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Piloting the feasibility of delivering cognitive-behavioral conjoint therapy online to military veterans and partners

Laura Josephine Hendriks ^a, Dawn Phee^a, and Dominic Murphy ^{a,b}

^aDepartment of Research, Combat Stress, Leatherhead, UK; ^bKing's Centre for Military Health Research, King's College, London, UK

ABSTRACT

Cognitive-Behavior Conjoint Therapy (CBCT) for PTSD has demonstrated efficacy among military couples in which the veteran is experiencing PTSD. Yet, no studies to date have investigated delivering CBCT online. This brief report aims to describe the feasibility of delivering CBCT online to UK military couples. Six military veterans and their partners received CBCT, delivered using an online video platform. They completed mental health measures at the start and end of treatment as well as 12-weeks follow-up. Data trends suggested reduced psychological distress and trauma symptoms as well as increased wellbeing of veterans and partners. On the individual level, most veterans (83.3%) demonstrated clinically significant reductions in PTSD symptoms. Therapist reflections suggested client acceptability of treatment and highlighted considerations for delivering CBCT online. Clinical implications and the need for further empirical investigation of online-delivered CBCT are discussed.

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KEYWORDS

Cognitive-behavioral conjoint therapy; couples therapy; PTSD; veteran; military

What is the public significance of this article?—This study provides preliminary evidence of the feasibility of delivering Cognitive-Behavior Conjoint Therapy online to military veterans and partners. Results of this study encourage further rigorous examination of the efficacy of Cognitive-Behavior Conjoint Therapy when delivered online, to support its use in treating veterans with PTSD and partners who face barriers to accessing in-person support.

Evidence supports the efficacy of Cognitive Processing Therapy (CPT), Prolonged Exposure Therapy (PE), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Eye Movement Desensitization and Reprocessing (EMDR) in treating PTSD (Cusack et al., 2016; National Institute for Health and Care Excellence [NICE], 2018). Despite their efficacy in reducing PTSD intrusions, avoidance and hyperarousal symptoms, difficulties in intimate relationship functioning may persist (Schnurr et al., 2006). As negative interpersonal relationships can predict worse PTSD treatment outcomes (Price et al., 2013), engaging partners in veteran treatment may help foster outcomes (Kugler et al., 2019). Veterans and partners often report a preference of joint involvement in veteran psychological support (Batten et al., 2009; Spencer-Harper et al., 2019).

The impact of posttraumatic stress disorder (PTSD) on intimate relationships of military veterans is well-documented (Galovski & Lyons, 2004). Partners of veterans with mental health difficulties may experience caregiver burden (Caska & Renshaw, 2011), and commonly report feelings of relationship inequality, isolation, and responsibility for controlling veteran's PTSD triggers (Fredman et al., 2011; Lawn & McMahon, 2014). They are also at risk of psychological difficulties including depression, anxiety, and secondary traumatization (Ahmadi et al., 2011; Murphy et al., 2016). Veterans experiencing PTSD may be more likely to divorce than those without PTSD (Jordan et al., 1992; Letica-Crepulja et al., 2020). As such, military intimate relationships in which the veteran is experiencing PTSD may hold a level of intricacy that may not be adequately addressed by individual veteran PTSD treatment.

Cognitive-Behavioral Conjoint Therapy (CBCT) for PTSD, developed as an intervention for romantic couples in which one partner is experiencing PTSD (Monson & Fredman, 2012), has demonstrated efficacy in reducing PTSD and comorbid symptoms as well as enhancing intimate relations among veteran couples (Fredman et al., 2011). Contrary to other couples therapies that primarily focus on resolving relationship issues, CBCT is a PTSD-focused intervention that involves the individual's romantic partner. Still, military couples may

face a range of barriers, such as childcare difficulties, work responsibilities and travel distance, that prevent them from engaging in psychological support (Hendrikx & Murphy, 2021). Delivering CBCT online may thus be a helpful treatment alternative for couples facing such barriers. Evidence that teletherapy is as effective in treating PTSD as in-person treatment, and that dropout rates may be similar (e.g., Sunjaya et al., 2020), supports that online-delivered CBCT may similarly be effective in treating veterans with PTSD.

