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# Couple-based therapeutic interventions aimed at treating the individual and relational impact of childhood abuse

Megan A. Maguire

Pepperdine University

Graduate School of Education and Psychology

# COUPLE-BASED THERAPEUTIC INTERVENTIONS AIMED AT TREATING THE INDIVIDUAL AND RELATIONAL IMPACT OF CHILDHOOD ABUSE

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by

Megan A. Maguire

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Kathleen Eldridge, Ph.D. – Dissertation Chairperson

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Megan A. Maguire

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

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Doctoral Committee:

Kathleen Eldridge, Ph.D., Chairperson

Veronica Viesca, Ph.D.

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# VITA

## Education

**Pepperdine University** **July 2023**
**Doctorate in Clinical Psychology- APA Accredited**
Association of Neuropsychology Student Training Representative

**California State University, Long Beach** **2018**
**M.S. in Psychology Counseling, Marriage and Family Therapy**
Graduated Dean's Honor List

**University of California, Irvine** **2016**
**B.A. in Psychology and Social Behavior**
**B.A. in Education Sciences**
Dean's Honor List 2014-2016

## Clinical Experience – Pre-Doctoral Internship

**Penn Medicine Lancaster General Health Institute for Neuroscience Aug. 2022 – Jul. 2023**
**Clinical Neuropsychology Intern (APA-Accredited)**
Supervisors: Sabrina Everett, Psy.D., Jesse Main, Psy.D., David Marino, Ph.D., & Edward Purzycki, Ph.D., ABN

- A primary focus of the pre-doctoral internship training at Penn Medicine Lancaster General Health is to cultivate well rounded neuropsychologists within a multidisciplinary treatment setting involving both outpatient and inpatient treatment.

## Clinical Experience- Practicum

**UCLA Semel Institute for Neuroscience & Human Behavior** **Jul. 2021 – Jun. 2022**
**Advanced Medical Psychological Assessment Center (MPAC)**
**Neuropsychology Extern**
**Supervisor: Patricia Walshaw, Ph.D.**

- Reason for referral include neurodevelopment disorders (ADHD), neurodegenerative disorders (Alzheimer's, Parkinson's), pre-post operative assessment, TBI, stroke, epilepsy, and psychiatric illness.
  Participated in neuropsychological and neuroanatomy didactics, epilepsy surgery and movement disorder conference meetings, and case presentations.

**Harbor-UCLA Medical Center** **Sept. 2021 – Jul. 2022**
**Neuropsychology Extern**
**Supervisor: Matthew J. Wright, Ph.D.**

- Gained experience providing neuropsychological assessment to underserved populations within the Department of Mental Health system of California.

**Kaiser Los Angeles Medical Center, Department of Psychiatry** **Sept. 2020 – Aug. 2021**
**Neuropsychology Extern**
**Supervisor: Karen D. Earnest, Ph.D., ABPP-CN**

- Responsible for the clinical interview and administration of a fixed-flexible comprehensive neuropsychological battery with a diverse population of patients presenting with a wide variety of medical and psychiatric diagnoses via a telehealth platform.
- Conducted pre- and post-surgical evaluations to determine cognitive functioning for patients undergoing neurosurgery for neurological disorders such as epilepsy, Parkinson's disease, and other movement disorders (i.e., DBS).
- Additional patient referrals include TBI, dementia, and mild cognitive impairment.
- Presenting pre/post-surgical evaluation results to the neurosurgical team to inform surgical intervention and post-operative prognosis.

**Pepperdine Counseling Center, Irvine** **Sept. 2019 – Dec. 2021**
**Supervisor: Joan I. Rosenberg, Ph.D.**

- Provided outpatient psychotherapy to adult clients from diverse socioeconomic and multicultural backgrounds.
- Presenting patient diagnoses included anxiety, depression, panic disorder, and posttraumatic stress disorder (PTSD).

**Rich & Associates Private Practice** **Jul. 2020 – Jun. 2021**
**Group Co-Facilitator**
**Supervisor: Seth Shaffer, Psy.D.**

- Co-facilitated multiple therapy groups with young adolescents focusing on social skills, emotion regulation, and behavioral counseling.
- Child diagnoses include neurodevelopmental disorders such as attention-deficit/hyperactivity disorder (ADHD), autism, learning and intellectual disabilities.

**Friendship Island Social Skills Summer Program** **Jul. 2020 – Aug. 2020**
**Group Facilitator**
**Supervisor: Erika C. Rich, Ph.D.**

- Provided group therapy within an intensive outpatient social skills group with children ages 6 through 12 focusing on improving peer communication, emotion regulation, adaptive behavioral responses, and self-esteem.

**The Long Beach Trauma Recovery** **Jan. 2018 – Dec. 2018**
**Marriage and Family Therapist Trainee**
**Supervisors: Bita Ghafoori, Ph.D., & Debora Luken, LMFT**

- Provided evidence-based treatment to survivors of trauma with PTSD, depression, anxiety, and other comorbid psychological disorders.
- Trained in the implementation of Cognitive Processing Therapy, Prolonged Exposure, Trauma-Focused Cognitive Behavioral Therapy, Narrative Exposure Therapy, and Seeking Safety.

**Outreach Concern Inc.** **Sep. 2015 – Jun. 2016**
**School Therapy Intern**
**Supervisors: Brandy Henning, LMFT**

- Utilized a combination of different learning theories and interventions to improve the behavior, emotional wellbeing, and academic performance of students in kindergarten through sixth grade.

**Academic Advisor** **Mar. 2013 – Jun. 2016**
**University of California, Irvine**

- Counseled undergraduate students on academic requirements and university policy.
- Guided students towards reaching their academic goals and building their class schedules.

## Research & Teaching Assistant Experience

**Teaching Assistant** **Aug. 2020 – Jun. 2022**

**Courses: Cognitive & Neuropsychological Assessment, Personality Assessment**
**Susan Himelstein, Ph.D.**
**Pepperdine University**

**Teaching Assistant** **Aug. 2020 – Dec. 2020**

**Course: Sociocultural Foundations of Behaviors**
**Shelly Harrell, Ph.D.**
**Pepperdine University**

**Research Assistant** **Jun. 2019 – Aug. 2020**
**Edward Shafranske, Ph.D., ABPP, & Carol Falender, Ph.D.**
**Pepperdine University**

- Responsible for the APA formatting of references and appendix measures for second edition of *Clinical Supervision: A Competency-Based Approach*.

**Thesis Author/Principal Investigator** **Published Dec. 2018**
**Faculty Chair: Bita Ghafoori, Ph.D.**
**California State University, Long Beach**

- Project Title: Investigation of Factors Associated with Reducing the Risk of Future Intimate Partner Violence Among Interpersonal Trauma Survivors Following Psychotherapeutic Intervention

**Research Assistant** **Jun. 2017 – Dec. 2018**
Bita Ghafoori, Ph.D.
California State University, Long Beach

- Responsible for administration and scoring of psychological assessments, and participant data input.

**Research Assistant** **Jun. 2015 – Dec. 2016**
Sean Drake, Ph.D.
University of California, Irvine
- Investigated stereotypes and perceptions of success in African American youth regarding academic achievement in school systems.

**Teaching Assistant** **Sept. 2015 – Dec. 2015**
Course: Equality & Education
Jeanne Stone, Ph.D.
University of California, Irvine

**Research Assistant** **Jun. 2015 – Dec. 2015**
Gil Conchas, Ph.D.
University of California, Irvine
- Conducted comprehensive literature review investigating disparities in access to advance healthcare technology of Latin American low-income populations.

## Academic Publication

Maguire, M. A. (2018). *Evidence-based psychotherapeutic treatment for victims of intimate partner violence: An investigation of the relationship between patient presenting characteristics and treatment*. California State University, Long Beach.

## Academic/Professional Presentations

Maguire, M. A. (2018). *Evidence-based psychotherapeutic treatment for victims of intimate partner violence: An investigation of the relationship between patient presenting characteristics and treatment.* The International Society for Traumatic Stress Studies Annual 2018 Conference, Washington, DC, United States.

Maguire, M. A. (2018). *Trauma 101: Survivors of sexual assault considerations & interventions: Information regarding common reactions to trauma and sexual assault.* [Power Point slides]. Long Beach Trauma Recovery Center.

# ABSTRACT

Childhood abuse can have a significant and lasting impact on an individual's mental health and relationships, including their ability to trust, communicate, and form healthy attachments. While the greater literature focuses on individual interventions to address childhood trauma, there is limited research on the potential positive impact of a couple-based therapeutic approach on outcomes of individual mental health and relationship distress. This dissertation sought to summarize empirically researched couples-based psychotherapies designed to address the effects of childhood abuse and review evidence regarding therapeutic outcomes. The dissertation implemented the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) to ensure a high-quality systematic review. The systematic review includes empirical peer-reviewed quantitative research, researcher extraction of data from articles that met criteria, and narrative synthesis of results. Results highlighted that couples-based therapies show promise to reduce symptoms of depression and PTSD, while also effectively improving relationship quality. This dissertation provides a valuable contribution to clinical literature and expands treatment options to address the negative impact of childhood abuse.

## Chapter 1: Background and Rationale

In 2020 it was estimated that within the United States, one in seven children had experienced some form of abuse or neglect, with rates being five times higher in families of low socioeconomic status (Centers for Disease Control [CDC], 2022). Based on the National Child Abuse and Neglect Data System in 2018, the aggregate lifetime burden for victims alone was 592 billion dollars (CDC, 2022; Letourneau et al., 2018). The psychological impact childhood abuse or neglect may have on an individual has been well documented in the academic literature (Horwitz et al., 2001; Nelson et al., 2002; Spataro et al., 2004). For example, the ACE's (Adverse Childhood Experiences) study found that individuals who experienced childhood abuse or other adverse childhood experiences had a higher likelihood of experiencing physical and mental health problems, as well as social and economic challenges, later in life, underscoring the importance of addressing childhood trauma and providing support to individuals who have experienced it (Felitti et al., 1998). Neuroscience has shown that the stress caused by experiences of abuse and neglect in early development has the potential to rewire human neurophysiological structures and compromise their physiological functioning throughout the lifespan (Cozolino, 2002). This early rewiring can increase agitation, hypersensitivity to stress, and decreased cortical functioning, increasing susceptibility to later psychiatric illness (Teicher et al., 2003). Numerous studies have found that these individuals, as adults, are at significantly higher risk for practically all types of psychological conditions, such as depression, anxiety, personality disorders, and substance use disorders (Horwitz et al., 2001). Experiencing childhood maltreatment may also increase the long-term risk for cardiovascular disease, respiratory problems, gastrointestinal disorders, obesity, and exacerbate many other physical health issues (Hemmingsson et al., 2014; Romans et al., 2002; Wegman & Stetler, 2009). Additionally,

individuals with a history of childhood abuse or neglect may display increased aggressive behavior and engage in unsafe sexual practices (Banducci et al., 2014). Furthermore, research has demonstrated that adults who were victimized as children are at greater risk of adult revictimization by nonintimate and intimate partners, perpetuating and compounding the impact of abuse (Banyard et al., 2003; Desai et al., 2002; Meade et al., 2009).

Childhood abuse is differentiated from many other traumas due to the abuse's interpersonal nature, which may often be convoluted with love and affection (Briere & Runtz, 1990). The literature has generally acknowledged that childhood experiences of abuse may often impact adults' interpersonal functioning. However, there has been less research investigating the impact these atrocities may have on adults' intimate relationships and even less on how to help (Nelson et al., 2002). Men and women who reported a history of child abuse or neglect tended toward decreased marital satisfaction compared with couples where neither partner reported a history of child abuse (Colman & Widom, 2004; Fleming et al., 1999). The research has suggested that these adults may experience intense feelings of isolation even within a relationship and exhibit significant mistrust towards partners (Davis & Petretic-Jackson, 2000). Individuals with a history of childhood maltreatment have been shown to display decreased emotional and physical involvement within their romantic partnership, increasing a sense of isolation (Bagley & Ramsay, 1986; Bifulco et al., 1991; Colman & Widom, 2004).

Additionally, several studies suggest that a pattern of emotional withdrawal and lack of trust in others may increase infidelity and divorce rates among child abuse survivors (Colman & Widom, 2004; Mullen et al.,1996). Research has demonstrated that men and women who reported a history of childhood victimization are more likely to engage in or become victims of intimate partner violence (Bevan & Higgins, 2002; Widom et al., 2006). Finally, also of

importance to mention recent research highlights how the non-abused partner may experience vicarious trauma impacting the overall quality of the relationship (Nelson & Wampler, 2000).

While survivors of childhood sexual abuse may often struggle to form romantic, healthy attachments as adults, they demonstrate a marked longing for a secure and stable partnership (Allen et al., 2001). Despite the challenges couples with a history of abuse might face, research has demonstrated that developing a healthy interpersonal relationship can significantly buffer childhood trauma's negative impact (Runtz & Schallow, 1997). Furthermore, couples' therapy is beneficial for addressing intimate relationship function and processing past traumatic experiences that cause individual distress (MacIntosh & Johnson, 2008). Unfortunately, there has been a striking lack of literature exploring how best to cultivate and utilize this potential protective factor within a clinical treatment setting (Whiffen et al., 1999).

Due to the prevalence of individuals who experience childhood maltreatment and the substantial impact on both individual and relational functioning, it is a critical variable to consider in psychological treatment, which often may go overlooked. Given the interpersonal nature of childhood abuse and the negative impact on intimate relationships, it is likely that couple therapists will encounter partnerships where one or both individuals may report a history of abuse (Paradis & Boucher, 2010). Additionally, Miller and Sutherland (1999) emphasized that childhood abuse experience can significantly impact couple therapy's effectiveness, signifying a need for expanded clinical knowledge and treatment approaches.

**Theoretical Understanding**

In reviewing the relevant literature relating to childhood abuse and its impact on adult intimate-partner relationships, three theoretical approaches were utilized to explain the impact of these early traumatic experiences.

### *Cognitive Social Learning Theory*

Social learning theory, developed by psychologist Bandura (1969), posits that as children, we learn through imitation, adopting the thoughts, feelings, and actions of those around us. As adults, we display similar patterns of responding to the environment that we witnessed as children (Abbassi & Aslinia, 2010). Bandura and Jeffrey (1973) theorized that others' behaviors are the most influential force in learning response patterns to the environment. Learning theory emphasizes the external stimuli associated with a particular response (Anderson & Kras, 2005). Internal cognitive and emotional factors reinforce behavioral responses (Tedeschi & Felson, 1994). Bandura and Jeffrey (1973) asserted that this is especially true when in situations of stress and conflict with other people. Significant individuals close to children act as role models for their adult coping skills and ways of reacting to others (Colman & Widom, 2004; Dorr & Kovaric, 1980). The patterns of interaction we observe, and experience between people as children can lay a framework for interacting with romantic partners as adults (Colman & Widom, 2004).

When children experience abuse, they are more likely to incorporate those messages within their cognitive functioning, impacting their relationships as adults (Halford et al., 2003; Mihalic & Elliott, 1997). Skuja and Halford (2004) found that children exposed to violence exhibited a pattern of more negative cognitions as adults. Research may suggest that prior exposure to abuse as a child predisposes adults to perceive behaviors by their romantic partner more often as unfavorable. Abused children may often receive conflicting messages regarding conflict, violence, affection, and love, especially if the abuser is a close friend or family member. According to social learning theory, it is possible that the learned patterns of abusive behavior in times of stress may be generalized to other situations as adults (Dollard & Miller, 2013; Johnson

& Williams-Keeler, 1989; Leonard et al., 2006). The individual may exhibit heightened sensitivity to the partner's behaviors and may experience their actions as signs of rejection, maltreatment, or neglect while simultaneously being less likely to notice positive or repair attempts made by their partner (Feldman & Downey, 1994; Johnson & Williams-Keeler, 1989). For adult victims of child abuse, romantic partnerships may be especially triggering negative learned patterns of interaction. Vranceanu et al. (2007) suggest that healthy relationships may also be a potent mediator between child maltreatment experiences and present psychological distress symptoms. Anderson and Kras (2005) asserted that these stimulus-response patterns during stressful situations between intimate partners must be addressed to promote new learning and relationship improvement. Therapeutic intervention between the couple may pose an opportunity to improve the quality of the relationship, manage the impact of prior childhood abuse, address maladaptive learned behaviors, and strengthen protective factors for the individual (Larsen et al., 2011).

***Object Relations Theory***

Object Relations Theory takes a developmental approach that incorporates an attachment-based perspective proposing that individuals create concepts of self, others, and relationships based on early patterns of interaction and experiences with caregivers (Crittenden & Ainsworth, 1989). In applying this theory to individuals who have experienced childhood maltreatment, early abuse leads to developing thoughts, feelings, and behaviors, which may damage one's ability to develop and maintain healthy romantic partnerships (Ornduff, 2000). Adult abuse survivors often may create patterns of interacting with their romantic partners, which reenacted the traumatic patterns they experienced as children representing their subconscious self-object relationship (Buttenheim & Levendosky, 1994; Maltas, 1996; Scharff, J. S. & Scharff, 1997).

