GIV CARE: A Group Intervention to Reduce Accommodation Among Relatives of Individuals With Fear-Based Disorders

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Fear-based disorders (FBDs) occur in an interpersonal context as relatives (e.g., partners, parents) often accommodate symptoms. Symptom accommodation, which is ubiquitous and reinforces FBD behavior, is associated with increased FBD symptom severity and interferes with treatment. Accordingly, reducing accommodation represents a crucial aim for intervention. We describe a brief, manualized group intervention to decrease symptom accommodation and caregiver burden among cohabitating relatives of individuals with FBDs. The intervention is the first to date that (a) jointly includes parents and partners to target symptom accommodation, and (b) uses a transdiagnostic group treatment approach. We also provide preliminary empirical support for this group-based intervention among adult relatives (N = 20) that participated in the five weekly intervention sessions and completed assessments at baseline, posttreatment, and 1-month follow-up (1MFU). Preliminary results suggest that the group intervention is feasible and acceptable. Completers (n = 18) exhibited significant reductions in symptom accommodation and self-reported burden between baseline and 1MFU. The discussion identifies study limitations and future directions.

Collectively referred to as fear-based disorders (FBDs), DSM-5 anxiety disorders (e.g., specific phobia, social anxiety disorder, panic disorder) and obsessive-compulsive disorder (OCD) represent the most prevalent psychiatric conditions (e.g., Kessler et al., 2005). FBDs are characterized by pervasive fear and recurrent catastrophic thoughts, which are accompanied by avoidance and safety-seeking behaviors to reduce anxiety. Given the intrusive and time-consuming nature of said fears and rituals, individuals with FBDs experience significant functional impairment, increased burden, and decreased quality of life (e.g., Eisen et al., 2006).

Typically conceptualized from the individual’s perspective, FBDs often occur in an interpersonal context. An FBD can contribute to relationship distress by provoking negative emotions and stress (Baucom et al., 2003). As tension heightens, couples and families may experience more frustration, anger, and conflict. Families of individuals with FBDs report significant burden and decreased quality of life (e.g., Storch et al., 2009; Amir et al., 2000). The pervasive burden negatively affects various domains of functioning (e.g., physical and emotional intimacy; Senaratne et al., 2010). Further, FBDs incur direct (e.g., medication) and indirect costs (e.g., caregiver burden, decreased productivity due to missed work; Bodden et al., 2008) for families.

Relatives (e.g., partners, parents) of individuals with FBDs often behave in various ways that unintentionally maintain FBDs. For example, relatives may engage in arguments over the illogic of their loved one’s fears or attempt to alleviate distress by helping with avoidance or anxiety-reduction behaviors (e.g., compulsive rituals). Symptom accommodation (SA), in which another person modifies their routine to prevent or immediately relieve their loved one’s anxiety, is common across FBDs and relationships (e.g., Reuman & Abramowitz, 2018), is associated with poorer treatment outcomes (Lebowitz et al., 2014), and may decrease an individual’s motivation to seek cognitive behavioral therapy (CBT; Abramowitz, Baucom, Wheaton, et al., 2013). Further, family members who accommodate often express frustration with a double bind (i.e., “lose-lose” situation) in which altering the family routine is disruptive on the one hand and withholding accommodation results in family conflict on the other (Amir et al., 2000). Thus, helping relatives of anxious individuals skillfully reduce SA represents a crucial

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aim for family-based treatment for FBDs (Thompson-Hollands et al., 2014).

An emerging body of literature has examined relative-specific factors that predict SA. Constructs of interest include trait anxiety (Amir et al., 2000), anxiety sensitivity (AS), and expressed emotion (EE). Parents and partners with high trait anxiety may have difficulty tolerating both their own and their loved one’s anxiety and may accommodate in order to exert control or reduce their own distress. Some studies have found that a family member’s manifestation of AS—a “fear of fear” (Taylor, 1999)—is also associated with increased SA. A partner or parent who imagines catastrophic consequences of not accommodating (e.g., “If I don’t help out, they’ll be overcome by anxiety, and I won’t be able to handle it”) demonstrates this construct (Cosentino et al., 2015). Expressed emotion (EE) refers to how much hostility (i.e., rejection), emotional overinvolvement (i.e., overprotective attitude), and criticism a relative displays towards another family member with psychopathology. Relatives of individuals with FBDs show high levels of EE (Shanmugiah et al., 2002), and SA is associated with greater degrees of rejection towards the individual with an FBD (Calvocoretti et al., 1999). EE can also arise as a result of distress and affect SA (Amir et al., 2000).

Individual CBT, which can include psychoeducation, self-monitoring, cognitive restructuring, and exposure and response prevention, is a first-line evidence-based treatment for FBDs (Higa-McMillan et al., 2016; Hofmann & Smits, 2008). Although individual CBT is effective, a sizeable proportion of those with FBDs either refuse CBT or may terminate treatment prematurely (e.g., Choy, Fyer, & Lipsitz, 2007). A variety of reasons—such as a poor insight or dread related to confronting feared stimuli—may account for lower-than-ideal treatment utilization rates (e.g., Lincoln et al., 2005). In other cases, individuals may not participate in treatment if they do not recognize the disability associated with a FBD or find that a family member’s SA quells their concerns. Room for improvement remains.