As such, the present pilot explores the feasibility of delivering CBCT online to six military couples. Reductions in quantitative outcome data are used to infer potential benefits of online-delivered CBCT, and therapist qualitative reflections are used to identify client acceptability and considerations of the online modality.

Methods

Participants and recruitment

Six military couples were recruited from a UK charity offering nationwide psychological support to UK armed force veterans. Potential participants were identified from a list of military partners who had previously taken part in a randomized controlled trial (RCT) investigating a webinar program developed for military partners ($N = 102$). Clinical notes were screened according to the study inclusion criteria: i) veteran and partner in a current relationship, and ii) veteran PTSD diagnosis. Exclusion criteria included evidence of personality disorder, history of multiple suicide attempts, excessive alcohol or drug use, and any safeguarding concerns. The present pilot was approved by the charity's research committee.

Procedure

Couples identified as eligible during screening ($N = 50$) were emailed or posted study information and baseline measures. Couples interested in taking part contacted the researcher, returned study measures, and underwent an informal online assessment with the therapist to verify suitability ($n = 14$). Exclusion of couples following the assessment was primarily due to couples not being able or willing to commit to therapy (e.g., no time to attend sessions) and no longer meeting inclusion criteria (i.e., no longer in relationship). Those excluded due to and not being able to access online sessions (i.e., no access to desktop/laptop or WiFi, not able to use Microsoft (MS) Teams or Skype) were limited, and technological difficulties encountered were largely resolved. Couples were made aware of the voluntary

nature of participation and were encouraged to discuss any concerns they had. Couples were required to provide verbal consent if they wished to take part in the study. No compensation was offered for participation.

Couples who consented to participate then received CBCT, delivered in accordance with Monson and Fredman's (2012) treatment manual. Couples were encouraged to attend from the same location as much as possible but were allowed to attend from separate locations if necessary (e.g., self-isolation due to COVID-19). Prior to each session, couples were emailed a link to the online room. After each session, they were sent relevant homework worksheets. Couples completed questionnaires at the end of treatment and at 12-weeks follow-up. At the end of treatment, they discussed their experience of CBCT and the online delivery with the therapist. The therapist provided reflections of client experiences and own experience of the online delivery of CBCT.

Measures

Veterans and partners completed mental health measures at the start and end of treatment, and 12-weeks follow-up. Quality of life (QoL) was assessed using a single item, scored on a 5-point scale ranging from 1 (*very good*) to 5 (*very bad*). General psychological distress was assessed using the 12-item General Health Questionnaire (GHQ-12; Goldberg & Williams, 1988). Participants indicated how much they had been bothered by difficulties over the past month on a 4-point scale, ranging from 0 (*not at all*) to 3 (*much more than usual*). Higher scores are indicative of greater psychological distress.

Veteran PTSD symptoms were assessed using the 20-item Posttraumatic Stress Disorder Checklist (PCL-5; Weathers et al., 2013). Participants indicated how much they were bothered by difficulties over the past month on 5-point scale, ranging from 0 (*not at all*) to 4 (*extremely*). As previously validated as the optimum cutoff score among UK treatment-seeking veterans (Murphy et al., 2017), case criteria are defined as 34 or more. Partner secondary trauma symptoms were assessed using the 17-item Secondary Traumatic Stress Scale (STSS; Bride et al., 2004). Participants indicated their experience of various symptoms on a 5-point scale, ranging from 1 (*never*) to 5 (*very often*). Higher scores are indicative of greater severity of secondary traumatization.

General wellbeing was assessed using the 7-item Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS; Stewart-Brown et al., 2009). Participants indicated how they have felt over the past two weeks on

a 5-point scale, ranging from 1 (*none of the time*) to 5 (*all of the time*). Higher scores are indicative of greater mental wellbeing.