Bromberg (1998) suggested that due to a tendency for victims to dissociate from their own experience, these individuals may unconsciously utilize projective identification with their partners in times of stress, contributing to perpetuating patterns of conflict within the relationships and intensifying psychological distress in the individual. Nevertheless, childhood sexual abuse survivors' romantic relationships are often characterized by a tumultuous relationship dynamic in which traumatic patterns are continually reenacted and reinforced (Buttenheim & Levendosky, 1994; Maltas, 1996). Such traumatic patterns encompass self and object representations, frequently split off from consciousness, leaving them often unaddressed. Powerful unconscious processes of projective identification then reveal and express each partner's distinct and sometimes dissociated self-states (Bromberg, 1998).

While research suggests that the retelling of the abuse within a safe relationship can help promote healing of these damaged self-object concepts, the memory of the trauma can impede engaging in such vulnerable self-disclosure (Caruth, 1995; Herman, 1992; van der Kolk, 1989). Instead, victims may end up retelling their stories through their experiences of relationships throughout their life (Maltas, 1996). Seligman et al. (2006) suggested that therapy may be complex for the victim to retell their story to their significant other and may offer them a witness to the trauma when they did not have one before. The utilization of retelling in couples' therapy may identify patterns of interaction between victim and partner that develops due to past trauma. Nasim and Nadan (2013) wrote that identifying and analyzing these patterns brings them into the couple's consciousness, allowing for a break in the cycle of traumatic reenactment the couple has employed. Telling the story in the couple's context allows the survivor and their partner to share in the experience. Witnessing in a safe, supportive environment creates a powerful opportunity for a corrective emotional experience. Finally, it is essential to note the therapist's pivotal role in

creating a safe space to bring awareness to the unconscious patterns of interaction between the couple and guide the couple by extracting themselves from the reenactment cycle.

### *Attachment Theory*

Attachment Theory was initially developed by Bowlby (1982) and emphasized an instinctual biological drive child has for closeness to their parents to feel safe and secure. He asserted that a child's experiences with those closest at a young age become an internalized working model for a person's experiences and expectations for intimate relationships as adults. Swanson and Mallinckrodt (2001) demonstrated that children who have their physical and emotional needs met grow up to have positive and secure attachments making them more likely to foster healthy intimate relationships. However, children whose needs went unmet and were maltreated, or neglected, are more likely to develop insecure attachments as adults and exhibit interpersonal dysfunction patterns when forming or maintaining relationships. Secure attachment is the product of having childhood needs attended to, resulting in low levels of anxiety and avoidance as adults (Bartholomew & Horowitz, 1991). Fraley and Shaver (2000) proposed a two-dimensional model to classify attachment styles as anxious or avoidant. Anxious attachment refers to an individual's heightened sensitivity to threat or rejection perceptions. In contrast, people identified with an avoidant attachment style will be more likely to emotionally or physically withdraw from threatening situations. Finally, an individual may exhibit both a highly anxious and avoidant attachment, which results in an over-sensitivity to and avoidance of discomfort or rejection.

Over the years, research has consistently demonstrated that attachment styles can remain stable throughout a person's life and are generally resistant to change (Hazan & Shaver, 1994; Muller et al., 2012; Riggs et al., 2011). The experience of childhood maltreatment can

significantly negatively impact an individual's view of the self as an adult (Bartholomew & Horowitz, 1991). The attachment styles individuals develop as children play an essential role in their adult romantic relationships, communication style, the experience of intimacy, reaction to conflict, and overall relationship satisfaction (Fraley & Shaver, 2000; Labadie et al., 2018; Simpson et al., 2007). Data from Muller et al. (2012) showed that individuals who reported experiencing childhood maltreatment exhibited higher insecure attachment styles. Additionally, Finzi et al. (2002) found that childhood abuse victims most often demonstrated anxious-avoidant attachment patterns. Riggs et al. (2011) found that those who have experienced emotionally or physically abusive relationships as children may often adopt unhealthy representations of romantic relationships as adults.

McLewin and Muller (2006) found that when adult victims of childhood abuse can establish a secure attachment style, this correlated with a decrease in psychological distress. Targeting attachment styles through couples' therapy may represent an opportunity to mediate the relationship between childhood and adult experiences (Riggs et al., 2011). Unger and de Luca (2014) found the creating supportive relationships had a significant effect on controlling attachment avoidance and anxiety. Couples therapy provides an optimal setting for addressing relationship difficulties and the impact of childhood maltreatment targeting memories of abuse contributing to and maintaining an anxious-avoidant attachment style. The therapeutic environment creates a safe space for the couple to develop a deeper understanding of the individuals' abuse experience improving adult attachment styles and related mental distress.

**Overview of Couple-Based Psychotherapies**

The approaches identified and discussed in this introduction to provide readers with a basic theoretical understanding of the topic are cognitive-behavioral conjoint therapy (CBCT;

Monson & Fredman, 2012), emotion-focused therapy (see Johnson, 2002); object-relations therapy (Scharff, D. E. & Scharff, 2014); and narrative therapy (NT; Johnson et al., 2019).

### *Cognitive-Behavioral Conjoint Therapy*

The therapeutic approach of CBCT was developed by researchers Monson and Fredman (2012). The approach was designed to utilize the relationship between a couple as a tool for processing individual or shared distress resulting from a traumatic event addressing such experiences' interpersonal impact. Additionally, symptoms of distress resulting from trauma may often be reinforced or exacerbated by patterns of interaction between intimate partners, especially during the conflict (Monson et al., 2004; Pukay-Martin et al., 2015; Pukay-Martin et al., 2017). While the model was initially developed to target PTSD symptoms, it has been expanded to address depression, guilt, anger, substance use, and anxiety (Monson & Fredman, 2012). In addition to improving individual psychological symptoms of distress, evidence suggests the treatment may also improve the overall quality of the relationship and dyadic functioning (Monson et al., 2010).

The manualized model provides a framework for therapists to work with a couple, one of the first modalities to move away from trauma therapy's individual-based focus (Monson & Fredman, 2012). These authors developed a detailed session-by-session model designed to be carried out over 15 sessions and broken into three phases. Phase 1 focuses on psychoeducation with the couple regarding trauma's individual and relational impact. Phase 2 looks to assess and address relationship satisfaction and avoidance. Finally, phase 3 focuses on creating or reauthoring the meaning associated with the traumatic experience and therapy conclusion. Each session is broken down by goals, interventions, and out-of-session homework, including handouts for the couple (Brown-Bowers et al., 2012). Overall, research has been promising in

applying the model to address individual trauma utilizing a couple-based cognitive-behavioral approach (Macdonald et al., 2016; Pukay-Martin et al., 2015, 2017; Shnaider et al., 2015).

### *Emotion-Focused Couples Therapy*

Johnson (2002), the theorist of emotion-focused couple therapy, suggested that a couple's dysfunction arises from disrupting the emotional connection brought on by a withdrawal or anxious attachment. It is pivotal for a therapist to assess a couple's abuse history as a potential underlying component to individual partners' attachment styles and their patterns of relating to one another, particularly in times of conflict (MacIntosh & Johnson, 2008). Johnson's (2002) approach is unique in that it also emphasizes an acknowledgment, assessment, and focus on the non-abused partner's potential experience of vicarious traumatization. If this goes unnoticed or untreated, the partners may continue to trigger each other intensifying the emotional distress within the relationship. Based on assessing the individual's attachment styles, the therapist can quickly work with the couple to implement and improve methods of responding to each other and developing a secure attachment (Johnson & Denton, 2002).

Emotion-focused therapy for couples dealing with trauma was designed to be a short-term therapy lasting between 12–20 sessions (Johnson & Williams-Keeler, 1998). The therapist utilizes experiential interventions to help couples access and expand their emotional experience (Johnson & Williams-Keeler, 1998; Makinen & Johnson, 2006). The approach also looks to identify and externalize the pattern or choreography between partners, contributing to individual and relational distress. The approach aims at identifying and adapting behaviors of withdrawal/avoidance or pursued/attack. Next, utilizing this understanding of the dance between partners, the therapist helps create new interaction patterns. Johnson and Williams-Keeler (1998) broke this process into nine steps:

1. the initial assessment,
2. identifying relationship cycles and harmful patterns of interaction,
3. patterns are framed as the problem to externalize the issue,
4. identification of feelings and underlying fears in the partners,
5. acceptance of emotional experience between partners,
6. acknowledgment of needs and an invitation to the partner to meet them,
7. develop new positive ways of coping related to the trauma, and
8. integration of new understanding and skills into the relationship between.

Through the experience of reconnecting within a safe environment, the couple can help soothe each other while developing a new understanding of the impact the past trauma has on their relationship cycle (Makinen & Johnson, 2006). This new learning can help mitigate the trauma's impact and provide a corrective emotional experience (Dalton et al., 2013; MacIntosh & Johnson, 2008).

***Object-Relations Therapy***

The object-relations psychoanalytic approach is a well-suited intervention for applying to marital interaction (Bevilacqua & Dattilio, 2007; Scharff, D. E. & Scharff, 2014). As infants, children look to develop secure attachments to their significant caregivers, and these attachment relationships influence their patterns of responsiveness as adults (Arcaya & Gerber, 1990; Scharff, D. E. & Scharff, 2014). Individuals develop object representations that later apply to adult romantic partnerships and images of themselves in relation to these objects. When these relationships embody feelings of insecurity and rejection, they may lead to anger, resentment, and hostility (Scharff, D. E. & Scharff, 2014). When two people enter a relationship, unconscious influences may lead to healthy complementary interactions or unhealthy defensive

responses (Bevilacqua & Dattilio, 2007; Scharff, D. E. & Scharff, 2014). Unconscious internalized defenses appear in projective and introjective identification (Arcaya & Gerber, 1990; Scharff, D. E. & Scharff, 2014). The model uses the concept of collusion to conceptualize the unconscious dynamics between a couple and the process that plays out between the pair to avoid anxiety (Scharff, D. E. & Scharff, 2014). The approach asserts dysfunction results when there is too much distress, which overwhelms the balance of the unconscious processes that regulate the relationship (Scharff, D. E. & Scharff, 2014).

The therapist's role in this approach is to help the couple assess the unconscious processes at play to begin rebalancing the system while exploring the traumatic experiences of the past (Scharff, D. E. & Scharff, 2014). Scharff, D. E. and Scharff broke the process of object relations couples therapy into nine key tasks/components: (a) listening to the unconscious, (b) maintaining a neutral position of involved impartiality, (c) creating a psychological space, (d) use of the therapist's self: negative capability, (e) transference and countertransference, (f) interpretation of defense and anxiety, (g) working through, (h) working with unique situations, (i) termination. The therapist utilizes a nondirective style of active listening while building trust between the partners, providing observations and interpretations when needed, and being aware of any countertransference that may arise, leading to more in-depth insight (Basham & Miehls, 1998). The therapist may also act as an object within the room and, by doing this, can identify couples' anxieties and defenses while creating safety for more in-depth exploration.

When an adult experiences abuse in childhood, they are more likely to have developed maladaptive projections that cause distress in their current romantic relationship (Arcaya & Gerber, 1990). Retelling the survivor's trauma story can help recreate a more coherent and empowering narrative while increasing understanding and intimacy between partners (Nasim &

Nadan, 2013). In situations where one or both partners have a history of abuse, the therapist must be aware of potential dissociation by the victim or resistance. Utilizing a psychoanalytic approach to addressing the impact of childhood abuse in the context of couple's therapy creates a unique opportunity for both the victim and their partner to experience a corrective emotional experience (Arcaya & Gerber, 1990; Nasim & Nadan, 2013). Through therapy, the couple works to improve their containment of projections, altering and improving their conscious and unconscious reactions (Arcaya & Gerber, 1990).

***Narrative Therapy***

Utilizing Narrative Therapy (NT) in a couple's context focuses on creating a space for clients to express, explore, and reauthor the meaning of their trauma (Johnson et al., 2019). Conducting this therapeutic modality with a couple allows for a systemic emphasis on the treatment, which may often be underutilized via an individual approach (Francis Laughlin & Rusca, 2020). The narrative approach empowers clients to explore how they conceptualize themselves within their world (Francis Laughlin & Rusca, 2020). Research has demonstrated that abuse experiences can negatively impact both males' and females' sense of identity and grow up carrying immense internalized shame (Harvey, 2000; Kleiner-Paz & Nasim, 2021; Miller et al., 2007). Victims of child abuse are potentially robbed of developing a positive self-identity, which may persist into adulthood and negatively impact their relationships (Harvey, 2000). Addressing survivors' beliefs about themselves and their relationships makes NT adept at targeting the client's perceptions of self-worth and empowerment, simultaneously aiming to decrease PTSD symptoms and increase relationship satisfaction (Harvey, 2000; Kleiner-Paz & Nasim, 2021).

In the researcher's work with adult-child sexual abuse survivors, Payne (2006) illustrates four critical NT phases. The first step to NT often focuses on the survivor's acknowledgment and

naming of the abuse they experienced. Secondly, the therapist helps the couple target self-blame by deconstructing the narrative and exploring how the abuse occurred. Third, the couple identifies and expands on the trauma's impact on the victim's concept of self and others. Finally, both members of the partnership are invited to share their accounts of how the trauma has impacted their relationship and co-create a new narrative together, promoting healing to the survivor and the couple (Johnson et al., 2019; Kleiner-Paz & Nasim, 2021; Payne, 2006).

**Rationale**

Given that it is estimated that over a quarter of the adult population has experienced childhood abuse and resulting psychological distress, it is highly probable that clinicians will treat survivors in their practice (Horwitz et al., 2001; Paradis & Boucher, 2010; World Health Organization, 2016). Extensive evidence validates individual psychotherapy for addressing past trauma in adults (Lewis et al., 2020). However, little research has investigated couples therapy, despite the evidence that childhood trauma can cause significant distress in survivors' intimate relationships (Colman & Widom, 2004; Fleming et al., 1999; Nelson et al., 2002). Furthermore, supportive relationships are an essential moderator of psychological distress resulting from past trauma but fostering such support is generally neglected in individual treatment (Vranceanu et al., 2007). Clinicians must be equipped with a knowledge of couples-based approaches to addressing the damaging impact of childhood trauma on individuals and their relationships (Miller & Sutherland,1999).

**Research Questions**

The specific research questions proposed for this study are as follows:

- RQ1: What therapeutic modalities have been utilized to address past traumatic experiences in a couples-based therapeutic format?

    - Single Modality
    - Integrative Modality
- RQ2: To what extent have the identified approaches been utilized with diverse populations?
    - Age, Gender, Ethnicity/Race
    - Sexual Orientation
    - Psychiatric Diagnosis
- RQ3: What type of traumatic experiences have these approaches been used to target?
    - Childhood Physical Abuse
    - Childhood Sexual Abuse
    - Childhood Emotional Abuse
    - Childhood Neglect
    - Other
- RQ4: Have the identified approaches been shown to effectively reduce psychiatric and relational symptoms of distress?
    - Psychological Symptoms of Distress
        - PTSD
        - Anxiety
        - Depression
    - Relationship Quality

# Chapter 2: Methods

## Systematic Review Approach

This study aimed to provide a narrative synthesis of quantitative data, along with a summary of the interventions utilized. The narrative synthesis summarizes the intervention's impact on individual psychological distress and improvements in relationship quality outcomes when utilized with couples where one partner has a history of childhood abuse. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA-P) was utilized as a protocol for this systematic review's overall design and methodology. PRISMA-P provides a systematic framework to encourage the presentation of reliable findings to inform both treatment and future research (Liberati et al., 2009). The results of the systematic investigation into the literature are reported in the PRISMA flowchart (see Appendix A).

## Eligibility Criteria

### *Inclusionary Criteria*

The studies were required to meet all the following criteria to be included.

**Source Eligibility.** Due to the limited amount of research available on the topic, the study did not place restrictions on the country of origin or the year of publication. However, the studies included must have been published and available in English to be reviewed.

**Population.** Given that this review focused on interventions with couples, studies must have consisted of romantic-couple dyads. Additionally, one or both partner(s) must have reported an experience of childhood maltreatment. The World Health Organization (2016) defines childhood maltreatment as the physical, sexual, or emotional abuse or neglect of a child under 18 years old. Finally, all participants must have been over the age of 18 at the time of treatment.

**Setting.** Due to the lack of research, studies from all settings, such as inpatient and outpatient facilities, were included.

**Design.** Studies included for review were randomized controlled trials (RCTs) or quasi-experimental designs such as single-group pretest-posttest design. The inclusion of quasi-experimental designs was necessary due to a preliminary search showing that a limited number of RCTs had been conducted on the topic.

**Intervention.** Studies included must have utilized a treatment approach that met the following requirements: (a) a theoretical understanding and approach to addressing childhood abuse in adult romantic couples, (b) the treatment incorporates work with both individuals of the partnership, and (c) treatments target either trauma-related psychological distress, relationship functioning, or both simultaneously.

**Outcome.** In order to examine the effectiveness of couples-based intervention for childhood abuse survivors, the study must have contained at least one measure of intervention outcome either related to individual psychological distress (e.g., Clinician-Administered PTSD Scales for DSM-5 [CAPS-5], Beck Anxiety Inventory (BAI), Beck Depression Inventory [BDI]), or relationship quality (Couples Satisfaction Index [CSI], Revised Conflict Tactics Scale [CTS2]). Therefore, studies included must have been of either quantitative or mixed-method design providing quantitative outcome data.

### *Exclusionary Criteria*

Sources excluded from the review include presentations, periodicals, blogs, or video presentations. Dissertation studies were thoughtfully considered for inclusion but underwent a thorough evaluation to ensure they were methodologically sound. However, no dissertations ultimately met the criteria for inclusion.