Clinical observations (e.g., frequent inquiries from relatives of individuals with FBDs) suggest that relatives are interested in—and could benefit from—a clinical intervention, despite treatment refusal by the identified patient. Many existing family-based interventions for SA, however, occur in the context of individuals already receiving treatment for FBDs (e.g., Waters et al., 2001). In some cases, patient participation is not feasible due to issues including, but not limited to, heightened anxiety, poor insight or denial of the problem, or oppositional tendencies. When patient participation is not possible, however, skills training for the family member may be a helpful option. Evidence supporting the role of family involvement in FBD maintenance and treatment outcome further suggests that family member training may be useful (Lebowitz et al., 2014). Thus, an intervention that includes parents and partners of individuals suffering from various FBDs without the loved one’s involvement is warranted to address this shortcoming. Indeed, some previous study designs have successfully adopted a unilateral approach (i.e., working with the family member without the patient present) to address family member involvement in FBD symptoms (e.g., Lebowitz et al., 2014; Thompson-Hollands et al., 2014). As such, the current intervention does not include individuals with FBDs; rather, the family members participate independently.

To date, the majority of family-based interventions for SA have been tested with parents or partners. Given the ubiquity of SA across parents and partners, it may be appropriate to offer common intervention strategies to parents and partners. Although the interpersonal issues vary depending on developmental stage, SA and interpersonal effects of FBDs exist across all age groups. Further, SA is common across FBDs (Lebowitz et al., 2013). FBDs not only are conceptualized similarly and treated comparably, but also are often comorbid with one another (Abramowitz & Deacon, 2005). Thus, the current intervention adopts a transdiagnostic approach to simultaneously address various FBDs and SA in various relationships (i.e., parents, partners).

The majority of existing family-based CBT for FBD interventions have utilized a single-dyad format (i.e., treating one couple or one family at a time). Although this method is effective and feasible (e.g., Abramowitz, Baucom, Boeding, et al., 2013), a group format that includes multiple relatives can help to normalize the experience of caring for an individual with an FBD and enhance social support. Further, individuals may learn vicariously from other group members by hearing about their experiences and brainstorming with one another. Empirical evidence (e.g., Van Noppen et al., 1997) suggests that multifamily CBT for FBDs is well-tolerated and offers cost savings. In an era of increased demand and faltering support for mental health services, efficiency is important to consider. The current intervention is offered in a group format.

To date, the majority of research regarding family-based CBT for SA in FBDs has not explicitly addressed predictors of accommodation. Given that research regarding psychological predictors of SA has increased in recent years, there exists a need to explicitly address said constructs (e.g., AS, EE) via empirically based techniques. Accordingly, the current intervention includes empirically based techniques to address the aforemen-
tioned constructs. Specifically, psychoeducation provides corrective information about anxiety, its treatment, AS, accommodation, caregiver burden, and self-care. Cognitive restructuring is included to challenge the relatives’ beliefs about anxiety (AS), EE (e.g., hostility towards the anxious loved one), and the ability to change SA behaviors. Participants also learn communication skills to replace reassurance and EE (i.e., hostile remarks) with more assertive and supportive comments.

Interventions that help cohabitating parents and partners to modify their SA behaviors and beliefs about FBDs may promote adaptive changes (e.g., improved family communication patterns). First, relatives can learn skills (e.g., cognitive restructuring) to modify beliefs about anxiety and minimize SA. Second, relatives can identify obstacles to reducing SA, such as one’s own AS. Addressing these factors can help to improve the relatives’ capacity for coping with the burden of caring for a loved one and, in turn, affect a loved one’s FBD symptomatology and quality of life. Third, family members can learn skills for reducing SA and replacing these maladaptive patterns with helpful behaviors (e.g., assertive communication). Only a handful of interventions for FBDs explicitly target SA (e.g., Abramowitz, Baucum, Boeding, et al., 2013; Lebowitz et al., 2014; Thompson-Hollands et al., 2014; Waters et al., 2001; Rosa-Alcázar et al., 2017). Given that (a) SA occurs across relatives (i.e., not just parents), (b) SA occurs across FBDs, (c) many individuals with FBDs do not seek treatment for various reasons, and (d) group formats of CBT can offer benefits (e.g., reduced cost, efficiency, social support), a transdiagnostic relative-only group-based protocol to reduce SA warrants investigation.

The aim of the current study was to develop and test the feasibility, acceptability, and preliminary outcomes of a transdiagnostic group treatment for relatives to reduce SA and accompanying burden. On the basis of Lebowitz and colleagues’ (2014) findings regarding an intervention to reduce SA among parents of anxious children, we predicted that participants would find this intervention to be feasible and acceptable. Given that SA is modifiable via treatment (e.g., Thompson-Hollands et al., 2014), we hypothesized that SA would decrease over the course of the intervention.