Treatment approach

CBCT is a dyadic treatment for PTSD, consisting of 15 75-minute sessions (Monson & Fredman, 2012). The intimate relationship dyad is considered the “client,” and all interventions are designed to support the dyad. The first two sessions include PTSD psychoeducation focused on promoting understanding and management of anger and irritability difficulties. The following five sessions focus on developing communication and problem-solving skills and reducing avoidance via approach tasks. The final eight sessions involve engaging the dyad in cognitive work to address trauma-related thoughts relating to acceptance, blame, trust, power, control, emotional and physical intimacy, and posttraumatic growth. Couples are assigned between-task assignments to engage with the various tools and interventions outside of the session. Further details on the session-by-session focus and content can be found in Monson and Fredman’s (2012) detailed treatment manual.

CBCT was administered in the present study by an experienced senior psychologist who had completed the CBCT foundation training. All couples completed all 15 treatment sessions. Adherence to attending weekly sessions was high across participants, with only 6 sessions being rescheduled for the following week due to, for example, unanticipated changes in childcare or work demands. Therapy breaks were planned due to, for example, moving house or therapist leave. On average, couples took 19 weeks to complete treatment.

Analysis methods

Given the small sample of the present pilot, reliance on test statistics and p-values would be unreliable and invalid. As such, changes in general psychological distress, trauma symptoms and general wellbeing were inferred by visual inspection of outcome measure data trends. Change in veteran PTSD scores as indicated by the PCL-5 were inspected on an individual level. Reductions by 5–10 points on the PCL-5 are suggestive of reliable change, and reductions by 10–20 points are suggestive of clinically significant change. Feedback from the therapist around client experiences and considerations of the online delivery of CBCT are discussed.

Results

Sample characteristics

The sample consisted of six heterosexual military couples. Five couples reported living together at the time of participation. Three couples reported being in a relationship for 0–3 years, one reported 7–9 years, and the remaining two reported 16+ years. Three couples reporting having a child and/or dependent living with them.

All veterans were male ($M_{age} = 47.00$, $SD_{age} = 11.71$). Veteran military service ranged from 8 to 23 years. Veteran onset of PTSD diagnosis ranged from 1 to 12 years prior. In terms of veteran educational level, two had no formal qualification and four had completed lower-level education. In terms of veteran employment, four were employed full-time, one was unemployed and seeking work, and one was unemployed and not seeking work.

All partners were female ($M_{age} = 41.5$, $SD_{age} = 12.22$). One partner had served in the military. In terms of partner educational level, five had completed lower-level education and one had completed higher-level education. In terms of partner employment, four were employed full-time, one was part-time employed, and one was a stay-at-home parent.

Quantitative outcome data

Data trends suggested reduced general psychological distress (see Figure A1) and trauma symptoms (see Figure A2), as well as increased wellbeing (see Figure A3), of veterans and partners between the start and end of treatment. Trends suggested that while veteran and partner scores continued to reflect improved mental health at follow-up compared to pre-treatment, veterans appeared more likely to experience a slight deterioration in general psychological distress, trauma symptoms, and mental wellbeing at follow-up compared to the end of treatment.

Veteran PTSD symptoms. Symptom scores were $M = 57.0$ (Range = 42–73) at baseline, $M = 44.0$ (Range = 35–53) at end of treatment, and $M = 44.5$ (Range = 35–52) at follow-up. Although all veterans still met criteria of probable PTSD at follow-up, 83.3% demonstrated PTSD symptom reductions suggestive of clinical significance at follow-up, compared to start of treatment (Table 1).

Therapist reflections

Couple experiences

The experience of the couples, as reported by the therapist, reflected overall acceptability of the intervention. They reported feeling comfortable, in control and able to

Table 1. PTSD scores as indicated by PCL-5 at baseline, end of treatment, and follow-up.

No	Pre-treatment	Post-treatment	Follow-up	Pre to Post Change	Pre to Follow-up Change
1	57	42	46	15**	11**
2	62	50	52	12*	10**
3	48	39	35	9*	13**
4	42	35	38	7*	4
5	60	53	46	7*	14**
6	73	45	50	28**	23**

Reliable change is indicated by “*” Clinically significant change is indicated by “**”.

engage during sessions within their own environment rather than in a physical room with a therapist. Couples reported that the key benefit of the intervention was it being the first time they spoke openly about their emotions and ongoing difficulties, for example, around parenting stepchildren, ex-partners, and balancing demands during the COVID-19 pandemic. It was evident that veterans experienced difficulties in identifying, labeling, and communicating emotions while many partners silently held anger and resentment toward the veteran. Veterans often reported being unaware of their partners’ emotional experience because they were caught in their own PTSD symptoms and themselves felt angry that their partners were not able to understand them. Couples reflected improved emotional, physical and sexual intimacy due to being able to understand their partners’ and own beliefs and assumptions of what relationships look like. Finally, in addition to enhancing relationship closeness, many couples also reported a positive impact on their children and overall family life.