## Search and Screening Strategy

### *Information Source*

Systematic reviews must employ an exhaustive literature search and utilize systematic strategies to collect and analyze published and unpublished academic research. The following electronic databases were investigated using the EBSCOhost platform: PsychINFO, PsychArticles, Pub Med, Medline, and ProQuest for unpublished dissertations and published Dissertations and Thesis. Reference list searches of each eligible study were also conducted to identify additional studies for inclusion.

### *Search Terms*

Within each database, the search strategy consisted of terms related to three major themes: couples, interventions, and childhood abuse (see Appendix B for alternative forms). Synonyms and alternative forms of the primary terms were included but not limited to the following: terms representing romantically involved couples (e.g., couples, marriage, relationship, dyadic, conjoint), terms representing treatment (e.g., therapy, psychotherapy, treatment, intervention), and finally terms representing childhood abuse (childhood physical abuse, childhood sexual abuse, childhood emotional abuse, childhood neglect, childhood trauma). The electronic database searches applied terms to titles, keywords, abstracts, authors, and reference lists within articles (see Appendix C for Search Plan). Some examples of search term combinations utilized are (a) couples therapy OR couples counseling OR marriage counseling OR marriage therapy AND child abuse OR child neglect OR child maltreatment, yielding 216 articles; and (b) couples therapy AND child abuse OR child neglect OR child maltreatment AND intervention OR treatment OR therapy, yielding 129 articles. The search results yielded for each individual set of terms and specifiers within the previously mentioned

databases were recorded in a separate spreadsheet. The number of records generated, and additional notes were collected (see Appendix D).

**Screening and Selection of Studies**

The screening of studies for selection began with an initial review of abstracts, titles, and keywords. The primary author read abstracts, titles, and keywords for relevant articles based on content (i.e., articles discussing couples therapy for childhood trauma). Studies selected for the initial screening were then compiled into an Excel spreadsheet (see Appendix E for screening and selection record) if they met the following criteria:

- Independent variable: Does the article reference couples therapy for individuals with a history of childhood abuse?
- Dependent variable: Does the article explore outcomes related to psychological distress, relationship quality, both, and/or other?
- Population: Does the study engage both members of the couple in the therapeutic process?

After determining which studies met the initial screening process, a full-text screening was conducted (see Appendix E). The eligibility criteria were employed to identify which research studies would be included in the narrative synthesis to address the research questions mentioned above. The previously listed questions were applied, along with the other previously listed inclusion and exclusion criteria (e.g., language and methodology). Finally, the primary researcher reviewed the data that were populated into the spreadsheet. Upon completing the screening and selection process, the PRISMA Flow Diagram was populated (see Appendix A), which summarizes the procedure for selecting the final studies for inclusion in the systematic review.

## Data Collection and Extraction

A form was utilized for data extraction and analysis, populated with the previously mentioned information and any additional identified targeted variables. The data collection and extraction form (see Appendix F) was completed for each selected research study. The data extraction form includes (a) general information from the study, including title, study ID, year of publication, data of study extraction, publication source, publication status, and study's published language; (b) study information, methodological design, the study aims, duration of the study; (c) risk of bias, use of deception, and incomplete outcome reporting; (d) study participating couple's characteristics, sample size, recruitment strategy, gender, sexual orientation, race, diagnosis, and comorbidity; Intervention utilized and control group if utilized; (e) outcome measures utilized, the validity of tools, and time points for outcome assessment; and (f) reporting of results, quantitative approaches utilized, and qualitative description of results if utilized. The data extracted for analysis was directly related to the criteria for study eligibility, study characteristics, and results. The relevant extracted data were then organized into tables corresponding to the research question.

## Data Management

### *Database Development*

Excel spreadsheets were used for the organization and storage of data. The excel spreadsheet was populated via the information gathered via the data extraction form.

### *Data Synthesis and Analysis*

The process of data synthesis and analysis was guided by the research questions posited within this review: (a) identify therapeutic modalities which have been utilized to address experiences of childhood abuse in a couples-based therapeutic format, (b) explore to what extent

identified modalities have been utilized with diverse populations, (c) identify the types of childhood abuse modalities have been used to target, and (d) identify the effectiveness of couples-based therapeutic modalities at reducing symptoms of psychological and relationship distress.

Tables were created to address each research question after reviewing, extracting, and synthesizing all data from the completed list of selected studies. Information from all studies were organized into four sections to address each question, and I analyzed it for data points applicable to the topic. I then independently analyzed all the variables for each question, constructed a descriptive overview of the statistics, and identified key findings. Next, findings were combined to represent meaningful relationships between variables to compare treatment approaches, type of childhood trauma experienced, symptoms of distress, and individual patient demographics. The grouping of similar findings allowed for observing and identifying patterns across interventions that may pertain to specific research questions.

***Reporting of the Results***

Seven evidence tables were created to present the systematic review findings including identified studies and therapeutic approaches, participant demographics, identified index trauma, symptoms of PTSD, anxiety, depression, and relationship distress.

## Chapter 3: Results

Given the individual and relational impact experiences of childhood abuse can have on a survivor's adult life, this dissertation aimed to provide a descriptive synthesis of the available quantitative literature on couples-based therapeutic approaches designed to address the impact of childhood trauma. Variations of the previously discussed search terms relating to "couples therapy" and "childhood abuse" were utilized to search electronic databases, including ProQuest, PsychArticles, PsychINFO, Pubmed, and Medline. The culmination of database searches yielded a total of 1,222 articles. Of the 1,222 records identified, 945 studies were duplicate articles which were immediately removed. The remaining 277 articles underwent a preliminary screening of titles and abstracts, which brought the number of articles to 41 studies that met inclusion criteria. Finally, a full-text review of these remaining studies was conducted, which brought the final number of studies to be included for systematic review down to nine (see Appendix A).

The most prevalent reason for exclusion was using an individual treatment instead of a couples-based approach. Additionally, many studies did not utilize a quantitative measure of symptomology within their design that would allow for an objective measure of pre/post-treatment outcome concerning symptoms of PTSD, anxiety, depression, or relationship satisfaction.

To analyze the nine remaining sources which successfully met criteria, relevant data were extracted using a data collection and extraction form (see Appendix F) and compiled into tables according to the corresponding research question. The results section provides a narrative synthesis that addresses each research question.

**Summary of Reviewed Studies**

Six unique couple-based interventions designed to address the psychological and relational impact of childhood abuse were identified within the nine studies included for the final review (see Table 1). The therapeutic approaches include brief conjoint therapy (BCT; *n* = 1; 11%; Trute et al., 2001), CBCT for PTSD (CBCT-PTSD; *n* = 3; 33%; Monson et al., 2012), MDMA facilitated CBCT for PTSD (MDMA-CBCT-PTSD; *n* = 1; 11%; Monson et al., 2020), couples and family therapy (CFT; *n* = 1; 11%; Whittaker et al., 2023), emotion focused therapy (EFT; *n* = 1; 11%; Dalton et al., 2013), and present-focused CBCT (Pf-CBCT; *n* = 2; 22%; Pukay-Martin et al., 2017).

**Table 1**

*Selected Studies and Psychotherapeutic Treatment Modalities*

| ID# | Reference | Intervention(s) | Method |
|---|---|---|---|
| 1 | Trute, Docking, & Hiebert-Murphy, (2001). Couples therapy for women survivors of child sexual abuse who are in addictions recovery: A comparative case study of treatment process and outcome. *Journal of Marital and Family Therapy*, *27*(1), 99–110. | Brief Conjoint Therapy (Integrative Approach) | Case Study Analysis |

| ID# | Reference | Intervention(s) | Method |
|---|---|---|---|
| 2 | Monson, Fredman, Macdonald, Pukay-Martin, Resick, & Schnurr, (2012). Effect of cognitive-behavioral couple therapy for PTSD: A randomized controlled trial. *JAMA*, *308*(7), 700–709. | CBCT for PTSD | Randomized Control Trial |
| 3 | Shnaider, Pukay-Martin, Sharma, Jenzer, Fredman, Macdonald, & Monson, (2015). A preliminary examination of the effects of pretreatment relationship satisfaction on treatment outcomes in CBCT for PTSD. *Couple and Family Psychology: Research and Practice*, *4*(4), 229–238. | CBCT for PTSD | Randomized Control Trial |
| 4 | Macdonald, Pukay-Martin, Wagner, Fredman, & Monson, (2016). Cognitive–behavioral conjoint therapy for PTSD improves various PTSD symptoms and trauma-related cognitions: Results from a randomized controlled trial. *Journal of Family Psychology*, *30*(1), 157–.162 | CBCT for PTSD | Randomized Control Trial |

| ID# | Reference | Intervention(s) | Method |
|---|---|---|---|
| 5 | Whittaker, Johnson, Solbakken, Wampold, & Tilden, (2023). Childhood Trauma as a Predictor of Change in Couple and Family Therapy: A Study of Treatment Response. *Couple and Family Psychology: Research and Practice*. Advance online publication. http://dx.doi.org/10.1037/cfp0000181 | Couples and Family Therapy (Integrative Approach) | Mixed Model Analysis |
| 6 | Dalton, Greenman, Classen, & Johnson, (2013). Nurturing connections in the aftermath of childhood trauma: A randomized controlled trial of emotionally focused couple therapy for female survivors of childhood abuse. *Couple and Family Psychology: Research and Practice*, *2*(3), 209–221. | Emotion Focused Therapy | Randomized Control Trial |
| 7 | Monson, Wagner, Mithoefer, Liebman, Feduccia, Jerome, & Mithoefer, (2020). MDMA-facilitated CBCT for PTSD: An uncontrolled trial. *European Journal of Psychotraumatology*, *11*(1), Article 1840123. | MDMA Facilitated CBCT for PTSD (Integrative Approach) | Uncontrolled Trial |

| ID# | Reference | Intervention(s) | Method |
|---|---|---|---|
| 8 | Pukay-Martin, Torbit, Landy, Wanklyn, Shnaider, Lane, & Monson, (2015). An uncontrolled trial of a present-focused cognitive-behavioral conjoint therapy for posttraumatic stress disorder. *Journal of Clinical Psychology*, *71*(4), 302–312. | Present-focused CBCT | Randomized Control Trial |
| 9 | Pukay-Martin, Torbit, Landy, Macdonald, & Monson, (2017). Present-and trauma-focused cognitive–behavioral conjoint therapy for posttraumatic stress disorder: A case study. *Couple and Family Psychology: Research and Practice*, *6*(2), 61–78. | Present-focused CBCT vs. CBCT for PTSD | Case Study Analysis |

**Research Questions**

RQ1 was, what therapeutic modalities have been utilized to address past traumatic experiences in a couples-based therapeutic format? Of the nine articles included in the final review, six (67%) were single-modality therapeutic approaches, and three (33%) were integrated therapeutic approaches. As per the criteria for inclusion, all approaches involved the identified patient (an individual with a history of childhood abuse) and their romantic partner in the therapeutic process.

## Single Modality

### *Cognitive-Behavioral Conjoint Therapy for PTSD (n = 3)*

CBCT is a form of psychotherapy involving intimate partners who undergo 15 sessions of a manualized treatment designed to treat PTSD and comorbid symptoms of distress in which one partner endorses a trauma history (Monson et al., 2004, 2012). The theory of CBCT for PTSD aims to address maladaptive cognitive and behavioral patterns as the primary mechanism for change via the use of cognitive restructuring, communication training, and providing tools for affect regulation. Sessions are 75 minutes long, and treatment is broken into three distinct phases: (a) rationale for treatment and psychoeducation regarding the impact of trauma on the individual and couple; (b) strategies to enhance relationship satisfaction and address patterns of avoidance; and (c) cognitive interventions target maladaptive beliefs, thoughts, and feelings that develop in response to trauma (Macdonald et al., 2016; Monson et al., 2012; Shnaider et al., 2015). While CBCT was initially designed to address PTSD using a couples-based approach, it is not exclusively used with distressed couples (Monson et al., 2012; Shnaider et al., 2015).

### *Present-Focused Cognitive-Behavioral Conjoint Therapy (n = 2)*

Similar in structure to the original treatment modality CBCT for PTSD, present-focused CBCT employs psychoeducation and targeted interventions for relationship improvement (Pukay-Martin et al., 2015). It also incorporates here-and-now techniques to address symptoms of PTSD that are nontrauma focused, which may be helpful for couples who do not wish to engage directly in trauma processing. Present-focused CBCT for PTSD consists of 15 conjoint sessions broken into three phases: (a) psychoeducation; (b) behavioral strategies aimed at relationship functioning; and (c) cognitive interventions to target maladaptive patterns of thought, which focus on the here and now. Discussion in the therapy of the index trauma is

neither prohibited nor encouraged, but instead, it is the therapist's role to maintain a here-and-now focus regarding the impact of the trauma rather than specifically revisiting the event(s) of the past (Pukay-Martin et al., 2015, 2017). Avoidance within the couple is not directly targeted but addressed through positive relationship-building tasks. The final sessions focus on identifying growth in the present and planning for future challenges as a couple.

### *Emotion Focused Couples Therapy (n = 1)*

Emotionally focused couples therapy (EFCT) is an empirically validated treatment for relationship distress, and evidence thus far has supported EFCT's application for individual treatment of childhood abuse survivors (Dalton et al., 2013). Johnson (2002) suggested EFCT for couples may be useful for trauma survivors because the approach aims to establish and maintain secure attachment bonds between partners. EFT for couples is broken into three stages. Stage one is geared towards de-escalation through identifying problematic styles of interaction and attachment that contribute toward patterns of demand-withdraw. Stage 2 is normalizing and uniting the couple against the externalized problem. Stage two seeks to restructure the bond and promote a deeper awareness of partners' emotional needs to create acceptance, responsiveness, and security in their connection. In the final stage, new insight is consolidated as the couple unites as a team to implement new solutions to old problems. Therapy consisted of 22 dyadic sessions and two individual sessions, each 75 minutes in length (Dalton et al., 2013).

## Integrative Modalities

### *Brief Conjoint Therapy (n = 1)*

BCT is a flexible dyadic approach to treatment that is developed and adapted to fit each couple's unique needs. Couples attended between six to 20 sessions depending on their presenting level of distress and rate of improvement. The mixture of modalities includes

elements from structural theory, solution-focused therapy, and transgenerational theory (Trute et al., 2001). Structural methods dissect and reorganize communication patterns and individual roles within the dyad (Minuchin & Fishman, 1981). Solution-focused methods help couples to envision versions of their shared life in which the problem did not exist and collaboratively accomplish these goals (De Shazer & Berg, 1997). The transgenerational technique may include several sessions focused on exploring family-of-origin influences on learned experience and responses to increase mutual understanding and collaboration (Kerr & Bowen, 1988). BCT therapy fosters skills in effective communication, mutual problem-solving, negative emotional affect regulation, and behavioral self-management (Trute et al., 2001).

***MDMA Facilitated Cognitive-Behavioral Conjoint Therapy for PTSD (n = 1)***

As previously described above, CBCT for PTSD is a manualized treatment that has received empirical validation for its ability to improve symptoms of relationship distress, PTSD, and comorbid conditions (Monson & Fredman, 2012). Monson et al. (2020) suggested that MDMA's (methylenedioxymethamphetamine) empathogenic and neurocognitive properties make it a promising accompanying treatment to aid trauma-focused therapy, improving patient outcomes. Therapy followed the manualized approach of CBCT in addition to accompanying MDMA sessions during the cognitive processing stage of treatment. The treatment outlined by Monson et al. (2020) is as follows: the first three sessions of CBCT were conducted in person the day before the first administration of MDMA session (4 hours), and sessions four and five focused on feelings and thoughts (1 hour) the morning before MDMA administration (6–8 hours). An integrated session (1.5 hours) was conducted after the MDMA session. After conclusion of the intensive treatment session and first administration of MDMA, sessions six through nine of CBCT were then delivered biweekly via telehealth over the next 2.5 weeks (1.25

hours each). Then, the second intensive began consisting of sessions 10 and 11 focusing on the appraisal of blame and trust in the relationship (2 hours) before the second MDMA session, the second MDMA session (6–8 hours), and an integrative session (1.5 hours) the following day. The final four sessions of CBCT (sessions 12 to 15) were conducted weekly via telehealth (1.25 hours each). The entire treatment was administered over the course of 7 weeks. Each partner was given 75 mg of MDMA in the first MDMA session and 100 mg in the second MDMA session, with an optional supplemental half-dose 1.5 hours later in both sessions.

***Couples and Family Therapy (n = 1)***

CFT refers to a broad range of therapeutic approaches administered in the context of a dyad or family to address symptoms of mental or relational distress (Carr, 2018; Whittaker et al., 2023). The theory of CFT is based on research that shows over half of the adults with severe psychiatric disorders endorse a history of sexual or physical childhood abuse, and such abuse also impairs relationship functioning (Bowlby, 1982, Grubaugh et al., 2011). Interventions delivered via CFT aim to alleviate psychological and relationship distress by increasing empathetic capacity toward partners, reducing maladaptive patterns of communication, increasing vulnerability, and providing the opportunity for healing within the partnership by developing a sense of trust and safety (Carr, 2018; Johnson, 2002; Whittaker et al., 2023). To develop a treatment plan, clinicians should collaboratively explore with clients their previous experiences of abuse and the resulting impact to tailor an approach that meets their specific needs (Whittaker et al., 2023). In the present study, couples participated in approximately 6 to 12 weeks of treatment, including semiweekly couple and individual therapy, art therapy, psychoeducation, and physical exercise sessions in a holistic approach to fostering individual and systemic change (Whittaker et al., 2023).