**Group Intervention for Caregivers of Anxious Relatives (GIV CARE)**

GIV CARE consists of five, 90- to 120-minute weekly group sessions (see Table 1 for an overview of session content). Session 1 serves as an introduction to the group and provides psychoeducation about FBDs, the maintenance and treatment of FBDs, and family responses to FBDs (i.e., SA). Participants develop group guidelines (i.e., confidentiality, mutual respect), learn the purpose and rationale of the program (i.e., to learn strategies to skillfully reduce SA), and set personal goals. Psychoeducation serves a critical role to describe potential advantages of anxiety (e.g., “how is anxiety adaptive?”) and provides context for fear-based rituals and avoidance. Participants discuss family responses to anxiety and the consequences of accommodation. They are encouraged to explore answers to questions such as, “Can you think of ways that you help your relative avoid becoming anxious?” and “How might you take on more and responsibilities?” Last, participants learn about self-monitoring to track maladaptive accommodation behaviors and complete self-monitoring for homework (Craske & Tsao, 1999). This evidence-based CBT strategy allows relatives to bring awareness to ingrained accommodation patterns in order to make subsequent changes. For example, participants track their provision of reassurance and completion of rituals (e.g., assisting a spouse with checking behaviors) to explore the nature and frequency of their SA.

**Session 2 provides a rationale for ceasing accommodation behaviors (i.e., response prevention; Merlo et al., 2009).** Further, participants set three specific accommodation reduction treatment goals based upon behaviors that are identified as frequent, distressing, and important to change. With assistance from the group leader and fellow group members, participants establish concrete strategies to enact their first accommodation reduction goal over the course of the coming week. Participants also discuss strategies for informing their relatives of their participation in the group (e.g., how to remain calm, clear, and supportive) and impending behavioral shifts. The session also offers CBT skills for reducing high levels of AS (e.g., psychoeducation and cognitive restructuring to modify maladaptive beliefs about anxiety). Cognitive restructuring is used to help relatives identify thinking errors (e.g., catastrophizing; “My partner will hate me forever if I don’t help them out”). As a group, participants jointly challenge a sample maladaptive belief, such as “I’m a bad mom if I don’t make anxiety go away.” Ultimately, participants work to develop helpful reminders and generate a rational mantra: “This is probably anxiety, and the best thing I can do is . . . ” For homework, participants continue self-monitoring, practice cognitive restructuring, and begin addressing their first accommodation reduction goal.
<table>
<thead>
<tr>
<th>Session</th>
<th>Duration</th>
<th>Components</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15 min</td>
<td>Telephone screen to assess initial eligibility</td>
</tr>
<tr>
<td>Baseline</td>
<td>30 min</td>
<td>Informed consent, MINI</td>
</tr>
<tr>
<td></td>
<td>30 min</td>
<td>Self-report questionnaires via Qualtrics</td>
</tr>
</tbody>
</table>
| 1       | 120 min  | ● Welcome  
          ● Ground rules  
          ● Overview of intervention  
          ● Psychoeducation (anxiety, treatment, accommodation)  
          ● Introduction to self-monitoring  
          ● Homework: Read handout, practice self-monitoring |
| 2       | 120 min  | ● Review homework, self-monitoring  
          ● Discuss strategies, goal-setting to reduce accommodation  
          ● Address dysfunctional beliefs about anxiety via cognitive restructuring (CR)  
          ● Test dysfunctional beliefs about anxiety via interoceptive exposure  
          ● Homework: Self-monitoring, practice CR, reduce accommodation |
| 3       | 120 min  | ● Review homework, self-monitoring, CR  
          ● Discuss communication skills to address potential conflict re: accommodation  
          ● Assertiveness training (to replace criticism and overly empathic responding)  
          ● Homework: Self-monitoring, practice communication skills, reduce accommodation |
| 4       | 120 min  | ● Review homework, self-monitoring, communication skills  
          ● Problem solving re: hostility, stopping accommodation  
          ● Psychoeducation about caregiver burden & strategies for self-care  
          ● Homework: Self-monitoring, reduce accommodation, self-care |
| 5       | 120 min  | ● Review homework  
          ● Discuss stages of change  
          ● Wrap up: Review and relapse prevention  
          ● Feedback  
          ● Goodbyes |
|         | 30 min   | Posttreatment self-report questionnaires via Qualtrics |
|         | 30 min   | 1MFU self-report questionnaires via Qualtrics  
          (followed by participant remuneration via email) |

Note. MINI = Mini-International Neuropsychiatric Interview; CR = Cognitive restructuring; 1MFU = one month follow up.