Therapist experience

The therapist found that CBCT could be delivered effectively online. Couples were able to maintain the dyad-focus of CBCT, avoiding the perception of the “veteran as mentally unwell” and “partner as the carer” and instead viewing each other as equals with individual needs and difficulties. Furthermore, the online delivery did not impede the learning of healthy relationship skills, such as early problem identification. The therapist reported that all couples adapted quickly to the online delivery of conjoint therapy and that sessions overall ran smoothly even when veteran and partner joined from separate locations (and were on separate screens). Finally, it was reflected that the online delivery appeared to support couple motivation to engage. There remained a high commitment throughout treatment with a total of six appointments being rescheduled across couples due to unforeseen circumstances.

Therapist considerations

The therapist noted a few considerations regarding the online delivery of CBCT. While the therapist found that delivering CBCT online offered further insight into couple home functioning, sessions had the potential to feel less controlled than in-person therapy given occasional unpredicted disruptions such as the baby needing feeding or neighbors knocking. Importantly, the therapist also noted that couple interaction and engagement during sessions was occasionally impacted by where the couple sat, for example, on a sofa versus at a table and whether they were closer or further away from the screen. For example, couples communicated more frequently and openly with each other when they sat further away from the screen at an angle to each other, compared to depending more on the therapist’s interaction when they sat nearer the screen. While the choice was left to the couple, they were encouraged to sit in a position where could easily see each other rather instead of focusing on the screen. The therapist also reported that the session flow could sometimes be impacted by the functionality of the online MS Teams and Skype platforms, specifically regarding the ease of document sharing and reviewing. Activating the platforms’ whiteboard and document sharing functions caused the document to cover the majority of the screen while the therapist and couple icons would move to the periphery of the screen, which seemed to cause a distraction for some. One of the main challenges of the online delivery related to reviewing couples’ homework worksheets. Reviewing completed worksheets often took more time as couples often wrote down information rather than modifying the relevant PDF sheets that could be shared on the platform during the session. Finally, to prevent technological difficulties, couples were provided with a simple worksheet to help manage minor difficulties such as the screen freezing or losing the invitation to the online session appointment. When technological difficulties arose during sessions, they were resolved rapidly by asking the couple moving to another area of the house and/or moving the internet router. As with any online intervention, some technological difficulties occurred but were thought to be minimal.

Therapist recommendations

The therapist has recommended that future delivery of CBCT online should consider how to minimize interferences or difficulties related to the online modality. Specifically, attention should be given to the way relevant treatment material is shared with couples and how homework worksheets are reviewed in session to minimize distractions and support session flow. For example,

hardcopies of treatment material could be shared with the couple prior to the start of treatment and therapy agreements could involve setting the expectation that couples take a photo of completed assignments to e-mail to the therapist prior to the session. Alternatively, creating an online platform with an accessible interface can allow the couple and therapist to have access to all relevant (completed) worksheets online, without needing to disrupt session flow by sharing documents on the video platform.

The therapist has also made a few recommendations to control for certain losses of control that therapists in an in-person setting may have. Firstly, therapists are recommended to have an initial informal assessment with the couple prior to treatment to assess online interaction and communication skills, potential risk or safeguarding concerns, and confirm that the couple can meet the demands of CBCT (including interacting with the relevant platforms used for sharing treatment material). It is recommended that this initial meeting also focuses on setting clear boundaries to support treatment adherence. Such conversations should include problem-solving together with the couple to ensure proactive actions to minimize distractions and promote session flow as well as create contingency plans for when any unexpected distractions may occur. Secondly, given the highly specialized CBCT treatment model and challenges associated with couple work, the therapist strongly recommends that therapists have access to regular clinical supervision with an experienced CBCT practitioner to support treatment adherence.