RQ2 was, to what extent have the identified approaches been utilized with diverse populations? Of the nine studies included for analysis, two (Pukay-Martin et al., 2015; Trute et al., 2001) did not report data on the mean age of the participants. For those studies which reported average participant age, participants ranged from 33.8 to 47.1 years old (Dalton et al., 2013; Macdonald et al., 2016; Monson et al., 2012, 2020; Pukay-Martin et al., 2017; Shnaider et al., 2015; Whittaker et al., 2023). In the study of BCT, the identified patients within the partnerships were women of European descent (Trute et al., 2001). All three (33%) studies which utilized CBCT for treatment of PTSD conducted therapy with a combination of male and female-identified patients of varying ethnicities/races, including Caucasian, African, Hispanic, Asian or Pacific Islander, or other (Macdonald et al., 2016; Monson et al., 2012; Shnaider et al., 2015). In the application of CFT, half of the patients identified as female (53.15%), but the authors did not provide the racial makeup of the sample (Whittaker et al., 2023). The EFT patient population was entirely female ($n$ = 11) and comprised of White (86%), Black (6%), East Asian (2%), and other (6%) identified participants (Dalton et al., 2013). When the use of MDMA in conjunction with CBCT was investigated (Monson et al., 2020), trauma-reporting individuals were predominantly male (60%) and all Caucasian identifying. Present-focused CBCT-identified patients consisted of females ($n$ = 5; 31%) and males ($n$ = 4; 25%), and whom majority identified as white (78.57%; Pukay-Martin et al., 2015, 2017). See Table 2 for information regarding patient demographics per individual study.

Eight (89%) of the studies included in the final analysis identified the sexual orientation of couples who participated (Dalton et al., 2013; Macdonald et al., 2016; Monson et al., 2012, 2020; Pukay-Martin et al.,2015, 2017; Trute et al., 2001; Whittaker et al., 2023). The majority of treatment approaches included for review included BCT (Trute et al., 2001), CFT (Whittaker et

al., 2023), EFT (Dalton et al., 2013), MDMA facilitated CBCT (Monson et al., 2020), and present-focused CBCT (Pukay-Martin et al., 2015, 2017), which were applied to populations consisting only of heterosexual couples. Two investigations implementing CBCT for the treatment of PTSD included heterosexual and same-sex couples (Macdonald et al., 2016; Monson et al., 2012). See Table 2 for information regarding the couple's sexual orientation per individual study.

**Table 2**

*Participant Demographics*

| ID# | Intervention | Number of Couples | Mean Age | Gender | Ethnicity | Sexual Orientation | Psychiatric Diagnosis |
|---|---|---|---|---|---|---|---|
| 1 | Brief Conjoint Therapy | *n* = 8 | (---) | Female: *n* = 8<br>Male: *n* = 8 | European Decent = 100% | Heterosexual: 8(100%) | (---) |
| 2 | CBCT for PTSD | Tx: *n* = 20<br><br>Wait List: *n* = 20 | CBCT Patient: *M* = 40.4<br>Partner: *M* = 40.7<br><br>Wait List Patient: *M* = 33.8<br>Partner: *M* = 34.9 | Male: *n* (%)<br><br>CBCT Patient: 7(35.0)<br>Partner: 10(50.0)<br><br>Wait List Patient: 3(15.0)<br>Partner: 17(85.0) | Non-White: *n* (%)<br><br>CBCT Patient: 5(25.0)<br>Partner: 4(20.0)<br><br>Wait List Patient: 6(30.0)<br>Partner: 4(20.0) | Treatment Heterosexual: 17(85.0)<br>Same-Sex (Female): 3(15.0)<br><br>Waitlist Heterosexual: 20(100.0) | CBCT PTSD: 20(100.0); Mood Dx: 7(35.0); Other Anxiety Dx: 9(45.0); Substance Abuse: 9(45.0); Other: 5(25.0)<br><br>Wait List PTSD: 20(100.0); Mood Dx: 9(45.0); Other Anxiety Dx: |

| ID# | Intervention | Number of Couples | Mean Age | Gender | Ethnicity | Sexual Orientation | Psychiatric Diagnosis |
|---|---|---|---|---|---|---|---|
| | | | | | | | 10(50.0); Substance Abuse: 8(40.0); Other: 4(20.0) |
| 3 | CBCT for PTSD | Tx: *n* = 20<br><br>Wait List: *n* = 20 | Patient: *M* = 37.78<br>Partner: *M* = 38.70 | Female<br>Patient: 72.97%<br>Partner: 64.86% | Patients: Caucasian: 70.27%; African: 5.41%; Hispanic: 5.41%%; Asian or Pacific Islander: 2.70%; Other: 13.51%<br><br>Partners: Caucasian: 81.08%; African: 2.70%; Hispanic: 2.70%; Asian or Pacific Islander: 5.41%; Other: 2.70% | (---) | Patient: PTSD = 40 (100%)<br><br>Comorbidity not provided |
| 4 | CBCT for PTSD | Tx: *n* = 20<br><br>Wait List: *n* = 20 | Patient: *M* = 37.10 | Female<br>Patient: 75% | Non-White: 11(28%) | Same-Sex Couples: 3(8%) | Patient: PTSD = 40 (100%) |

| ID# | Intervention | Number of Couples | Mean Age | Gender | Ethnicity | Sexual Orientation | Psychiatric Diagnosis |
|---|---|---|---|---|---|---|---|
| 5 | Couples and Family Therapy | *n* = 36 | Patient: *M* = 39.59 | Female Patient: 53.1% | (---) | Heterosexual: 36(100%) | Affect Dx: 34.5%; Anxiety Dx: 12.3%; PTSD 14.8%; Adjustment Dx: 19.7%; Personality Dx: 3.7%; Other: 6.1%; No Dx: 25.9%; Histories of Addiction: 16%; Self-harm: 13.6%; Attempts at suicide: 6.2% |
| 6 | Emotion Focused Therapy | Tx: *n* = 12 Control: *n* = 10 | Patient: *M* = 36 | Female Patient: 100% | White: 86% Black:6% East Asian:2% Other:6% | Heterosexual: 22(100%) | (---) |
| 7 | MDMA Facilitated CBCT for PTSD | *n* = 6 | Patient: *M* = 47.1 | Patient Males: 4(60%) Female: 2(40%) | Caucasian = 100% | Heterosexual: 100% | PTSD: *n* = 6(100%); Depressive Dx: *n* = 6(100%); Anxiety Dx: *n* = 5(83.3%); Substance Use Dx: *n* = 3(50%); Anorexia Nervosa: *n* = 1(16.7%) |
| 8 | Present-focused CBCT | *n* = 7 | Patient: *M* = 45.86 Partner: *M* = 44.86 | Patient Female: *n* = 4 | White = 78.57% | Heterosexual: 100% | PTSD: *n* = 7(100%) Anxiety Dx: *n* = |

| ID# | Intervention | Number of Couples | Mean Age | Gender | Ethnicity | Sexual Orientation | Psychiatric Diagnosis |
|---|---|---|---|---|---|---|---|
| | | | | | | | 4(57%) Depressive Dx: *n* = 2(29%) |
| 9 | Present-focused CBCT vs. CBCT for PTSD | *n* = 1 | (---) | Female: *n* = 1<br>Male: *n* = 1 | (---) | Heterosexual: 100% | PTSD: *n* = 1 |

*Note.* (---) Data Not Provided

"Patient" denotes individual within the romantic partnership who experienced childhood trauma and is the identified focus of treatment.

***Psychiatric Diagnosis***

Seven (78%) studies took inventory of and reported descriptive data of the sample's psychiatric diagnoses. Investigations of brief conjoint therapy and emotion focused therapy did not report information regarding participants' preexisting psychiatric diagnoses (Dalton et al., 2013; Trute et al., 2001). In the application of CBCT for the treatment of PTSD, all identified patients within the dyad had an established diagnosis of PTSD (Macdonald et al., 2016; Monson et al., 2012; Shnaider et al., 2015). In Monson et al. (2012) patients also reported comorbid diagnoses of mood disorder (40%), anxiety disorder (48%), substance abuse (43%), or other (23%). Whittaker et al. (2023) utilized an inpatient referral source who reported a variety of prior psychiatric issues, including affective disorder (35.4%), anxiety (12.3%), PTSD (14.8%), adjustment disorder (19.7%), personality disorder (3.7%), history of addiction (16%), self-harming behavior (13.6%), attempted suicide (6.2%), other (6.1%), and no formal diagnosis (25.9%). In Monson et al. (2020) investigation into the utility of combining MDMA to facilitate the application of CBCT, all identified patients diagnosed with PTSD before treatment.

Additional comorbid diagnoses included depression (100%), anxiety (83.3%), substance use (50%), and anorexia nervosa (16.7%). All identified patients included in the application of present-focused CBCT had diagnoses of PTSD (100%), in addition to anxiety (57%), and depression (29%). See Table 2 for information regarding the patient's psychiatric diagnoses per individual study.

RQ3 was, what type of traumatic experiences have these approaches been used to target? Per the requirements for inclusion, all articles included for analysis consisted of couples in which one partner reported prior experience of childhood abuse, including physical, sexual, emotional or neglect (Dalton et al., 2013; Macdonald et al., 2016; Monson et al., 2012, 2020; Pukay-Martin et al., 2015, 2017; Shnaider et al., 2015; Trute et al., 2001; Whittaker et al., 2023). Five of the nine studies included patients who reported other index traumas such as adult physical/sexual assault, combat-related, motor vehicle accident, illness, and sudden death (Macdonald et al., 2016; Monson et al., 2012, 2020; Pukay-Martin et al., 2015; Shnaider et al., 2015). See Table 3 for information regarding patient index trauma per individual study.

**Table 3**

*Index Trauma: Identified Experience of Childhood Abuse*

| ID# | Intervention | Patient Index Trauma |
|---|---|---|
| 1 | Brief Conjoint Therapy | Childhood Sexual Abuse: 100% |
| 2 | CBCT for PTSD | Treatment *n*(%): Adult Sexual Trauma: 4(20); Child Sexual Trauma: 3(15); Noncombat Physical Assault: 4(20); MVA: 1 (5); Witnessing: 2(10); Combat: 2(10); Other: 4(20)<br><br>Wait List *n*(%): Adult Sexual Trauma: 4(20) Child Sexual Trauma: 8(40) Noncombat Physical Assault: 2(10) MVA: 2(10) Witnessing: 3(15) Combat: 0 Other: 1(5) |

| | | |
|---|---|---|
| 3 | CBCT for PTSD | Adult sexual trauma = 21.62%; Childhood sexual trauma = 21.62%; Physical assault = 16.22%; Sudden death = 10.81%; Accident = 8.11%; Combat = 5.41%; Illness = 2.70%; Other = 13.51% |
| 4 | CBCT for PTSD | Combat-related = 5.0%; Childhood Sexual Assault or Abuse = 27.5%; Adult Sexual Trauma = 20.0%; Noncombat Physical Assault = 15.0%; Other = 32.5% |
| 5 | Couples and Family Therapy | Childhood Sexual Abuse = 21.2% (Repeated Incidents = 84.6%); Childhood Physical Abuse = 15.2% (Repeated Incidents = 75%) |
| 6 | Emotion Focused Therapy | Female partners with history of childhood abuse (physical or sexual) = 32% |
| 7 | MDMA Facilitated CBCT for PTSD | Childhood Physical Abuse/Neglect: *n* = 2(33.2%); Childhood Sexual Abuse: *n* = 3(50%); Adult Combat: *n* = 1(16.7%) |
| 8 | Present-focused CBCT | (Numeric data not provided): Childhood Sexual Abuse/Assault, Physical Abuse, Adult Sexual Assault, and Combat Related |
| 9 | Present-focused CBCT vs. CBCT for PTSD | Childhood Sexual Abuse = 100% |

RQ4 was, have the identified approaches been shown to effectively reduce psychiatric and relational symptoms of distress?

**Psychological Symptoms of Distress**

***PTSD***

Of the nine studies, eight (89%) provided quantitative data regarding the pre/post treatment effects upon symptoms of PTSD. Of these studies, six utilized a version of the PTSD

Checklist (PCL), which is a self-report measure of PTSD symptom severity within the past month (Weathers et al., 1993; Wortmann et al., 2016). The Clinically Administered PTSD Scale (CAPS), considered the most heavily validated measure to assess symptom frequency and intensity via a clinical interview, was utilized in six studies (Weathers et al., 2017). Additional less prevalent measures, which each appeared once throughout the systematic review, included the Dissociative Experiences Scale (DES; Bernstein & Putnam, 1986), Modified Posttraumatic Beliefs and Reactions Scale (PBRS-M; Mechanic & Resick, 1993), Trauma-Related Guilt Inventory (TRGI; Kubany et al., 2000), and the Trauma Symptom Inventory (TSI; Briere, 1995).

Of the studies that reported pre/post treatment data, three (37.5%) studies calculated effect size using Cohen's *d*, and four (50%) utilized Hedge's *g*, which includes an adjustment for smaller sample sizes. Cohen *d* and Hedges *g* have similar interpretations of 0.80 and greater is considered large, 0.50 to 0.79 medium, and 0.20 to 0.49 is small (Card, 2012; Cohen, 1992). More specifically, three studies utilizing CBCT for PTSD demonstrated medium to large ($g$ = 0.66–1.82) effect sizes on the CAPS, PCL, TRGI, and PBRS-M (Macdonald et al., 2016; Monson et al., 2012; Shnaider et al., 2015). When CBCT for PTSD was paired with MDMA to facilitate the processing of traumatic experiences, the treatment produced large effect sizes on the CAPS ($d$ = 2.10) and PCL-5 ($d$ = 2.72). Two of the nine included studies (22%) investigated the application of present-focused CBCT. The first study by Pukay-Martin et al. (2015) showed medium to large effect sizes on the CAPS ($g$ = 0.78) and PCL ($g$ = 1.26). However, a second case study analysis of a single couple by Pukay-Martin et al. (2017) provided pre/post results on the PCL and CAPS, neither of which showed a significant reduction in symptoms (see Table 4 for raw scores). Dalton et al. (2013) did not provide quantitative results of their investigation regarding EFT's effectiveness at targeting symptoms of PTSD; however, the effect size was

insignificant. CFT was shown to have a small effect size ($d$ = 0.33) on the PCL-5, and the EFT report of quantitative findings on the TSI and DES produced no significant change.

Apart from CFT and EFT, the current review of couples-based treatments produced comparable, and in some cases, more significant effect sizes than were found in a meta-analysis of individual treatments for PTSD conducted by Watts et al. (2013), which ranged from $g$ = 0.73–1.69. The overall summary from the eight reviewed studies provides support for the use of interventions of CBCT for PTSD, MDMA-facilitated CBCT, and present-focused CBCT at effectively reducing symptoms of PTSD from pre to posttreatment among couples in which one partner reported a history of childhood abuse (see Table 4).

**Table 4**

*Symptoms of PTSD*

| ID# | Intervention | Measure | PTSD-Identified Partner | | PTSD-Identified Partner | | Effect Size Pre/Post Tx of Identified Patients<br><br>Hedge *g* or Cohen's *d* |
|---|---|---|---|---|---|---|---|
| | | | Pre-Tx Baseline | WL Baseline | Post-Tx | WL Post Tx | |
| 1 | Brief Conjoint Therapy | (---) | (---) | (---) | (---) | (---) | (---) |
| 2 | CBCT for PTSD | CAPS | 68.87 | 73.03 | 33.45 | 60.82 | $g$ = 1.82 |
| | | PCL | 49.92 | 57.89 | 30.38 | 46.8 | $g$ = 0.71 |
| 3 | CBCT for PTSD | CAPS | 67.04 | (---) | 31.22 | (---) | $g$ = 1.68 |
| | | PCL | 49 | (---) | 31.04 | (---) | $g$ = 1.41 |

| ID# | Intervention | Measure | PTSD-Identified Partner | | PTSD-Identified Partner | | Effect Size Pre/Post Tx of Identified Patients<br><br>Hedge *g* or Cohen's *d* |
|---|---|---|---|---|---|---|---|
| | | | Pre-Tx Baseline | WL Baseline | Post-Tx | WL Post Tx | |
| 4 | CBCT for PTSD | CAPS | 68.94 | 73.04 | 38.62 | 60.87 | *g* = -1.30 |
| | | TRGI | 8.93 | 8.79 | 5.22 | 9.11 | *g* = -0.66 |
| | | PBRS-M Total | 41.35 | 39.88 | 24.23 | 36.18 | *g* = -0.68 |
| 5 | Couples and Family Therapy | PCL-5 | 28.16 | (---) | 4.61 | (---) | *d* = .33 |
| 6 | Emotion Focused Therapy | TSI | (---) | (---) | (---) | (---) | Not Sig. |
| | | DES | (---) | (---) | (---) | (---) | Not Sig. |
| 7 | MDMA Facilitated CBCT for PTSD | CAPS | 41.42 | (---) | Immediate: 19.37; 3-Month: 17.43 6-Month: 15.52 | (---) | *d* = 2.10 |
| | | PCL-5 | 62.64 | (---) | Immediate: 23.96; 3-Month: 20.56; 6-Month: 17.20 | (---) | *d* = 2.72 |
| 8 | Present-focused CBCT | CAPS | 72.43 | (---) | 54.43 | (---) | *g* = 0.78 |

| ID# | Intervention | Measure | PTSD-Identified Partner | | PTSD-Identified Partner | | Effect Size Pre/Post Tx of Identified Patients<br><br>Hedge *g* or Cohen's *d* |
|---|---|---|---|---|---|---|---|
| | | | Pre-Tx Baseline | WL Baseline | Post-Tx | WL Post Tx | |
| | | PCL | 55 | (---) | 40 | (---) | $g = 1.26$ |
| 9 | Present-focused CBCT | CAPS[a] | 66 | (---) | 65 | (---) | Not Sig. |
| | | PCL[a] | 45 | (---) | 39 | (---) | Not Sig. |

*Note*. Mean scores reported for sample.