Session 3 begins with a review of homework and content from the previous session. Participants both cheer each other's progress and aid one another in troubleshooting with regard to SA reduction. Participants also develop a plan to implement their second accommodation reduction goal. The majority of the session focuses on communication skills to: (a) address family conflict that may result from decreasing accommodation, (b) reduce reassurance, and (c) reduce critical and hostile comments that are typical of high EE (Morris et al., 2007). Specifically, participants receive assertiveness training (e.g., Abramowitz, 2012) to learn phrases to replace reassurance with more constructive statements that do not directly reinforce the anxiety. This includes a description of the communication continuum ranging from passive (nonassertive) to aggressive remarks and the introduction of the DEAR acronym to make requests (Define the problem; Express your feelings; Ask for what you want; Provide reinforcement). Further, communication training (e.g., Miklowitz & Chung, 2016) helps family members replace EE (e.g., hostile comments or threats such as “You’d better not ritualize or I’ll . . .”) with kinder remarks such as “How can I help you without doing rituals for you?” Participants receive a handout with sample supportive statements (e.g., “Great job – I know this is not easy for you”) and also work with peers to outline an assertive response for a recent situation in which they wish they had responded more assertively. For homework, participants continue self-monitoring, practice assertive communication skills, and address their second accommodation reduction goal.
Session 4 offers an opportunity to continue practicing the skills learned in earlier sessions, discuss problem-solving strategies to replace accommodation behaviors, and make a plan to target the third accommodation reduction goal. The problem-solving portion reviews steps to clarify the problem, brainstorm solutions, evaluate potential solutions (e.g., identify pros/cons and categorize solutions), and develop an action plan to determine necessary resources and steps to take. Participants solicit feedback from group members. For example, a group member might follow these steps to brainstorm responses to a husband’s verbal threats after a partner refuses to provide reassurance. Given the high levels of distress that relatives of individuals with FBDs experience, this session also provides psychoeducation about caregiver burden and self-care strategies. The group leader leads a discussion regarding warning signs of caregiver burden and why self-care is important. Group members learn about pleasant events scheduling, self-soothing skills, and the importance of sleep, exercise, proper nutrition, and relaxation. Group members also solicit and provide novel ideas for self-care practice in the coming week.

For homework, participants address their third accommodation reduction goal and practice self-care.

During Session 5, participants continue skills practice. After sharing details about their self-care practice and reviewing progress on their third accommodation reduction goal, participants learn about the transtheoretical model of change to set future expectations, ascertain strategies for relapse prevention and maintaining gains, and summarize their progress. The group leader also shares resources for additional support including books, websites, and local clinical referrals. Last, participants provide both verbal and written feedback (as a group and individually, respectively).

Each session includes a combination of didactic and interactive learning. The group leader sets the agenda for each session, delivers the material, provides structure, and offers expertise in FBDs and cognitive behavioral skills. The group members participate in lively discussion, offer personal examples from their daily lives and from homework assignments throughout the session, and ask questions about the session content. Based upon these anecdotes and questions, the group members discuss potential solutions (e.g., brainstorm creative ideas for response prevention, suggest self-care strategies), provide support to one another (e.g., offer hope and advice based upon personal experiences), and engage in live practice (e.g., collective cognitive restructuring using the whiteboard or practice role-plays of assertive responding). This group approach not only helps to normalize the experience of anxiety and instill a sense of support, but also encourages an array of novel thoughts and behaviors to help shift habits related to SA.

Participants

Twelve parents and eight partners of individuals with FBDs participated in the pilot study. The majority of participants were White (n = 19; 95%), female (n = 17; 85%), well-educated (n = 17 had a graduate degree; 85%), and married (n = 16; 80%). On average, participants were 50.11 years old (SD = 8.22; range = 35.33 to 64.66). All participants were currently living with their relative with an FBD. On average, participants had lived with the identified relative for 15 years (SD = 9.94; range = 1 to 45). Nine participants self-reported psychiatric diagnoses (all mood disorders). Demographic characteristics are presented in Table 2.

Participants reported that their relatives were formally diagnosed (by a psychologist or psychiatrist) with the following FBDs: generalized anxiety disorder (GAD; n = 8), panic disorder (n = 3), OCD (n = 3), posttraumatic stress disorder (PTSD; n = 2), social anxiety disorder (SAD; n = 1), or two FBDs (e.g., GAD and OCD; n = 3). Eight participants reported that their relatives also had a comorbid psychiatric diagnosis: depression (n = 4), ADHD (n = 2), autism (n = 1), and a sleep-wake disorder (n = 1). Of the 20 identified relatives with FBDs, 16 (80%) were currently receiving individual treatment (therapy, medication, or a combination). Among parents (n = 12), the average age of the participants’ child was 17.6 years old (SD = 5.58; range = 8–28).

