys did a great job of fleshing out and adding stuff to the list of things that you avoid as a result of trauma related problems. So I'm curious what you guys can agree to do off of this list before I see you next time. I don't want you to pick the biggest item. I also don't want you to pick an easy item. Something that would be hard for you, but we want you to have a success at it.

Wife
I mean for me, what I would like most is just more of the closeness, and so maybe we can pick something about that.

Husband
Like what do you mean? Like holding hands? Something like that?

Wife
Yeah.

Dr. Monson
Are you doing that now? You're not holding hands at all, right now? Would that be hard for you guys to do?

Husband
I don't know. I just, for me, it feels pretty, I mean, it feels pretty awkward. I don't know. But, I don't know. That might be…

Wife
Yeah.

Husband
I could do it, I could do it.

Dr. Monson
So are we're talking about holding hands on a daily basis? Or are we talking about one time before I see you next time? Let's be concrete.

Husband
I think for me, probably one time is the most realistic.

Wife
I think I want like once a day. So…

Husband
I don't know if that's going to happen.

Wife
I know.

Dr Monson
What would every other day be like, if you made a commitment for every other day?

Husband
We could try that.

Wife
Yeah.

Dr. Monson
What's that going to be like? What do you anticipate are going to be the challenges? What's going to go through your head at the time?

Wife
Even just getting close enough to him, to get to his hands has been a problem.

Dr. Monson
How would it be for you to initiate that, Jeff?

Husband
Pretty weird, I mean I…

Dr. Monson
Did you use to initiate it?

Husband
Sometimes, I guess.

Dr. Monson
So, it's something you use to do. If you're reclaiming your life that would be a part of what you would do.

Husband
Yeah. I suppose so. Yeah.

Wife
I would love that.

Husband
Yeah. I guess I'll just be like remembering to do it, you know.

Dr. Monson
Would it help to schedule it? I really want us to make this a success. Would that be helpful?

Wife

If feels a little weird to do that, to schedule hand holding. But, maybe we can do it while we're sitting on the couch. You know, when we're watching the few shows that we watch together. Like maybe we can just do it right then.

Husband
So now wait a minute. But am I doing it every time? I'm initiating it?

Dr. Monson
Let's talk about that.

Wife
I can do it, like, the first time.

Husband
I mean I'll try to remember. But like if I forget or something, maybe you could.

Dr Monson
Jeff, I'm actually wondering if you would be willing to be the first one to try it.

Husband
Sure.

Wife
Ok.

Dr. Monson
So, I'm going to see you in a week. So, three times, if it's like about every other day, three times. And at least you're going to do at least the first initiation at that.

Husband
Yeah.

Dr. Monson
Okay. I was wondering about if there's anything else on the list that that might be not about intimacy. I think it's important that we are doing that goal, but what about something that's related to a place or a situation that's related to your trauma?

Husband
We could talk about the supermarket, but maybe like, I don't know, during like the night or something, when not as many people are there. You know I still hate that.

Wife
I know. Okay.

Dr. Monson
Let make sure I get it. So, you're saying going to the supermarket, but at night. Do you do that now?

Husband
No.

Dr. Monson
No. No. No. Okay. Is it something that you are willing to do?

Husband
Yeah.

Dr. Monson
You sure?

Husband
Yeah. It just makes me…makes me nervous to think about it.

Dr. Monson
Now are you going to go by yourself? Or are you guys going to go together? How is this going to look?

Wife
Well if you cannot snap at me when we're going through the supermarket.

Husband
I can try, I mean I can't promise anything. But…

Wife
We can go together. Is it worse or better for you if I'm there?

Husband
I think it's better if you're there. If you're not there, I don't know if I can do it.

Dr. Monson
Okay. So, supermarket at night. Together. Okay. So, I'm going to check in on how that went. I'll be very curious to hear how that goes.

Thus far CBCT for PTSD has been tested in an uncontrolled manner with both community and Veterans samples. It's currently being tested in a randomized controlled trial. With regard to PTSD and co-morbid conditions, there have been significant and generally large treatment effects revealing improvements in the Veterans and the community samples. And those effects in terms of the treatment of PTSD are very consistent with the effects found in individual therapy trials. There are also significant and large improvements in Veterans and community samples in self reported depression, general anxiety, and social functioning.

With regard to intimate relationship adjustment, the simultaneous goal of the treatment, we have found significant and large improvements in the partner's relationship satisfaction with effects similar or greater than those found in couple therapy trials. In particular, focused on partners who attend the therapy and participate, we found significant and large improvements in their general anxiety, their social functioning, and in those cases where there have been PTSD symptoms in the partner, improvements in those symptoms in the Veterans sample. And we're currently analyzing the partner results from our community sample.

So in summary, PTSD is an individual mental health condition that has substantial interpersonal effects. So hopefully this presentation will help you think beyond the individual, to think about ways in which you can include loved ones in the assessment and treatment process in order to more fully appreciate the reverberating effects of PTSD on intimate relationships and vice versa.

Also, significant others can provide important information in the assessment and treatment planning process. Perhaps information we otherwise would not be privy to that can really facilitate the ways in which we better understand the experience of the person with PTSD but also can hopefully enhance the treatment that we provide to them.

And finally, there are a variety of ways that we can include loved ones in treatment to improve the relationship environment. So decrease the ambient stress that the person may be experiencing in their relationship and the stress that's associated with that. But also we can include the loved ones in treatment to really improve the effects of that treatment for the individual.

As we marshal all of the resources possible to help in the lives of those with PTSD, it's my hope that you will consider the inclusion of significant others in both the treatment and assessment process to improve the treatments that we provide to those that we serve.