Effect sizes of $g > 0.80$ are considered large; $g = 0.50$ to 0.79 are considered moderate; and g = 0.20 to 0.49 are considered small. Negative values indicate no improvement or worsening post intervention. Hedge's g includes a bias correction for small sample size.

Cohen's (1992) convention effect sizes ranged from small ($d = .31$) to large ($d = .92$).

(---) Data Not Provided

Clinically Administered PTSD Scale (CAPS); The Dissociative Experiences Scale (DES); Modified Posttraumatic Beliefs and Reactions Scale (PBRS-M); PTSD Check List (PCL); Post-traumatic Check List for *DSM-5* (PCL-5); Trauma-Related Guilt Inventory (TRGI); Trauma Symptom Inventory (TSI)

[a]Reliable change criteria were +/- 10 points on the CAPS (Blake et al., 1995), +/- 5 points on the PCL (Weathers et al., 1993).

***Depression***

Five studies (56%) of the nine assessed for treatment effect on depressive symptoms. Four of these studies utilized a version of the BDI (Beck et al., 1988, a widely used 21-item questionnaire that assesses symptoms of depression. The remaining measure used was the depression subscale of the Depression, Anxiety, and Stress Scale (DASS; Lovibond & Lovibond, 1995), a 21-item self-report questionnaire.

Trute et al. (2001) investigated the use of brief conjoint therapy to reduce symptoms of depression. While the study did not provide quantitative data using the BDI, researchers reported an observed reduction in female-identified patients' depressive symptoms upon completion of therapy. In applying CBCT for PTSD, the treatment produces a large effect size ($g = 1.16$), significantly reducing depressive symptoms per the BDI-II (Monson et al., 2012). Couples and Family therapy also produced significantly large effect sizes ($d = 0.87$) in reducing levels of depression on the BDI (Whittaker et al., 2023). When MDMA was paired with CBCT, treatment successfully reduced symptoms of depression with a large effect size ($d = 1.50$) measured by the BDI-II (Monson et al., 2020). Finally, the Pukay-Martin et al. (2017) case study failed to produce a significant reduction in symptoms on the DASS. A systematic review by Dominguez et al. (2021) showed that trauma-focused individual treatments effectively reduce depressive symptoms posttreatment with a large effect size ($d = 1.17$), similar to results produced by couple-based interventions. While the research was limited, results from this systematic review are promising for CBCT for PTSD and paired CBCT with MDMA at producing a significant reduction in symptoms of depression for individuals with a history of childhood abuse utilizing a couples-based treatment approach (see Table 5).

**Table 5**

*Symptoms of Depression*

| ID# | Intervention | Measure | PTSD-Identified Partner | | PTSD-Identified Partner | | Effect Size Pre/Post Tx of Identified Patients<br><br>Hedge *g* or Cohen's *d* |
|---|---|---|---|---|---|---|---|
| | | | Pre-Tx Baseline | WL-Baseline | Post-Tx | WL-Post Tx | |
| 1 | Brief Conjoint Therapy | BDI | Men entered and left conjoint therapy within "normal levels" for symptoms of depression. [a]<br>Women tended to enter couples therapy with high levels of depression and leave therapy with moderate levels. [a] | | | | |
| 2 | CBCT for PTSD | BDI-II | 24.36 | 22.6 | 12.16 | 20.32 | *g* = 1.16 |
| 3 | CBCT for PTSD | (---) | (---) | (---) | (---) | (---) | (---) |
| 4 | CBCT for PTSD | (---) | (---) | (---) | (---) | (---) | (---) |
| 5 | Couples and Family Therapy | BDI | 20.83 | (---) | 8.02 | (---) | *d* = 0.87 |
| 6 | Emotion Focused Therapy | (---) | (---) | (---) | (---) | (---) | (---) |
| 7 | MDMA Facilitated CBCT for PTSD | BDI-II | 32.91 | (---) | Immediate: 12.75; 3-Month: 10.98; 6-Month: 9.23 | (---) | *d* = 1.50 |

| ID# | Intervention | Measure | PTSD-Identified Partner | | PTSD-Identified Partner | | Effect Size Pre/Post Tx of Identified Patients<br><br>Hedge *g* or Cohen's *d* |
|---|---|---|---|---|---|---|---|
| | | | Pre-Tx Baseline | WL-Baseline | Post-Tx | WL-Post Tx | |
| 8 | Present-focused CBCT | (---) | (---) | (---) | (---) | (---) | (---) |
| 9 | Present-focused CBCT vs. CBCT for PTSD | DASS | 7 | (---) | 6 | (---) | Not Sig. |

*Note.* BDI 2 (BDI-II); DASS

Effect sizes of $g > 0.80$ are considered large; $g = 0.50$ to 0.79 are considered moderate; and $g =$ 0.20 to 0.49 are considered small. Negative values indicate no improvement or worsening post intervention. Hedge's g includes a bias correction for small sample size.

Cohen's (1992) convention effect sizes ranged from small ($d = .31$) to large ($d = .92$).

[a]Qualitative description of findings provided by study authors. Quantitative data not provided within article.

***Anxiety***

Potentially due to the often-confounding presentation of anxiety and PTSD, only three (33.3%) studies included measures of generalized anxiety. Measures utilized include the DASS (Lovibond & Lovibond, 1995), the Generalized Anxiety Disorder Screener (GAD-7; Spitzer et al., 2006) which is a questionnaire consisting of seven items, and the State-Trait Anxiety Inventory (Spielberger, 1983) which is a self-report questionnaire with a maximum score of 80.

Of the three studies, two (66.7%) provided effect sizes utilizing either Cohen's *d* or Hedges *g*. The Monson et al. (2012) investigation into the application of CBCT for PTSD produced a large effect size decreasing anxiety symptoms per the State-Trait Anxiety Inventory ($g = 0.84$). Couples and family therapy (Whittaker et al., 2023) produced a small effect size per the GAD-7 ($d = 0.31$). Finally, the Pukay-Martin et al. (2017) case study of present-focused CBCT utilizing the DASS to assess anxiety symptoms did not significantly reduce patients' self-report rating. A meta-analysis of CBT-based individual interventions designed to target generalized anxiety produced effect sizes ranging from 0.70 to 0.80 (Olatunji et al., 2010), comparable to results reported by Monson et al. (2012) in which CBCT for PTSD produced an effect size of 0.84. Overall, the effectiveness of interventions included in the review showed mixed results in treatment efficacy at reducing anxiety symptoms (see Table 6). However, it is essential to note that just three of the nine studies specifically addressed this research question.

**Table 6**

*Symptoms of Anxiety*

| ID# | Intervention | Measure | PTSD-Identified Partner | | PTSD-Identified Partner | | Effect Size Pre/Post Tx of Identified Patients<br><br>Hedge *g* or Cohen's *d* |
|---|---|---|---|---|---|---|---|
| | | | Pre-Tx Baseline | WL-Baseline | Post-Tx | WL-Post Tx | |
| 1 | Brief Conjoint Therapy | (---) | (---) | (---) | (---) | (---) | (---) |
| 2 | CBCT for PTSD | State-Trait Anxiety Inventory | 49.25 | 50.9 | 38.65 | 51.73 | $g = 0.84$ |

| ID# | Intervention | Measure | PTSD-Identified Partner | | PTSD-Identified Partner | | Effect Size Pre/Post Tx of Identified Patients<br><br>Hedge *g* or Cohen's *d* |
|---|---|---|---|---|---|---|---|
| | | | Pre-Tx Baseline | WL-Baseline | Post-Tx | WL-Post Tx | |
| 3 | CBCT for PTSD | (---) | (---) | (---) | (---) | (---) | (---) |
| 4 | CBCT for PTSD | (---) | (---) | (---) | (---) | (---) | (---) |
| 5 | Couples and Family Therapy | GAD-7 | 6.84 | (---) | 1.41 | (---) | *d* = 0.31 |
| 6 | Emotion Focused Therapy | (---) | (---) | (---) | (---) | (---) | (---) |
| 7 | MDMA Facilitated CBCT for PTSD | (---) | (---) | (---) | (---) | (---) | (---) |
| 8 | Present-focused CBCT | (---) | (---) | (---) | (---) | (---) | (---) |
| 9 | Present-focused CBCT vs. CBCT for PTSD | DASS | 8 | (---) | 5 | (---) | Not Sig. |

*Note.* Effect sizes of $g > 0.80$ are considered large; $g = 0.50$ to 0.79 are considered moderate; and $g = 0.20$ to 0.49 are considered small. Negative values indicate no improvement or worsening post intervention. Hedge's g includes a bias correction for small sample size.

Cohen's (1992) convention effect sizes ranged from small ($d = .31$) to large ($d = .92$).

**Relationship Distress**

Eight (89%) studies in the review reported outcome data on pre to posttreatment relationship measures. Self-report measures utilized in the included studies to assess for treatment effect on relationship functioning were the CSI (Funk & Rogge, 2007) designed to assess relationship satisfaction, the Dyadic Adjustment Scale (DAS; Graham et al., 2006) developed to assess elements of cohesion and satisfaction, the Emotional Work Scale (EWS; Erickson, 1993) measures partners' provision and receipt of emotional support from their partners, the Inventory of Interpersonal Problems (IIP-64; Horowitz et al., 1988) measures problems one has in relationships in reference to one's personality traits, and the Marital Satisfaction Inventory (MSI; Snyder et al., 1981) a comprehensive measure of a couple's functioning.

Of the eight studies, six (75%) provided relationship outcome effect sizes using either Cohen's *d* or Hedge's *g*. CBCT for PTSD produced medium ($g = 0.59 – 0.64$) effect sizes on the DAS (Monson et al., 2012; Shnaider et al., 2015). CFT had a variable impact, producing a small ($d = 0.24$) effect size on the IIP-64 but exhibiting a large ($d = 0.85$) effect size on a revised version of the DAS (Whittaker et al., 2023). EFT was seen to have a medium ($g = 0.62$) effect size on the DAS (Dalton et al., 2013). When MDMA was paired with CBCT for PTSD, the effect size measured by the CSI ($d = 0.82$) and the Traumatic and Attachment Beliefs Scale (TABS; $d = 0.98$) was large (Monson et al., 2020). Present-centered CBCT produced the smallest ($g = 0.38$) effect sizes measured by the CSI (Pukay-Martin et al., 2017). Furthermore, the Pukay-Martin et al. (2015) case study did not show a significant improvement in the couple's score on the CSI. Finally, Trute et al. (2001) did not provide quantitative outcomes of the EWS and MSI but provided a qualitative description noting improvement in the couple's ability to regulate

frustration, improved coping skills, and a positive attitudinal shift toward their partner. Sijercic et al. (2022) conducted a meta-analysis of prominent couples-based therapies finding treatments have a large effect on relationship satisfaction ($g$ = 1.12). Collectively, the results of the present systematic review produced variable treatment effects on relationship outcomes but were not without promise (see Table 7).

**Table 7**

*Symptoms of Relationship Distress*

| ID# | Intervention | Measure | PTSD-Identified Partner | | PTSD-Identified Partner | | Effect Size Pre/Post Tx of Identified Patients |
|---|---|---|---|---|---|---|---|
| | | | Pre-Tx Baseline | WL-Baseline | Post-Tx | WL-Post Tx | Hedge $g$ or Cohen's $d$ |
| 1 | Brief Conjoint Therapy | MSI EWS | [a]Improvement Seen in the following areas: (1) Skill in dealing with their partners' anger. (2) Methods to cope with situational stressors (e.g., financial, extended family, children, etc.) (3) Attitudinal shifts towards partner. Measures of emotion work to assess changes in the emotional support provided by partners suggested that they can contribute to clinical understanding of couple relational dynamics and offer a useful indicator of emotional resources in the spousal relationship. | | | | |
| 2 | CBCT for PTSD | DAS | 100.64 | 97.63 | 112.87 | 100.42 | $g$ = 0.64 |
| 3 | CBCT for PTSD | DAS | 103.33 | (---) | 113.09 | (---) | $g$ = 0.59 |
| 4 | CBCT for PTSD | (---) | (---) | (---) | (---) | (---) | (---) |

| ID# | Intervention | Measure | PTSD-Identified Partner | | PTSD-Identified Partner | | Effect Size Pre/Post Tx of Identified Patients<br><br>Hedge *g* or Cohen's *d* |
|---|---|---|---|---|---|---|---|
| | | | Pre-Tx Baseline | WL-Baseline | Post-Tx | WL-Post Tx | |
| 5 | Couples and Family Therapy | IIP-64 | 1.3 | (---) | 0.11 | (---) | *d* = 0.24 |
| | | RDAS | 40.82 | (---) | 6.6 | (---) | *d* = 0.85 |
| 6 | Emotion Focused Therapy | DAS | 95.95 | 89.05 | 104.81 | 89.05 | *g* = 0.62 |
| 7 | MDMA Facilitated CBCT for PTSD | CSI | 105.37 | (---) | Immediate: 127.00<br>3-Month: 128.90<br>6-Month: 130.78 | (---) | *d* = 0.82 |
| | | TABS | 289.78 | (---) | Immediate: 232.70<br>3-Month: 227.69<br>6-Month: 222.73 | (---) | *d* = 0.98 |
| 8 | Present-focused CBCT | CSI | 110.13 | (---) | 125.17 | (---) | *g* = 0.38 |
| 9 | Present-focused CBCT vs. CBCT for PTSD | CSI[b] | 134 | (---) | 133 | (---) | Not Sig. |

*Note.* Effect sizes of $g > 0.80$ are considered large; $g = 0.50$ to 0.79 are considered moderate; and $g = 0.20$ to 0.49 are considered small.

Hedge's *g* includes a bias correction for small sample size.

Cohen's (1992) convention effect sizes ranged from small ($d = .31$) to large ($d = .92$).

[a]Qualitative description of findings provided by study authors. Quantitative data not provided within article.

[b]Reliable change calculated as +/- 15.7 points on the CSI (Funk & Rogge, 2007).

CSI; DAS; EWS; IIP-64; MSI; Revised Dyadic Adjustment Scale (RDAS); TABS

## Chapter 4: Discussion

Whether physical, sexual, emotional, or forms of neglect, experiences of child abuse can profoundly impact an individual well into adulthood. Research has shown that early experiences of abuse can significantly impact an individual's mental health, leading to issues such as depression, anxiety, PTSD, and substance abuse. Furthermore, childhood abuse often manifests in an adult survivor's intimate relationships, leading to difficulties with trust, communication, intimacy, and overall relationship satisfaction (Felitti et al., 1998; Horwitz et al., 2001; Nelson et al., 2002; Spataro et al., 2004). Therefore, psychotherapies for adults who have experienced childhood abuse must address its impact on individuals and their current relationships. As such, couples-based psychotherapies have a unique opportunity to target both domains of distress resulting from early abuse effectively. The primary goal of this review was to identify and summarize existing evidence regarding the use of couples-based psychotherapeutic treatment to address past experiences of childhood abuse and the effect on psychological symptoms of distress and relationship functioning.

Many individual psychotherapies have been shown effective in treating the psychological effects of childhood abuse (Anderson & Miller, 2006; Skowron & Reinemann, 2005). However, one of the presumed benefits of couples-based psychotherapy in addressing the impact of childhood abuse is that it recognizes that trauma can affect both individuals in a relationship and not just the partner who directly experienced the maltreatment. By including both partners in the therapy process, couples may work together to recover from the effects of trauma, providing each other support and understanding throughout the therapeutic process. This approach may also help address any negative coping strategies or relationship patterns that may have developed due to the trauma, helping the couple reshape how they respond to one another’s triggers. It is

important to note that a couples-based approach may not always be appropriate, particularly in cases where there are active safety concerns. Additionally, the treating therapist must have specific training in working with trauma and couples to provide the most effective treatment. The findings of this systematic review suggest that multiple couples-based treatments have been shown to produce significant improvements in symptoms of PTSD, depression, and relationship functioning.

Of the nine studies which met the criteria as documented using PRISMA, six therapeutic interventions were identified: BCT (Trute et al., 2001), CBCT for PTSD (Macdonald et al., 2016; Monson et al., 2012; Shnaider et al., 2015), CFT (Whittaker et al., 2023), EFT (Dalton et al., 2013), MDMA facilitated CBCT (Monson et al., 2020), and present-focused CBCT (Pukay-Martin et al., 2015, 2017). CBCT for PTSD, EFT, MDMA-facilitated CBCT, and present-focused CBCT are manualized structured approaches to treatment, whereas BCT and CFT are integrated therapeutic approaches without a standardized application.