Discussion

The present study piloted the feasibility of delivering CBCT online to military couples where the veteran is experiencing PTSD. Data trends suggested improvements in veteran and partner general psychological distress, trauma symptoms, and overall wellbeing. Change scores also suggested that most veterans experienced clinically significant reductions in PTSD symptoms. Such findings resemble those of investigations of in-person CBCT, however direct comparisons should be made with caution given their reliance on alternative measures of PTSD symptomatology (Macdonald et al., 2016; Monson et al., 2012). Importantly, previous studies have primarily focused on veteran wellbeing and overlooked partner psychological symptomatology. Contrary to studies of in-person CBCT, the present study demonstrated increases in veteran difficulties at follow-up (albeit remaining lower than at the start of treatment). While this may reflect the pervasiveness of PTSD difficulties that may require in-person treatment, evidence suggests that tele-therapy may

be as effective as in-person treatment in reducing PTSD symptomatology (Turgoose et al., 2017). An alternative explanation is that the current sample may be too small to detect maintained gains as reflected in previous studies of in-person CBCT (Monson et al., 2012).

While therapist reflections suggest that CBCT may be delivered effectively online, a few practical concerns were highlighted to ensure effective and safe delivery. Firstly, consideration should be given to the most suitable way to share treatment material with couples to minimize distractions and promote session flow. Secondly, consideration of appropriate monitoring and managing of risk and safeguarding concerns is paramount. Therapists delivering teletherapy may feel more uncertain about managing crisis situations, such as suicidal ideation, due to a perceived lack of control over clients' physical environments (Springer et al., 2020). Veterans experiencing PTSD may face a greater risk of suicidal behavior compared to those without (Pompili et al., 2013). Findings also suggest that, in the face of the unique military and integration related stressors, military couples may be at greater risk of domestic violence (DV) compared to civilians (Heyman & Neidig, 1999) and some military children may face an increased risk of attachment difficulties, psychological difficulties, maltreatment and exposure to DV (Lester et al., 2016; Rentz et al., 2007). Clearly, consideration of appropriateness of treatment in the face of risk or safeguarding concerns is required. For example, despite controversy around the suitability of couples therapy in the presence of DV, those supporting its use highlight the need for appropriate screening and monitoring to ensure safety of both partners (see, McCollum & Stith, 2008). Appropriate training to support therapist confidence may be essential in the online delivery of CBCT. Since the onset of the COVID-19 pandemic, professional bodies and work organizations quickly adapted an extensive collection of guidelines and policies for teletherapy. Existing guidance (e.g., Moring et al., 2020) provides a beneficial framework for appropriate risk management in online veteran therapy and should be used to guide future online delivery of CBCT.

There are limitations of the present study to consider. Firstly, being a small-scale pilot with no control group, it cannot be ruled out whether symptom reductions were due to chance or factors unrelated to the intervention. Secondly, the qualitative data on couple experiences is limited in that it reflects qualitative feedback from the therapist at the end of the trial, rather than data collected directly from the couples. Thirdly, the therapist delivering CBCT online had limited experience with the online platforms used and limited

experience in delivering CBCT. Fourthly, the sample was recruited from a list of military partners who had previously taken part in a psychoeducational webinar. Fifthly, no data on veteran previous treatment was collected. Finally, the study did not measure relationship satisfaction and potential changes in dyadic interaction cannot be inferred.

Future research is essential to determine the efficacy of CBCT when delivered online and to compare its efficacy to in-person delivery. For example, Morland et al. (2019) have proposed a RCT to compare the utility of a brief 8-session versus 15-session CBCT protocol delivered in-person versus online video-conferencing. Such an investigation could potentially extend the evidence of similar efficacy of teletherapy and in-person treatment of PTSD (e.g., Sunjaya et al., 2020). As is demonstrated in the proposed study design, it is essential for such research to focus on partner wellbeing in addition to veteran wellbeing and PTSD symptoms. Further evidence of the effectiveness of the online delivery of CBCT could grow the toolbox available to clinicians to support the mental health needs of military couples, such as those facing barriers to engaging with in-person treatment. Evidence for the online delivery of CBCT is particularly relevant in context of the expanded (and likely continued) use of online therapy following the COVID-19 pandemic.