Recruitment and Intervention Delivery

Participants were recruited through community flyers, referrals from local clinicians, and a mass email list-serv in a college town in the southeastern United States. Forty-five individuals inquired about the study between August 2017 and February 2018, and 35 individuals were screened by phone for eligibility. Individuals were excluded from participating if any of the following criteria were met: inability to communicate fluently in English with study personnel, current substance use disorder, mania, or lifetime psychosis, current suicidal ideation (as indicated by Beck Depression Inventory [BDI; (Beck et al., 1996)] Item #9 > 1), or evidence of current interpersonal violence or domestic abuse. Ultimately, 21 adult relatives (i.e., partner or parent) of individuals suffering from a diagnosed FBD enrolled in the study, 20 individuals began the group intervention, and 18 individuals completed the intervention. The group intervention was provided
Table 2
Sample Descriptive Statistics for Participants That Initiated Treatment (N = 20)

<table>
<thead>
<tr>
<th></th>
<th>M / N</th>
<th>SD / %</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>17</td>
<td>85.00</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>19</td>
<td>95.00</td>
<td></td>
</tr>
<tr>
<td>Relation to relative with FBD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td>8</td>
<td>40.00</td>
<td></td>
</tr>
<tr>
<td>Partner</td>
<td>12</td>
<td>60.00</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
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<td>80.00</td>
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</tr>
<tr>
<td>Divorced</td>
<td>2</td>
<td>10.00</td>
<td></td>
</tr>
<tr>
<td>Never married</td>
<td>2</td>
<td>10.00</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>50.11</td>
<td>8.22</td>
<td>35.33–64.66</td>
</tr>
<tr>
<td>Years of cohabitation</td>
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<td>9.94</td>
<td>1.00–45.00</td>
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<tr>
<td>Education</td>
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</tr>
<tr>
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<td>25.00</td>
<td></td>
</tr>
<tr>
<td>Income (n = 19)</td>
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<tr>
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<td>10.00</td>
<td></td>
</tr>
<tr>
<td>$40,000–$79,999</td>
<td>2</td>
<td>10.00</td>
<td></td>
</tr>
<tr>
<td>$80,000–$100,000</td>
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<tr>
<td>&gt;$100,000</td>
<td>11</td>
<td>55.00</td>
<td></td>
</tr>
</tbody>
</table>

at no cost, and participants were compensated with a $10 Visa e-gift card upon completing the 1-month follow-up (1MFU) assessment. For a detailed description of participant flow, please consult the CONSORT chart (Figure 1).

The groups (n = 4) were led by a fifth-year female clinical psychology doctoral student (LR) with extensive experience delivering transdiagnostic cognitive behavioral interventions in individual, couple, and group formats. Group composition (e.g., participant gender, number of parents and partners) and size varied (n = 3 to 6 participants). The intervention followed a treatment manual (developed by the authors), which included suggested scripts and handouts. All assessment and intervention sessions were recorded and reviewed for treatment fidelity. A licensed expert in CBT for FBDs (JA) listened to all sessions and provided weekly supervision.

All sessions were coded for adherence by at least one research assistant (n = 4). Research assistants rated each session on four items (e.g., “The therapist presented the material, worked to lead the discussions, and assigned the homework scheduled for the current session”) using a seven-point Likert scale ranging from 1 (%Not true at all%) to 7 (%Very true%). Across all sessions, the therapist was rated as having high adherence to the planned session material (M = 6.44, SD = 0.67), low rates of presenting additional information (M = 1.97, SD = 0.78), and appropriate responses to deviations in the event that they did occur (M = 6.41, SD = 0.67). Research assistants had 91% concordance (i.e., difference in item ratings ≤ 1) in adherence ratings for double-coded sessions (n = 11).

Assessments

In order to determine eligibility criteria and detect preliminary effects of the intervention, participants completed assessment measures at baseline, posttreatment (within 24 hours of the fifth group session), and 1-month follow-up (1MFU). Upon arriving for the in-person baseline assessment, participants were given an overview of the study and an opportunity to ask questions prior to providing informed consent. Next, participants completed a clinical interview (MINI) to determine whether criteria for any exclusionary diagnoses were met. Afterwards, participants completed demographic and self-report questionnaires (described below) via Qualtrics. The posttreatment and 1MFU assessments included a series of self-report measures administered via Qualtrics. Participants received an email with an anonymous link and instructions to complete the study measures promptly (i.e., within 24 hours of receiving the email). During the posttreatment assessment, participants also completed the Treatment Evaluation Inventory-Short Form (TEI-SF) to rate treatment satisfaction.
Mini-International Neuropsychiatric Interview Version 7.0 (MINI; Sheehan et al., 2013)

The MINI is a brief, structured diagnostic interview used to determine DSM-5 diagnoses. It exhibits adequate psychometric properties. Relevant MINI modules were used to ascertain information about exclusionary criteria (e.g., current substance use disorder, current mania, lifetime psychosis).

Family Accommodation Scale–Anxiety (FASA; Lebowitz et al., 2013)

The FAS-A is a nine-item measure designed to assess the degree to which parents accommodate a child’s FBD symptoms (within a 1-month period). The measure was adapted for the current study to assess accommodation of a relative’s symptoms by changing the word “child” to “relative”; the psychometric properties
of the FAS-A with regard to adult relatives, however, have not been published. The measure includes two subscales that measure (a) participation in symptom-related behaviors, and (b) modification of functioning. Items (e.g., “How often did you reassure your relative?”) are rated on a five-point Likert Scale from 0 (Never) to 4 (Daily). In the current study, the FAS-A displayed good internal consistency ($\alpha_{baseline} = 0.82$, $\alpha_{post} = 0.87$).