The reviewed studies had varied participant demographics, psychiatric diagnoses, and sexual orientations. Studies reviewed varied in whether the trauma-reporting partner was male or female. Eight out of the nine studies identified the sexual orientation of the couples who participated, with the majority of treatment approaches applied to populations consisting only of heterosexual couples. CBCT for PTSD had the most robust and variable sample and was conducted with a combination of male and female-identified patients of varying ethnicities/races, including Caucasian, African, Hispanic, Asian, or Pacific Islander. The studies also identified a range of psychiatric diagnoses among participants, primarily focused on PTSD, with comorbid conditions such as depression, anxiety, and substance use disorder. Research study samples included couples in which one partner reported experiencing childhood abuse, including

experiences of physical, sexual, emotional, or general neglect. Due to the limited availability of research on this topic, some studies also included patients who reported other traumatic experiences such as adult physical abuse, sexual assault, combat-related trauma, motor vehicle accidents, illness, and sudden death.

Regarding couple-based treatment effectiveness in targeting symptoms of PTSD, eight of the nine studies reviewed provided quantitative data on pre/post-treatment effect sizes. Of the studies that reported pre/post-treatment data, CBCT for PTSD produced medium to large effect sizes, while the combination of MDMA with CBCT for PTSD produced significantly large effect sizes (Macdonald et al., 2016; Monson et al., 2012, 2020; Shnaider et al., 2015). Couples who received CBCT demonstrated significant improvement in PTSD symptoms, including re-experiencing, avoidance, and hyperarousal, as well as targeting trauma-related cognitions, such as negative beliefs about oneself, others, and the world (Macdonald et al., 2016). In comparison, present-focused CBCT's results were variable, while CFT and EFT had small to insignificant effect sizes (Dalton et al., 2013; Pukay-Martin et al., 2015, 2017; Whittaker et al., 2023).

Five articles measured the treatment's effectiveness in reducing depressive symptoms. Results showed that BCT, CFT, CBCT for PTSD, and CBCT paired with MDMA all produced significant reductions in depressive symptoms with large effect sizes (Macdonald et al., 2016; Monson et al., 2012, 2020; Shnaider et al., 2015; Trute et al., 2001). However, one case study of present-focused CBCT did not significantly reduce symptoms (Pukay-Martin et al., 2015). The results from the systematic review suggest that couples-based interventions can effectively reduce depressive symptoms posttreatment, although trauma-focused approaches rather than present-focused ones may be more effective.

Only three studies implemented stand-alone measures of anxiety, perhaps due to the considerable overlap between anxiety and PTSD symptomatology. Among these studies, couples-based interventions showed mixed results in treatment efficacy in reducing anxiety symptoms. CBCT for PTSD produced a large effect size, significantly reducing participant-reported anxiety, and CFT produced a small effect size (Macdonald et al., 2016; Whittaker et al., 2023). The case study of present-focused CBCT did not show significant reductions in self-reported anxiety symptoms (Pukay-Martin et al., 2015). Overall, the effectiveness of interventions in reducing anxiety symptoms was inconclusive, as only three studies specifically measured this research question, with variable results.

Finally, eight studies examined the effectiveness of couples-based therapies for improving relationship quality when a partner experiences childhood abuse. CBCT for PTSD produced medium effect sizes on the DAS, while CFT had a variable impact, producing small effect sizes on the Inventory of Interpersonal Problems and a large effect size on a revised version of the DAS (Macdonald et al., 2016; Monson et al., 2012; Shnaider et al., 2015; Whittaker et al., 2023). Emotion-focused therapy produced medium effect sizes on the DAS, while present-centered CBCT produced the smallest effect sizes measured by the CSI (Dalton et al., 2013; Pukay-Martin et al., 2015, 2017). In summary, results showed variability in treatment effectiveness depending on modality, although overall promise for improving relationship outcomes.

Of the studies identified for this dissertation, CBCT for PTSD was the most widely researched and empirically supported couples-based intervention to address the impact of childhood abuse. Furthermore, research samples in which CBCT was implemented were observed to utilize the most diverse sample of participants regarding demographic characteristics

and presenting psychological diagnoses. The primary treatment methods in CBCT for PTSD include cognitive restructuring techniques and trauma-focused exposure therapy, in addition to the inclusion of a supportive partner in the treatment process via a conjoint format (Monson et al., 2012). Additionally, one case study paired the controlled administration of MDMA in conjunction with CBCT for PTSD, which produced even greater effect sizes than CBCT for PTSD alone (Monson et al., 2020). In a case study of present-focused CBCT versus CBCT for PTSD, Pf-CBCT produced smaller effect sizes but was also found to be a possible steppingstone before the administration of trauma-focused CBCT for PTSD, offering a possible alternative treatment for avoidant couples (Pukay-Martin et al., 2015). The results of these two fore mentioned studies suggest that CBCT for PTSD maintains its treatment effectiveness and may perhaps enhance outcomes when adaptively paired with other interventions depending on the unique needs of the couples. However, further research with larger, more diverse samples is needed to make a definitive statement. Other interventions included for review have received less empirical research but showed promise nonetheless at effectively reducing symptoms of PTSD and depression while improving relationship outcomes. Such interventions included BCT (Trute et al., 2001), CFT (Whittaker et al., 2023), and EFT (Dalton et al., 2013). While preliminary evidence of couples-based interventions to address childhood abuse's long-term individual and relational impact is promising, future research is greatly needed to expand the understanding and application of such treatments.

**Limitations**

While this dissertation attempted to review all peer-reviewed literature comprehensively, some limitations are noted. While every attempt was made to incorporate all relevant keywords in the search strategy, the possibility of unintentionally omitted terms persists. Furthermore, it

must be noted that a systematic review is open to bias and subjective interpretation of findings. However, a concerted attempt was made to comprehensively analyze the literature. Specifically, this dissertation utilized the PRISMA system to improve the quality and standardization of the systematic review to promote transparency and allow for future duplication of the results (Liberati et al., 2009). To minimize subjective bias, the dissertation relied most heavily on quantitative findings of the included research studies to avoid subjective interpretation, apart from one study of EFT for couples, which only provided a descriptive report of the quantitative findings.

When determining what research articles would be included for review, many studies were expelled due to a lack of incorporating objective measurement of symptomatology. Furthermore, while all studies focused on couples where one partner had endorsed a history of trauma, there is considerable variability in individual characteristics such as presenting symptoms, psychological diagnosis, type of trauma, and level of relational distress. Additionally, some studies included in their treatment population couples in which the identified patient reported an index traumatic event other than childhood abuse, which limits the degree such studies findings could be exclusively applied to childhood trauma.

A glaring limitation of all research studies included in this analysis is the lack of diversity, as samples were relatively small and homogenous. Samples were typically Caucasian heterosexual couples of Western cultures from middle-class socioeconomic status. The U.S. Department of Health and Human Services (2020) found that children from particular racial and ethnic groups, mainly Black and Native American children and those of lower socioeconomic status, are more likely to be victims of abuse and neglect. All studies included for review were conducted with exclusively English-speaking populations, which substantially limits the

generalizability to other cultures. Literature also has shown that an individual's response to trauma varies considerably based on demographic variables (Hinton & Good, 2016; Scher et al., 2004). Furthermore, the research emphasizes culture's importance in couples therapy and its implications when working with diverse couples in optimizing treatment outcomes (Poulsen & Thomas, 2007). The need for expanded representation of diversity within research has been well established, particularly within the application of psychotherapy, especially given the impact socioeconomic status and culture have on prevalence, perception, and coping with traumatic experiences (Hinton & Good, 2016). However, despite the continued call for greater representation over the years, even studies included for review, completed as recently as 2021, utilized samples of overwhelmingly Caucasian, middle-class, heterosexual, English-speaking participants. Perhaps the more significant question needing to be asked is what more needs to be done to ensure greater inclusivity in research which is continuing to fall short of this goal.

**Future Research**

As previously stated, the majority of peer-reviewed research has been conducted on the application of CBCT for PTSD. However, other promising therapeutic approaches exist and require investigation. One approach worth further investigation is Integrative Behavioral Couple Therapy (IBCT). IBCT is a couples therapy that combines traditional behavioral therapy elements with acceptance-based methods. It emphasizes a deeper understanding of differences between partners, strengthening emotional bonds, and improving communication between intimate partners within a relationship by restructuring how they interact (Christensen & Doss, 2017). A preliminary study by Christensen et al. (2010) found that IBCT was associated with reductions in PTSD symptoms and improved relationship satisfaction in a sample of military couples. However, further controlled research focused on specific experiences of trauma with

more diverse samples is needed. Another promising treatment approach is Eye Movement Desensitization and Reprocessing (EMDR) couples therapy for PTSD. Errebo and Sommers-Flanagan (2007) found that EMDR couples therapy produced positive improvements in relationship satisfaction while also reducing symptoms of PTSD in military couples in which one partner had experienced a combat-related trauma. Linder et al. (2021) found positive results when combining EMDR with EFT to address past trauma through couples therapy. However, it is essential to note that both studies were small noncontrolled investigations that call for more research with a broader array of couples and settings.

Future research designs would benefit by utilizing active control conditions to allow for the direct comparison of treatment outcomes between different couples-based treatments, for example, the utilization of CBCT for PTSD versus EFT. Furthermore, research that compares outcomes in trauma-reporting patients who undergo individual versus couples-based therapies would help provide further information for the potential efficacy of couples-based interventions.

To address the limitations of the current research in terms of diversity, a large sample size with both male and female trauma survivors and same-sex couples should be included in future treatment groups. Continued efforts to expand research to racial groups of varying socioeconomic status are also needed. In working with couples from underrepresented groups, I should seek to explore the potential impact of unique stressors these specific groups encounter, such as racial discrimination, on psychological and relationship treatment outcomes. Also, overlapping with the issue of underrepresented groups in research, Williams et al. (2022) highlighted how minorities may internalize and manifest responses to trauma differently due to their experiences of marginalization, particularly within the mental health field. As a result,

culturally informed approaches to treatment may be necessary for addressing mental health concerns among minority populations, requiring specific attention in future studies.

Pretreatment symptom presentation and severity received little attention in the presented research and may likely influence treatment outcomes. For example, higher pretreatment relationship satisfaction may also predict better treatment outcomes (Shnaider et al., 2015). Shnaider et al. examined the relationship between pretreatment relationship satisfaction and treatment outcomes in CBCT for PTSD. The study found that couples with higher pretreatment relationship satisfaction reported more significant improvement in symptoms of PTSD, anxiety, and depression posttreatment than those with lower relationship satisfaction. Findings may suggest that individuals with higher relationship satisfaction may benefit more from the couples-based intervention than those with lower relationship satisfaction. However, future research studies should examine patient pretreatment variables to optimize results. While not the primary focus of this review, it was observed that very few studies investigated the pre/post-treatment outcomes of the non-trauma reporting partner, which is an additional area for further investigation to determine if a couples-based approach brings benefit to both individuals. Overall, the outcome variables measured in the included studies were relatively narrow in scope. Future research would benefit from broadening psychological distress and relationship outcome measures to provide a more comprehensive assessment of pre and post-treatment effects. Finally, research often excluded couples with active substance abuse or a history of domestic violence, which remain populations needing quality intervention and are essential to address in future studies.

## Conclusion

In conclusion, couples-based psychotherapy offers a unique approach to addressing psychological and relationship distress domains affected by the long-lasting impact of childhood abuse. Research has shown that couples-based treatment approaches can effectively reduce symptoms of depression and PTSD while improving overall relationship satisfaction by enhancing communication and fostering mutual understanding between partners. The systematic review identified six couples-based psychotherapeutic interventions: BCT, CBCT for PTSD, CFT, EFT, MDMA-facilitated CBCT, and Pf-CBCT. CBCT for PTSD had the most robust and variable sample, producing the most significant effect sizes.

There are several important considerations when using couples-based psychotherapies to treat adults with a history of childhood abuse. Firstly, therapists must have training and experience in working with trauma survivors. Childhood abuse can have long-lasting and complex effects, and therapists must be prepared to address these issues sensitively and informally. Additionally, both partners must be willing to engage in the therapeutic process. Couples-based psychotherapies require a commitment from both partners to work together to improve their relationship. Finally, it is essential to recognize that couples-based psychotherapies may not be appropriate for all couples, mainly if there are active safety concerns.

This dissertation makes a valuable contribution to clinical psychology research by bringing attention to the opportunity for an alternative treatment to address the impact of childhood abuse. The findings of this review identify the need for further research in this area, including cross-comparison between different approaches with larger, more diverse samples. It is essential to continue exploring the potential of couples-based psychotherapeutic interventions as a promising way to promote healing and repair relationship distress amongst survivors of

childhood abuse. This study aims to help inform future research to optimize couples-based interventions with survivors of childhood abuse and provide clinical benefit to individuals and couples needing support.

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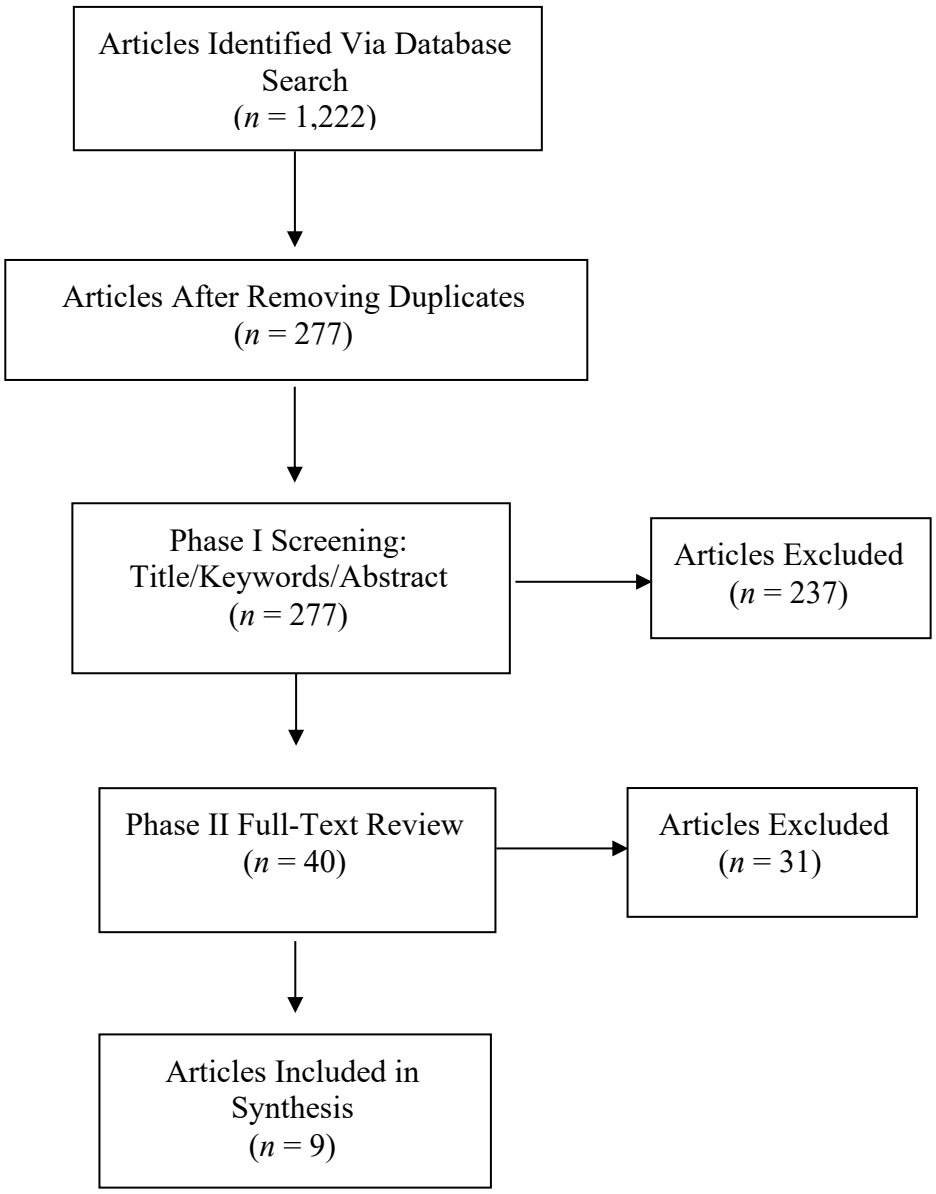
# APPENDIX A

## PRISMA Flow Diagram




*Note.* From "Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement," by D. Moher, A. Liberati, J. Tetzlaff, D. G. Altman, & The PRISMA Group, 2009, *PLoS Medicine, 6*(7), e1000097. (https://doi.org/10.1371/journal.pmed1000097).