Disclosure statement

No potential conflict of interest was reported by the author(s).

ORCID

Laura Josephine Hendriks  <http://orcid.org/0000-0001-6760-3373>

Dominic Murphy  <http://orcid.org/0000-0002-9530-2743>

Data availability statement

Data available on reasonable request from the authors.

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Appendix.

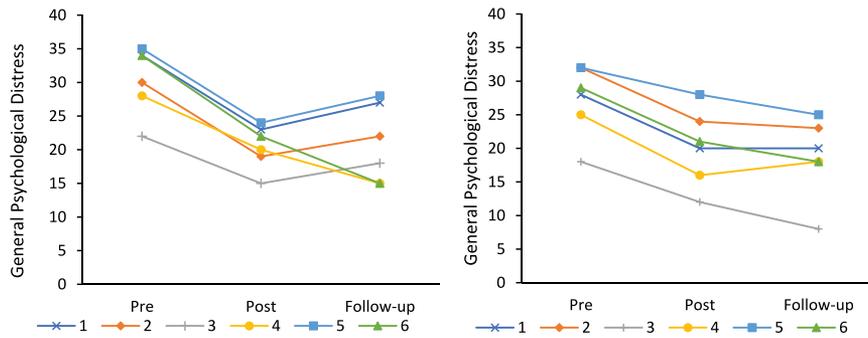


Figure A1. Veteran (left) and partner (right) general psychological distress at pre, post, and follow-up as indicated on the GHQ-12.

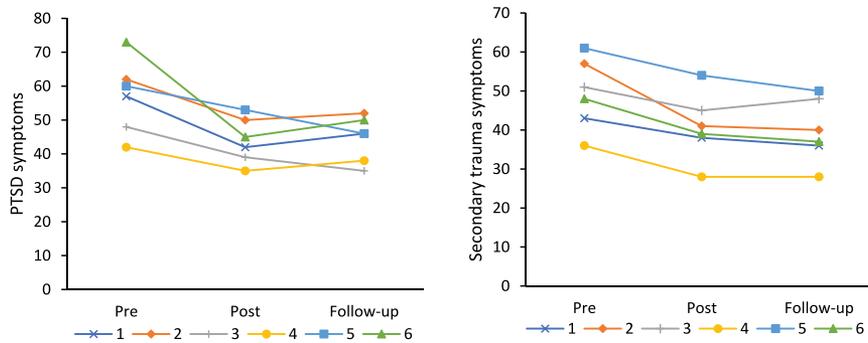


Figure A2. Veteran (left) and partner (right) trauma symptoms at pre, post, and follow-up, as indicated on the PCL-5 for veterans and the STSS for partners.

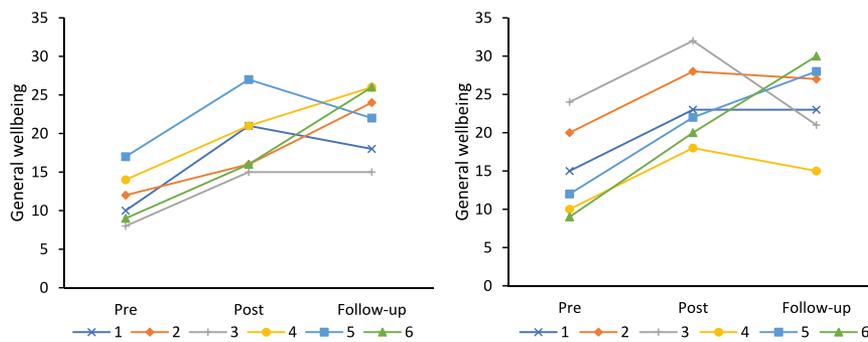


Figure A3. Veteran (left) and partner (right) general wellbeing at pre, post, and follow-up, as indicated on the SWEMWBS.