Zarit Burden Interview – Short Version (ZBI – SV; Béland et al., 2001)

The ZBI-SV is a 12-item self-report questionnaire that measures perceived burden among primary caregivers. Items are rated on a five-point Likert Scale from 0 (Never) to 4 (Nearly Always) and include questions such as “Do you feel that you don’t have as much privacy as you would like because of your relative?” In the current study, the ZBI displayed good to excellent internal consistency ($\alpha_{baseline} = 0.89$, $\alpha_{post} = 0.93$).

Credibility/Expectancy Questionnaire (CEQ; Devilly & Borkovec, 2000)

The CEQ is a six-item self-report inventory of perceived treatment credibility and expectancy for improvement. The first three CEQ items (e.g., “How logical does this type of treatment seem to you?”) assess credibility (CEQ-Credibility) and are rated on a Likert-scale from 1 to 9 (anchors vary). Total possible scores for the CEQ-Credibility subscale range from 3 to 27; higher scores indicate greater credibility beliefs. The final three CEQ items assess expectancy (CEQ-Expectancy), with one item rated from 1 (Not at all) to 9 (Very much) and two items rated from 0% to 100% (values from 1 to 11). These three items were standardized into z scores before summing to create the total expectancy score. Participants completed the CEQ at the beginning of the second session (after receiving the treatment rationale). Cronbach’s alpha in the current sample was excellent for each subscale (Credibility = 1.00, Expectancy = 0.90).

Treatment Evaluation Inventory-Short Form (TEI-SF; Kelley et al., 1989)

The TEI-SF assesses treatment acceptability following completion of a behavioral intervention. Participants completed a modified seven-item version (used by Twohig & Woods, 2004). Each question (e.g., “I liked the procedures used in this treatment”) is rated on a five-point scale from 1 (Strongly Disagree) to 5 (Strongly Agree). Answers are summed to derive a total score; scores over 21 indicate greater acceptability than unacceptability. The TEI-SF exhibited acceptable internal consistency ($\alpha = 0.79$).

Homework Completion, Treatment Attendance, and Attrition

The therapist rated each participant’s homework completion (1 = Attempted/done vs. 0 = Not done) at the start of each session, beginning with the second session. Each participant obtained a score ranging from 0 to 4 to gauge “# of assignments completed.” If participants missed a session, they received a “0” for both the missed session and the following session. For participants ($n = 2$) that did not complete the intervention, the number of sessions attended prior to termination was recorded.

Outcomes

Descriptive Statistics

Descriptive statistics for study measures at baseline, posttreatment, and 1MFU are presented in Table 3. Data regarding the ability to recruit the desired sample size (i.e., number of participants referred, phone screened, enrolled, and completed) can be found in the CONSORT Chart (Figure 1). Descriptive statistics pertaining to credibility, acceptability, and engagement are described below.

Treatment Credibility. Acceptability, and Engagement

To assess treatment credibility and acceptability, participant ratings and feedback was examined. The mean CEQ-Credibility subscale score was 21.16 ($SD = 2.79$), where higher scores (out of a total possible 27) indicated higher perceived credibility. The mean standardized CEQ-Expectancy subscale score was $-0.03$ ($SD = 2.76$). CEQ-Expectancy scores were not significantly associated with changes in FAS-A from baseline to posttreatment ($r = 0.44$, $p = 0.07$) or baseline to 1MFU ($r = 0.14$, $p = 0.70$). All participants scored above 21 (range 22 – 35) on the TEI-SF, and average scores ($M = 29.5$, $SD = 3.20$) indicated high acceptability.

In addition to standardized self-report measures, participants provided open-ended written feedback following the final session. Participants commented upon the helpful session content, which fostered “a deeper understanding of the whole dynamic,” useful handouts (“the binder full of info”), and clear structure of the program. For example, participants noted that “setting the stages of the complexity of anxiety [was] essential.” Multiple participants commented upon the positive group member interactions (e.g., “everyone sharing
Table 3
Means and Standard Deviations on Study Measures at Baseline (n = 20), Post (n = 18), and Follow-up (n = 13)