# APPENDIX B

## Search Terms

**LIST OF SEARCH TERMS**

| Search Term ID# | Primary Term | Synonyms/ Alternate Forms | Notes |
|---|---|---|---|
| 01 | Couples | "Romantic Partners", "Marriage", "Marrital", "Dyad", "Dyadic", "Conjoint" | |
| 02 | Interveniton | "Psychotherapy", "Psychotherapuetic Treatment", "Therapy", "Marital Therapy", "Treatment" | |
| 03 | Childhood Abuse | "Childhood Trauma", "Childhood Maltreatment", "Childhood Physical Abuse", "Childhood Sexual Abuse", "Childhood Verbal Abuse", "Childhood Emotional Abuse", "Childhood Neglect", | |

# APPENDIX C

## Search Plan

**SEARCH PLAN**

| Search Type | Databases or Sources | Search Term ID(s | Search Syntax or Instructions | Fields to Search | Specifiers | Plan Notes |
|---|---|---|---|---|---|---|
| Electronic Database | PsycINFO | 01, 02, 03 | (couples OR romantic Partners OR marriage OR marital OR dyad OR dyadic OR conjoint) AND (intervention OR psychotherapy OR psychotherapuetic treatment OR therapy OR marital therapy OR treatment) AND (childhood abuse OR childhood trauma OR childhood Maltreatment OR childhood physical abuse OR childhood sexual abuse OR childhood verbal abuse OR childhood emotional abuse OR childhood neglect) | Title, Keywords, Abstract | Peer Reviewed Articles | Each combination of 01, 02, and 03 will be attempted. |
| Electronic Database | PsychARTICLES | 01, 02, 03 | (couples OR romantic Partners OR marriage OR marital OR dyad OR dyadic OR conjoint) AND (intervention OR psychotherapy OR psychotherapuetic treatment OR therapy OR marital therapy OR treatment) AND (childhood abuse OR childhood trauma OR childhood Maltreatment OR childhood physical abuse OR childhood sexual abuse OR childhood verbal abuse OR childhood emotional abuse OR childhood neglect) | Title, Keywords, Abstract | Peer Reviewed Articles | Each combination of 01, 02, and 03 will be attempted. |
| Electronic Database | PubMed | 01, 02, 03 | (couples OR romantic Partners OR marriage OR marital OR dyad OR dyadic OR conjoint) AND (intervention OR psychotherapy OR psychotherapuetic treatment OR therapy OR marital therapy OR treatment) AND (childhood abuse OR childhood trauma OR childhood Maltreatment OR childhood physical abuse OR childhood sexual abuse OR childhood verbal abuse OR childhood emotional abuse OR childhood neglect) | Title, Keywords, Abstract | Peer Reviewed Articles | Each combination of 01, 02, and 03 will be attempted. |
| Electronic Database | Medline | 01, 02, 03 | (couples OR romantic Partners OR marriage OR marital OR dyad OR dyadic OR conjoint) AND (intervention OR psychotherapy OR psychotherapuetic treatment OR therapy OR marital therapy OR treatment) AND (childhood abuse OR childhood trauma OR childhood Maltreatment OR childhood physical abuse OR childhood sexual abuse OR childhood verbal abuse OR childhood emotional abuse OR childhood neglect) | Title, Keywords, Abstract | Peer Reviewed Articles | Each combination of 01, 02, and 03 will be attempted. |
| Electronic Database | Proquest | 01, 02, 03 | (couples OR romantic Partners OR marriage OR marital OR dyad OR dyadic OR conjoint) AND (intervention OR psychotherapy OR psychotherapuetic treatment OR therapy OR marital therapy OR treatment) AND (childhood abuse OR childhood trauma OR childhood Maltreatment OR childhood physical abuse OR childhood sexual abuse OR childhood verbal abuse OR childhood emotional abuse OR childhood neglect) | Title, Keywords, Abstract | Peer Reviewed Articles | Each combination of 01, 02, and 03 will be attempted. |

# APPENDIX D

## Search Documentation

**SEARCH DOCUMENTATION RECORD**

*Refer to your Review Protocol and "List of Search Terms" and "Search Plan" (document any added Search Terms since post-prelims Protocol approval)

*Remember to **save and export your searches** (with Abstracts!) to use in Phase 1 of your SCREENING AND SELECTION process

| Search Date | FULL SEARCH ID# | TYPE OF SEARCH | DATABASE/SOURCE | SEARCH TERM IDNs | SEARCH SYNTAX OR OTHER GUIDELINES FOR THE SEARCH | FIELDS SEARCHED | SEARCH SPECIFIER: Years | SEARCH SPECIFIER: Publication Type | (Columns for Other Specifiers as Needed) | # of Records |
|---|---|---|---|---|---|---|---|---|---|---|
| 11/5/20 | 101 | Electronic Database | Proquest | 01, 02, 03 | "Couples Therapy OR Couples Counseling OR Marriage Counseling OR Marriage Therapy" AND "Child Abuse OR Child Neglect OR Child Maltreatment" | Abstract | Unspecified | Unspecified | | 187 |
| 11/5/20 | 102 | Electronic Database | PsychArticles | 01, 02, 03 | "Couples Therapy OR Couples Counseling OR Marriage Counseling OR Marriage Therapy" AND "Child Abuse OR Child Neglect OR Child Maltreatment" | Title, Keywords, Abstract | Unspecified | Peer-Reviewed Articles only | | 2 |
| 11/5/20 | 103 | Electronic Database | PsychInfo | 01, 02, 03 | "Couples Therapy OR Couples Counseling OR Marriage Counseling OR Marriage Therapy" AND "Child Abuse OR Child Neglect OR Child Maltreatment" | Unspecified | Unspecified | Unspecified | | 219 |
| 11/5/20 | 104 | Electronic Database | Pubmed | 01, 02, 03 | "Couples Therapy OR Couples Counseling OR Marriage Counseling OR Marriage Therapy" AND "Child Abuse OR Child Neglect OR Child Maltreatment" | Abstract | Unspecified | Unspecified | | 254 |
| 11/5/20 | 105 | Electronic Database | Medline | 01, 02, 03 | "Couples Therapy OR Couples Counseling OR Marriage Counseling OR Marriage Therapy" AND "Child Abuse OR Child Neglect OR Child Maltreatment" | Abstract | Unspecified | Unspecified | | 254 |
| 8/7/22 | 106 | Electronic Database | PsychInfo | 01, 02, 03 | (couples intervention OR romantic partners intervention OR marriage intervention OR marital intervention OR dyad intervention OR dyadic intervention OR conjoint intervention OR couples psychotherapy OR romantic partners psychotherapy OR marriage psychotherapy OR marital psychotherapy OR dyad psychotherapy OR dyadic psychotherapy OR conjoint psychotherapy OR couples psychotherapeutic treatment OR romantic partners psychotherapeutic treatment OR marriage psychotherapeutic treatment OR marital psychotherapeutic treatment OR dyad psychotherapeutic treatment OR dyadic psychotherapeutic treatment OR conjoint psychotherapeutic treatment OR couples therapy OR romantic partners therapy OR marriage therapy OR marital therapy OR dyad therapy OR dyadic therapy OR conjoint therapy OR couples marital therapy OR romantic partners marital therapy OR marital therapy OR dyad marital therapy OR dyadic marital therapy OR conjoint marital therapy OR couples treatment OR romantic partners treatment OR marriage treatment OR marital treatment OR dyad treatment OR dyadic treatment OR conjoint treatment) AND (childhood abuse OR childhood trauma OR childhood Maltreatment OR childhood physical abuse OR childhood sexual abuse OR childhood verbal abuse OR childhood emotional abuse OR childhood neglect) | Title, Keywords, Abstract | Unspecified | Unspecified | Peer Review, Language: English | 273 |
| 8/7/22 | 107 | Electronic Database | PsychArticles | 01, 02, 03 | (couples intervention OR romantic partners intervention OR marriage intervention OR marital intervention OR dyad intervention OR dyadic intervention OR couples psychotherapy OR romantic partners psychotherapy OR marriage psychotherapy OR marital psychotherapy OR dyad psychotherapy OR dyadic psychotherapy OR conjoint psychotherapy OR couples psychotherapeutic treatment OR romantic partners psychotherapeutic treatment OR marriage psychotherapeutic treatment OR marital psychotherapeutic treatment OR dyad psychotherapeutic treatment OR dyadic psychotherapeutic treatment OR conjoint psychotherapeutic treatment OR couples therapy OR romantic partners therapy OR marriage therapy OR marital therapy OR dyad therapy OR dyadic therapy OR conjoint therapy OR couples marital therapy OR romantic partners marital therapy OR marital therapy OR dyad marital therapy OR dyadic marital therapy OR conjoint marital therapy OR couples treatment OR romantic partners treatment OR marriage treatment OR marital treatment OR dyad treatment OR dyadic treatment OR conjoint treatment) AND (childhood abuse OR childhood trauma OR childhood Maltreatment OR childhood physical abuse OR childhood sexual abuse OR childhood verbal abuse OR childhood emotional abuse OR childhood neglect) | Title, Keywords, Abstract | Unspecified | Unspecified | Peer Review | 14 |
| 8/7/22 | 108 | Electronic Database | PubMED | 01, 02, 03 | ("couples intervention"[Title/Abstract] OR "romantic partners intervention"[Title/Abstract] OR "marriage intervention"[Title/Abstract] OR "marital intervention"[Title/Abstract] OR "dyad intervention"[Title/Abstract] OR "dyadic intervention"[Title/Abstract] OR "conjoint intervention"[Title/Abstract] OR "couples psychotherapy"[Title/Abstract] OR "romantic partners psychotherapy"[Title/Abstract] OR "marriage psychotherapy"[Title/Abstract] OR "marital psychotherapy"[Title/Abstract] OR "dyad psychotherapy"[Title/Abstract] OR "dyadic psychotherapy"[Title/Abstract] OR "conjoint psychotherapy"[Title/Abstract] OR "couples psychotherapeutic treatment"[Title/Abstract] OR "romantic partners psychotherapeutic treatment"[Title/Abstract] OR "marriage psychotherapeutic treatment"[Title/Abstract] OR "marital psychotherapeutic | Title, Keywords, Abstract | Unspecified | Unspecified | | 7 |
| 8/7/22 | 109 | Electronic Database | Medline | 01, 02, 03 | ("couples intervention"[Title/Abstract] OR "romantic partners intervention"[Title/Abstract] OR "marriage intervention"[Title/Abstract] OR "marital intervention"[Title/Abstract] OR "dyad intervention"[Title/Abstract] OR "dyadic intervention"[Title/Abstract] OR "conjoint intervention"[Title/Abstract] OR "couples psychotherapy"[Title/Abstract] OR "romantic partners psychotherapy"[Title/Abstract] OR "marriage psychotherapy"[Title/Abstract] OR "marital psychotherapy"[Title/Abstract] OR "dyad psychotherapy"[Title/Abstract] OR "dyadic psychotherapy"[Title/Abstract] OR "conjoint psychotherapy"[Title/Abstract] OR "couples psychotherapeutic treatment"[Title/Abstract] OR "romantic partners psychotherapeutic treatment"[Title/Abstract] OR "marriage psychotherapeutic treatment"[Title/Abstract] OR "marital psychotherapeutic | Title, Keywords, Abstract | Unspecified | Unspecified | | 7 |
| 8/7/22 | 110 | Electronic Database | Proquest | 01, 02, 03 | noft(("couples intervention" OR "romantic partners intervention" OR "marriage intervention" OR "marital intervention" OR "dyad intervention" OR "dyadic intervention" OR "conjoint intervention" OR "couples psychotherapy" OR "romantic partners psychotherapy" OR "marriage psychotherapy" OR "marital psychotherapy" OR "dyad psychotherapy" OR "dyadic psychotherapy" OR "conjoint psychotherapy" OR "couples psychotherapeutic treatment" OR "romantic partners psychotherapeutic treatment" OR "marriage psychotherapeutic treatment" OR "marital psychotherapeutic treatment" OR "dyad psychotherapeutic treatment" OR "dyadic psychotherapeutic treatment" OR "conjoint psychotherapeutic treatment" OR "couples therapy" OR "romantic partners therapy" OR "marriage therapy OR marital therapy" OR "dyad therapy OR dyadic therapy" OR "conjoint therapy" OR "couples marital therapy" OR "romantic partners marital therapy" OR "marital therapy" OR "dyad marital therapy" OR "dyadic marital therapy" OR "conjoint marital therapy" OR "couples treatment" OR "romantic partners treatment" OR "marriage treatment" OR "marital treatment" OR "dyad treatment" OR "dyadic treatment" OR "conjoint treatment")) AND noft(("childhood abuse" OR "childhood trauma" OR "childhood maltreatment" OR "childhood physical abuse" OR "childhood sexual abuse" OR "childhood verbal abuse" OR "childhood emotional abuse" OR "childhood neglect")) | Anywhere Except Full Text | Unspecified | Unspecified | Dissertations, Language: English | 5 |

# APPENDIX E

## Screening and Selection Record

## SCREENING AND SELECTION RECORD

PHASE 1: Title/Keywords/Abstract (Screening) PHASE 2: Full-Text Review (Eligibility) PHASE 3: Final Decision (Selection)

DECISION CODES: INCLUDE/CONTINUE TO ABSTRACT/CONTINUE TO FULL TEXT/UNDECIDED/EXCLUDE (IN/CFT/CAB/UN/EX)
CRITERIA CODES: (IS THE CRITERIA MET?) YES/UNCLEAR/NO (Y/UC/NO)

| ID# | Authors | YEAR | ABBREVIATED TITLE | DATABASES/ SOURCES | TITLE AND/ OR KEYWORD SCREEN: DECISION - DATE | ABSTRACT SCREEN: DECISION - DATE |
|---|---|---|---|---|---|---|
| 1 | Trute, Barry; Docking, Bobbie; Hiebert-Murphy, Diane | 20010101 | Couples therapy for women survivors of child sexual abuse who are in addictions recovery: A comparative case study of treatment process and outcome. | PsychINFO | Yes 8/9/ | Yes 8/11/22 |
| 2 | Monson, C. M., Fredman, S. J., Macdonald, A., Puka | 2012 | Effect of cognitive-behavioral couple therapy for PTSD: A randomized controlled trial. | PsychINFO | Yes 8/9/ | Yes 8/11/22 |
| 3 | Monson, C. M., Wagner, A. C., Mithoefer, A. T., Liebman, R. E., Feduccia, A. A., Jerome, L., ... & Mithoefer, M. C. | 2020 | MDMA-facilitated cognitive-behavioural conjoint therapy for posttraumatic stress disorder: an uncontrolled trial. | PsychINFO | Yes 8/9/ | Yes 8/11/ |
| 4 | MacIntosh, Heather B.; Fletcher, Kara; Ainsworth, Laurie | 20190101 | Measuring mentalizing in emotionally focused therapy for couples with childhood sexual abuse survivors and their partners. | PsychINFO | Yes 8/9/ | Yes 8/11/22 |
| 5 | Dalton, E. Jane; Greenman, Paul S.; Classen, Catherine C.; Johnson, Susan M. | 20130901 | Nurturing connections in the aftermath of childhood trauma: A randomized controlled trial of emotionally focused couple therapy for female survivors of childhood abuse. | PsychArticles | Yes 8/9/ | Yes 8/11/ |
| 6 | Pukay-Martin, Nicole D.; Torbit, Lindsey; Landy, Meredith S. H.; Macdonald, Alexandra; Monson, Candice M. | 20170601 | Present- and trauma-focused cognitive–behavioral conjoint therapy for posttraumatic stress disorder: A case study. | PsychINFO | Yes 8/9/ | Yes 8/11/22 |
| 7 | Fitzgerald, Michael | 20210507 | Relating from the past or the present: Relationship mindfulness as a mediator linking childhood maltreatment to adult relationship quality. | PsychINFO | Yes 8/9/ | Yes 8/11/22 |
| 13 | Maltas CP. | 3/1/96 | Reenactment and repair: couples therapy with survivors of childhood sexual abuse | PubMED | Yes 8/9/ | ??? |
| 8 | Shnaider P, Pukay-Martin ND, Sharma S, Jenzer T | 2015 | A preliminary examination of the effects of pretreatment relationship satisfaction on treatment outcomes in cognitive-behavioral conjoint therapy for PTSD | PsychINFO | Yes 8/9/ | Yes 8/11/22 |
| 9 | Pukay-Martin, N. D., Torbit, L., Landy, M. S., Wanklyn, S. G., Shnaider, P., Lane, J. E., & Monson, C. M. | 2015 | An uncontrolled trial of a present-focused cognitive-behavioral conjoint therapy for posttraumatic stress disorder. | PsychINFO | Yes 8/9/ | Yes 8/11/ |
| 10 | Fitzgerald, Michael; Grames, Heath | 20210509 | Childhood maltreatment and mindfulness: Implications for older adult's marital outcomes. | PsychINFO | Yes 8/9/ | Yes 8/11/22 |
| 11 | Whittaker, Kristoffer J.; Johnson, Sverre Urnes; Solbakken, Ole André; Wampold, Bruce; Tilden, Terje | 20210617 | Childhood trauma as a predictor of change in couple and family therapy: A study of treatment response. | PsychINFO | Yes 8/9/ | Yes 8/11/22 |

| FULL-TEXT SCREEN | INCL(RV): | INCL (RV): Research Variable 2 | INCL (RV): Research Variable 3 | Treatment Variable | INCL(PAR): | INCL(PAR): Participant Variable 2 | INCL(PAR): Participant Variable 3 | INCL (M): Methodology Variable | Methodology Measure | INCL (SQ): *Sample Size > 50* | REVIEWER DECISION - DATE | SECONDARY/ CONFIMATORY DECISION | FINAL DECISION | FINAL DECISION DATE | DECISION NOTES |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| X | SUD | ionship | | Conjoint | | | | Mixed Method | | | Yes 8/27/22 | 12/1/22 | Yes | 12/1/22 | Breif Conjoint Therapy: Relationship Variables, Depression, Gender Differences |
| X | PTSD | | | CBCT | Couples | | | Quantitative | | | Yes 8/27/22 | 12/1/22 | Yes | 12/1/22 | CBCT for PTSD: PTSD, Relationship Satisfaction, partner-rated PTSD symptoms, and comorbid symptoms were secondary outcomes. |
| X | PTSD | | | CBCT and | Couples | | | | | | Yes 8/27/22 | 12/2/22 | Yes | 12/2/22 | CBCT with MDMA, PTSD, Other Comobidities, Relationship Satisfaction |
| X | Relationship | PTSD | | Mentalization | Couples | | | Mixed Method | DAS, TSI | 10 | Yes 8/27/22 | 12/2/22 | No | 12/2/22 | Did not included a quantitative validated measure of symptoms or relationship quality. |
| X | Relationship Impai | | | EFT | Couples | | | Quantitat | DAS | 24 | Yes 8/27/22 | 12/3/22 | Yes | 12/3/22 | EFT, RCT, Relationship Satisfaction, Therapuetic Alliance, Trauma Symptoms |
| X | Relationship Impai | PTSD | | CBCT | | | | Mixed Method | | | Yes 8/27/22 | 12/3/22 | Yes | 12/3/22 | Case study, present focused CBCT followed by Trauma focused CBCT |
| X | Relationship | | | Couple Based Mindful | Couples | | | Quantitative | | | Yes 8/27/22 | 4-Dec | No | 12/4/22 | Study does not provide intervention to both members of the couplel. |
| X | | | | Reenactment | | | | Mixed Method | | | ??? | 12/5/22 | No | 12/5/22 | Finally got access to the article, no formal measures or quantitative scales |
| X | Relationship | PTSD | | CBCT | Couples | | | Quantitative | PTSD, Dyadic Adjustme | 37 | Yes 8/25/22 | 12/5/22 | Yes | 12/5/22 | CBCT, Drop out rate, relationship satisfaction and PTSD |
| X | Relationship | PTSD | | CBCT | Couples | | | Quantitat | PTSD, Dyadic Adjustme | 6 | Yes 8/25/22 | 12/6/22 | Yes | 12/6/22 | Present focused CBCT, Relationship satisfcation, PTSD |
| X | Marital Satisf | | | Mindfulness | Couples | | | Moderation Analysis | | 560 | Yes 8/25/22 | 12/10/22 | No | 12/10/22 | Did not involve romantic partner in intervention or assessment. |
| X | Relationship | Anxiety | Depression | 6-12 Wk Residential | Couples & Individuals | | | Mixed Model Analysis | | 36 | Yes 8/25/22 | 12/10/22 | Yes | 12/10/22 | In-Patient hospital setting. Treatment considerations in an integrated a-theoretical approach which includes multiple forms of individual and couples therapy activitiess. |

# APPENDIX F

## Data Collection and Extraction Form

## Study/Document Identification

| | |
|---|---|
| Review title or ID | |
| Study ID *(surname of first author and year first full report of study was published e.g. Smith 2001)* | |
| Report ID | |
| Report ID of other reports of this study including errata or retractions | |
| Notes | |

## General Information

| | |
|---|---|
| Date form completed *(dd/mm/yyyy)* | |
| Name/ID of person extracting data | |
| Reference citation | |
| Study author contact details | |
| Publication type *(e.g. full report, abstract, letter)* | |
| Notes: | |

## Study eligibility

| Study Characteristics | Eligibility criteria *(Insert inclusion criteria for each characteristic as defined in the Protocol)* | Eligibility criteria met? Yes | No | Unclear | Location in text or source *(pg & ¶/fig/table/other)* |
|---|---|---|---|---|---|
| Type of study | Randomised Controlled Trial | ☐ | ☐ | ☐ | |
| | Quasi-randomised Controlled Trial | ☐ | ☐ | ☐ | |
| | Controlled Before and After Study<br>Contemporaneous data collection<br>Comparable control sites<br>At least 2 x intervention and 2 x control clusters | ☐ | ☐ | ☐ | |
| | Interrupted Time Series<br>At least 3 time points before and 3 after the intervention<br>Clearly defined intervention point | ☐ | ☐ | ☐ | |
| | Other design (specify): | ☐ | ☐ | ☐ | |
| Participants | | ☐ | ☐ | ☐ | |

| | | | |
|---|---|---|---|
| Types of intervention | | ☐ ☐ ☐ | |
| Types of comparison | | ☐ ☐ ☐ | |
| Types of outcome measures | | ☐ ☐ ☐ | |
| INCLUDE ☐ | EXCLUDE ☐ | | |
| Reason for exclusion | | | |
| Notes: | | | |

**Characteristics of included studies**

**Methods**

| | **Descriptions as stated in report/paper** | **Location in text or source** *(pg & ¶/fig/table/other)* |
|---|---|---|
| **Aim of study** *(e.g. efficacy, equivalence, pragmatic)* | | |
| **Design** *(e.g. parallel, crossover, non-RCT)* | | |
| **Unit of allocation** *(by individuals, cluster/ groups or body parts)* | | |
| **Start date** | | |
| **End date** | | |
| **Duration of participation** *(from recruitment to last follow-up)* | | |

| | | | |
|---|---|---|---|
| **Ethical approval needed/ obtained for study** | ☐ Yes ☐ No ☐ Unclear | | |
| **Notes:** | | | |

**Participants**

| | Description<br>*Include comparative information for each intervention or comparison group if available* | Location in text or source *(pg & ¶/fig/table/other)* |
|---|---|---|
| Population description *(from which study participants are drawn)* | | |
| Setting *(including location and social context)* | | |
| Inclusion criteria | | |
| Exclusion criteria | | |
| Method of recruitment of participants *(e.g. phone, mail, clinic patients)* | | |
| Informed consent obtained | ☐ Yes ☐ No ☐ Unclear | |
| Total no. randomised *(or total pop. at start of study for NRCTs)* | | |
| Clusters *(if applicable, no., type, no. people per cluster)* | | |
| Baseline imbalances | | |

| | | |
|---|---|---|
| Withdrawals and exclusions *(if not provided below by outcome)* | | |
| Age | | |
| Sex | | |
| Race/Ethnicity | | |
| Severity of illness | | |
| Co-morbidities | | |
| Other relevant sociodemographics | | |
| Subgroups measure | | |
| Subgroups reported | | |
| Notes: | | |

**Intervention groups**

*Copy and paste table for each intervention and comparison group*

**Intervention Group 1**

| | Description as stated in report/paper | Location in text or source *(pg & ¶/fig/table/other)* |
|---|---|---|
| Group name | | |
| No. randomised to group *(specify whether no. people or clusters)* | | |
| Theoretical basis *(include key references)* | | |
| Description *(include sufficient detail for replication, e.g. content, dose, components)* | | |
| Duration of treatment period | | |
| Timing *(e.g. frequency, duration of each episode)* | | |

| | | |
|---|---|---|
| Delivery *(e.g. mechanism, medium, intensity, fidelity)* | | |
| Providers *(e.g. no., profession, training, ethnicity etc. if relevant)* | | |
| Co-interventions | | |
| Economic information *(i.e. intervention cost, changes in other costs as result of intervention)* | | |
| Resource requirements *(e.g. staff numbers, cold chain, equipment)* | | |
| Integrity of delivery | | |
| Compliance | | |
| Notes: | | |

**Outcomes**

*Copy and paste table for each outcome.*

**Outcome 1**

| | Description as stated in report/paper | Location in text or source *(pg & ¶/fig/table/other)* |
|---|---|---|
| Outcome name | | |
| Time points measured *(specify whether from start or end of intervention)* | | |
| Time points reported | | |
| Outcome definition *(with diagnostic criteria if relevant)* | | |
| Person measuring/ reporting | | |

| | | |
|---|---|---|
| Unit of measurement *(if relevant)* | | |
| Scales: upper and lower limits *(indicate whether high or low score is good)* | | |
| Is outcome/tool validated? | ☐ Yes ☐ No ☐ Unclear | |
| Imputation of missing data *(e.g. assumptions made for ITT analysis)* | | |
| Assumed risk estimate *(e.g. baseline or population risk noted in Background)* | | |
| Power *(e.g. power & sample size calculation, level of power achieved)* | | |
| Notes: | | |

**Other**

| | | |
|---|---|---|
| Study funding sources *(including role of funders)* | | |
| Possible conflicts of interest *(for study authors)* | | |
| Notes: | | |

**Risk of Bias assessment**

*(See Handbook Chapter 8. Additional domains may be added for non-randomised studies.)*

| Domain | Risk of bias<br>Low High Unclear | Support for judgement<br>*(include direct quotes where available with explanatory comments)* | Location in text or source *(pg & ¶/fig/table/other)* |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Random sequence generation *(selection bias)* | ☐ ☐ ☐ | | |
| Allocation concealment *(selection bias)* | ☐ ☐ ☐ | | |
| Blinding of participants and personnel *(performance bias)* | ☐ ☐ ☐ | Outcome group: All/ | |
| *(if separate judgement by outcome(s) required)* | ☐ ☐ ☐ | Outcome group: | |
| Blinding of outcome assessment *(detection bias)* | ☐ ☐ ☐ | Outcome group: All/ | |
| *(if separate judgement by outcome(s) required)* | ☐ ☐ ☐ | Outcome group: | |
| Incomplete outcome data *(attrition bias)* | ☐ ☐ ☐ | Outcome group: All/ | |
| *(if separate judgement by outcome(s) required)* | ☐ ☐ ☐ | Outcome group: | |
| Selective outcome reporting? *(reporting bias)* | ☐ ☐ ☐ | | |
| Other bias | ☐ ☐ ☐ | | |
| Notes: | | | |

***For RCT/CCT***
***Dichotomous outcome***

| | Description as stated in report/paper | | | | Location in text or source *(pg & ¶/fig/table/other)* |
|---|---|---|---|---|---|
| Comparison | | | | | |
| Outcome | | | | | |
| Subgroup | | | | | |
| Time point *(specify from start or end of intervention)* | | | | | |
| Results | Intervention | | Comparison | | |
| | No. with event | Total in group | No. with event | Total in group | |
| | | | | | |
| Any other results reported *(e.g. odds ratio, risk difference, CI or P value)* | | | | | |
| No. missing participants | | | | | |
| Reasons missing | | | | | |
| No. participants moved from other group | | | | | |
| Reasons moved | | | | | |
| Unit of analysis *(by individuals, cluster/groups or body parts)* | | | | | |
| Statistical methods used and appropriateness of these *(e.g. adjustment for correlation)* | | | | | |
| Reanalysis required? *(specify, e.g. correlation adjustment)* | ☐ Yes ☐ No ☐ Unclear | | | | |
| Reanalysis possible? | ☐ Yes ☐ No ☐ Unclear | | | | |
| Reanalysed results | | | | | |

| Notes: |
|---|
| |

***For RCT/CCT***
***Continuous outcome***

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Description as stated in report/paper | | | | | | Location in text or source *(pg & ¶/fig/table /other)* |
| Comparison | | | | | | | |
| Outcome | | | | | | | |
| Subgroup | | | | | | | |
| Time point *(specify from start or end of intervention)* | | | | | | | |
| Post-intervention or change from baseline? | | | | | | | |
| Results | Intervention | | | Comparison | | | |
| | Mean | SD *(or other variance, specify)* | No. participants | Mean | SD *(or other variance, specify)* | No. participants | |
| | | | | | | | |
| Any other results reported *(e.g. mean difference, CI, P value)* | | | | | | | |
| No. missing participants | | | | | | | |
| Reasons missing | | | | | | | |
| No. participants moved from other group | | | | | | | |
| Reasons moved | | | | | | | |
| Unit of analysis *(individuals, cluster/ groups or body parts)* | | | | | | | |

| | | | | |
|---|---|---|---|---|
| Statistical methods used and appropriateness of these *(e.g. adjustment for correlation)* | | | | |
| Reanalysis required? *(specify)* | ☐ Yes | ☐ No | ☐ Unclear | |
| Reanalysis possible? | ☐ Yes | ☐ No | ☐ Unclear | |
| Reanalysed results | | | | |
| Notes: | | | | |

***For RCT/CCT***
***Other outcome***

| | Description as stated in report/paper | | | | Location in text or source *(pg & ¶/fig/table /other)* |
|---|---|---|---|---|---|
| Comparison | | | | | |
| Outcome | | | | | |
| Subgroup | | | | | |
| Time point *(specify from start or end of intervention)* | | | | | |
| No. participant | Intervention | | Control | | |
| | | | | | |
| Results | Intervention result | SE (or other variance) | Control result | SE (or other variance) | |
| | | | | | |
| | Overall results | | SE (or other variance) | | |
| | | | | | |
| Any other results reported | | | | | |
| No. missing participants | | | | | |

| | | | |
|---|---|---|---|
| Reasons missing | | | |
| No. participants moved from other group | | | |
| Reasons moved | | | |
| Unit of analysis *(by individuals, cluster/groups or body parts)* | | | |
| Statistical methods used and appropriateness of these | | | |
| Reanalysis required? *(specify)* | ☐ Yes ☐ No ☐ Unclear | | |
| Reanalysis possible? | ☐ Yes ☐ No ☐ Unclear | | |
| Reanalysed results | | | |
| Notes: | | | |

***For Controlled Before-and-After study (CBA)***

| | Description as stated in report/paper | | Location in text or source *(pg & ¶/fig/table/ other)* |
|---|---|---|---|
| Comparison | | | |
| Outcome | | | |
| Subgroup | | | |
| Time point *(specify from start or end of intervention)* | | | |
| Post-intervention or change from baseline? | | | |
| No. participants | Intervention | Control | |
| | | | |

| | | | | | |
|---|---|---|---|---|---|
| Results | Intervention result | SE *(or other variance, specify)* | Control result | SE *(or other variance, specify)* | |
| | | | | | |
| | Overall results | | SE *(or other variance, specify)* | | |
| | | | | | |
| Any other results reported | | | | | |
| No. missing participants | | | | | |
| Reasons missing | | | | | |
| No. participants moved from other group | | | | | |
| Reasons moved | | | | | |
| Unit of analysis *(individuals, cluster/ groups or body parts)* | | | | | |
| Statistical methods used and appropriateness of these | | | | | |
| Reanalysis required? *(specify)* | ☐ Yes ☐ No ☐ Unclear | | | | |
| Reanalysis possible? | ☐ Yes ☐ No ☐ Unclear | | | | |
| Reanalysed results | | | | | |
| Notes: | | | | | |

***For Interrupted Time Series study (ITS)***

| | Description as stated in report/paper | Location in text or source *(pg & ¶/fig/table/ other)* |
|---|---|---|
| Comparison | | |

| | | | | | |
|---|---|---|---|---|---|
| Outcome | | | | | |
| Subgroup | | | | | |
| Length of time points measured *(e.g. days, months)* | | | | | |
| Total period measured | | | | | |
| No. participants measured | | | | | |
| No. missing participants | | | | | |
| Reasons missing | | | | | |
| | Preintervention | | Postintervention | | |
| No. time points measured | | | | | |
| Mean value *(with variance measure)* | | | | | |
| Any other results reported | | | | | |
| Unit of analysis *(individuals or cluster/ groups)* | | | | | |
| Statistical methods used and appropriateness of these | | | | | |
| Reanalysis required? *(specify)* | ☐ Yes ☐ No ☐ Unclear | | | | |
| Reanalysis possible? | ☐ Yes ☐ No ☐ Unclear | | | | |
| Individual time point results | | | | | |
| Read from figure? | ☐ Yes ☐ No | | | | |
| Reanalysed results | Change in level | SE | Change in slope | SE | |
| | | | | | |
| Notes: | | | | | |

**Other information**

| | **Description as stated in report/paper** | **Location in text or source** *(pg & ¶/fig/table/ other)* |
|---|---|---|
| **Key conclusions of study authors** | | |
| **References to other relevant studies** | | |
| **Correspondence required for further study information** *(from whom, what and when)* | | |
| **Notes:** | | |

# APPENDIX G

IRB Non-Human Subjects

April 13, 2021

Protocol #: **41321**
Project Title: Couple-Based Therapeutic Interventions Aimed at Treating the Individual and

Relational Impact of Childhood Abuse.

Dear Megan:

Thank you for submitting a "GPS IRB Non-Human Subjects Notification Form" for *Couple-Based Therapeutic Interventions Aimed at Treating the Individual and Relational Impact of Childhood Abuse* project to Pepperdine University's Institutional Review Board (IRB) for review. The IRB has reviewed your submitted form and all ancillary materials. Upon review, the IRB has determined that the above titled project meets the requirements for *non-human subject research* under the federal regulations 45 CFR 46.101 that govern the protection of human subjects.

Your research must be conducted according to the form that was submitted to the IRB. If changes to the approved project occur, you will be required to submit *either* a new "GPS IRB Non-Human Subjects Notification Form" or an IRB application via the eProtocol system (httpw://irb.pepperdine.edu) to the Institutional Review Board.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at https://community.pepperdine.edu/irb/policies/.

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval.

On behalf of the IRB, we wish you success in this scholarly pursuit. Sincerely,

Institutional Review Board (IRB) Pepperdine University

cc: Mrs. Katy Carr, Assistant Provost for Research
Dr. Judy Ho, Graduate School of Education and Psychology IRB Chair