<table>
<thead>
<tr>
<th>Measure</th>
<th>M</th>
<th>SD</th>
<th>Range</th>
<th>Skew</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FAS-A</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>17.50</td>
<td>7.39</td>
<td>7–36</td>
<td>1.08</td>
<td>1.01</td>
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<tr>
<td>Post</td>
<td>14.06</td>
<td>7.82</td>
<td>3–34</td>
<td>0.87</td>
<td>1.06</td>
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<tr>
<td>1MFU</td>
<td>10.77</td>
<td>4.17</td>
<td>4–18</td>
<td>0.19</td>
<td>-0.54</td>
</tr>
<tr>
<td><strong>FAS-A Modification</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>10.80</td>
<td>4.02</td>
<td>3–20</td>
<td>0.52</td>
<td>0.55</td>
</tr>
<tr>
<td>Post</td>
<td>8.78</td>
<td>4.76</td>
<td>1–20</td>
<td>0.43</td>
<td>0.42</td>
</tr>
<tr>
<td>1MFU</td>
<td>7.62</td>
<td>2.93</td>
<td>4–14</td>
<td>0.71</td>
<td>0.32</td>
</tr>
<tr>
<td><strong>FAS-A Participation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>6.70</td>
<td>4.27</td>
<td>1–16</td>
<td>0.95</td>
<td>-0.16</td>
</tr>
<tr>
<td>Post</td>
<td>5.28</td>
<td>3.79</td>
<td>1–14</td>
<td>1.27</td>
<td>0.84</td>
</tr>
<tr>
<td>1MFU</td>
<td>3.15</td>
<td>2.08</td>
<td>0–6</td>
<td>0.02</td>
<td>-0.93</td>
</tr>
<tr>
<td><strong>ZBI-SV</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>38.15</td>
<td>14.17</td>
<td>15–66</td>
<td>0.47</td>
<td>-0.60</td>
</tr>
<tr>
<td>Post</td>
<td>35.61</td>
<td>14.87</td>
<td>9–69</td>
<td>0.30</td>
<td>0.29</td>
</tr>
<tr>
<td>1MFU</td>
<td>30.85</td>
<td>13.99</td>
<td>6–54</td>
<td>-0.08</td>
<td>-0.33</td>
</tr>
</tbody>
</table>

Note. FAS-A = Family Accommodation Scale – Anxiety; ZBI-SV = Zarit Burden Interview – Short Form.

their stories and successful strategies;” “it felt much less lonely being here with others who feel the same way;” “I loved the community and advice.”). Participants also noted that the class duration (90–120 minutes) was “fine.” Although some participants noted that a 6:00 pm start time was difficult or “tough,” most participants acknowledged that an earlier time wouldn’t be feasible given traditional work schedules and a later start time would be “too late.” In addition to suggestions for technology-based assistance with accountability (discussed below), participants recommended midweek support (“a mechanism for accountability for homework”) and follow up/“tune-up” sessions (e.g., phone calls, booster sessions, online check ins) to “see how the strategies [were] working” (e.g., “a check in to reinforce the utility of the materials would be of value.”)

To assess engagement, attendance and homework completion rates were calculated. Among the 18 individuals that completed treatment, the attendance rate was 93.3% [84 sessions attended out of a total possible 90 sessions (18 * 5)]. No single participant missed more than one session. Two individuals (both female partners) did not complete treatment; one individual discontinued after the first session, and another individual discontinued after the second session. One individual did not provide a reason for discontinuation, and the other provided a personal reason for discontinuing the intervention. On average, participants completed their homework for three out of four sessions in which homework was assigned (mode = 4; range = 1–4).

Repeated Measures ANOVAs and Paired Samples t-Tests

Repeated measures ANOVAs revealed an overall main effect of time (baseline, posttreatment, 1MFU) for FAS-A [F(2, 24) = 6.63, p < 0.01, η² = 0.36], FAS-A Modification [F(2, 24) = 3.72, p = 0.04, η² = 0.24], FAS-A Participation [F(2, 24) = 4.74, p = 0.02, η² = 0.28], and ZBI-SV [F(2, 24) = 3.55, p = 0.045, η² = 0.23]. Follow-up paired samples t-tests to examine where statistically significant changes occurred indicated no statistically significant differences between baseline and posttreatment. Significant differences, however, did emerge between baseline and 1MFU for FAS-A [t (12) = 3.22, p < 0.01], FAS-A Modification [t (12) = 2.34, p < 0.05], FAS-A Participation [t (12) = 2.64, p = 0.02], and ZBI-SV [t (12) = 2.16, p = 0.05]. Results appear in Table 4.

Within-Group Effect Sizes

Within-group effect sizes were computed to evaluate the magnitude of baseline to posttreatment and baseline to 1MFU changes in FAS-A and ZBI-SV. Effect sizes were calculated by dividing the mean difference (baseline to posttreatment and baseline to 1MFU) by the baseline standard deviation and accounting for dependence (Lakens, 2013; Morris & DeShon, 2002) and assessed according to Cohen’s (1988) recommendations. The within-group baseline-posttreatment FAS-A

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1 Independent samples t-tests confirmed that there were no significant differences on any baseline measures between individuals who completed the 1MFU assessment (n = 13) and participants who did not complete the 1MFU assessment (all ps > 0.05).
Table 4
Repeated Measures ANOVA F Statistics, Paired-Samples t-Test Statistics, and Within-Subjects Effect Sizes (d) for Study Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>F (2,24)</th>
<th>Baseline – Post</th>
<th>Baseline – 1MFU</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>t (17)</td>
<td>d</td>
</tr>
<tr>
<td>FAS-A-Total</td>
<td>6.63*</td>
<td>1.75</td>
<td>0.40</td>
</tr>
<tr>
<td>FAS-A-Modification</td>
<td>3.72*</td>
<td>1.51</td>
<td>0.37</td>
</tr>
<tr>
<td>FAS-A-Participation</td>
<td>4.74*</td>
<td>1.91</td>
<td>0.41</td>
</tr>
<tr>
<td>ZBI-SV</td>
<td>3.55*</td>
<td>1.14</td>
<td>1.88</td>
</tr>
</tbody>
</table>

Note. ANOVA = Analysis of Variance; FAS-A = Family Accommodation Scale – Anxiety; ZBI-SV = Zarit Burden Interview – Short Form. *p < .05.

The effect size was moderate (d = 0.40), and the within-group baseline-1MFU FAS-A effect size was large (d = 1.02). Overall, within-group effect sizes ranged in magnitude from medium to large. Within-group effect sizes for the FAS-A and ZBI-SV are displayed in Table 4.

Case Example

One fictional GIV CARE participant was a married mother of a high school-aged daughter with social anxiety disorder. Although the participant had pursued individual treatment for her daughter, the daughter refused to attend therapy sessions, in part due to her social anxiety symptoms. The participant reported that her daughter dreaded going to school, refused to help with running personal and household errands (e.g., ordering and picking up food, despite being able to drive) due to fear of having to speak to strangers, and objected to the participant having any guests in the home. The participant engaged in numerous behaviors to accommodate her daughter’s social anxiety and avoid “unnecessary arguments.” The participant joined the group to learn skills for supporting her daughter and “getting [her] own life back.”

The GIV CARE intervention applied to this composite participant as follows. Following the first session, the participant completed a self-monitoring worksheet to bring attention to the frequency and topography of her accommodation behaviors. After self-monitoring, the participant noticed that she was frequently spending time (daily) completing errands for her daughter to avoid anxious or angry “outbursts.” She documented that she constantly kept her cell phone visible to respond to her daughter’s text messages while not physically with her daughter (e.g., during the school day). The participant avoided inviting friends to the home (per her daughter’s request) and reported being bothered by not having time to herself to socialize. Accordingly, the participant’s three targeted accommodation reduction goals included: (1) reducing involvement in her daughter’s errands (e.g., taking out cash from the ATM on her daughter’s behalf), (2) reducing the provision of text message-based reassurance, and (3) denying her daughter’s request for avoidance by having a friend over to the house for dinner. These accommodation reduction goals were also in line with the participant’s overarching goal of reclaiming her personal time and her social life.

During the second session, cognitive restructuring skills were helpful to challenge the participant’s belief “I’m a bad mom if I don’t make anxiety go away” and the distress associated with seeing her daughter suffer in social situations (e.g., making a request of the bank teller). Group members helped the participant to challenge her belief and develop a rational response: “Doing things for my daughter will only hamper her in the long run. By reducing accommodation, I’m promoting her independence.” During the third session, the participant learned assertiveness skills to respond differently to her daughter’s text-based requests for reassurance throughout the school day. First, the participant set goals for reducing the frequency and length of responses and identified when she might ignore a request all together. With suggestions from fellow group members, the participant then drafted brief prepared responses that would gradually discourage her daughter’s frequent messaging. During the fourth session, the participant addressed her goal of inviting a guest into the home. This accommodation reduction goal was also in line with the participant’s identified self-care practice, which included spending quality time with a close friend. The participant worked through steps of problem solving to develop an action plan. With the help of fellow group members, the participant then role played how she would assertively and empathically inform her daughter of this plan.

Collectively, the group members helped the participant address these behavioral shifts. Over the course of the intervention, the group members provided support and encouragement for the participant to pursue her accommodation reduction and self-care goals. Group members also shared their own anecdotes to offer strategies for making shifts. The participant was part of a group that included men and women of varying
relationships to an identified patient with an FBD (e.g., a father of a young daughter with OCD, a partner of a husband with panic disorder). Although, the participant initially noted some skepticism about the utility of peer support given the relative diversity of relationships and presenting concerns in her particular cohort, she expressed increased appreciation for the varied perspectives and helpful advice that she received over the course of the five week intervention. Despite this initial skepticism, the participant attended each session and completed homework for each session.

Discussion

FBDs occur in an interpersonal context, as relatives often modify their daily routine to accommodate their loved one’s symptoms. Given that SA maintains FBDs and is associated with poorer treatment outcome, helping relatives of anxious individuals to reduce SA is an important intervention target. Further, anxious individuals may not engage with or respond to treatment for a variety of reasons (e.g., poor insight, low incentive to change, cannot comply with treatment). Yet, relatives of anxious individuals are often still motivated to support their loved one and can learn to make behavioral changes on their own. The aim of the current study, therefore, was to describe and explore the feasibility, acceptability, and preliminary effectiveness of a transdiagnostic, relative-only group intervention to reduce SA and associated burden. Overall, hypotheses regarding the intervention’s feasibility and acceptability were supported. The ability to recruit and enroll the desired sample size within a 6-month period suggested that there is an interest in this type of service (i.e., “skills for living with an anxious loved one”). High attendance and homework completion rates lent further support to the feasibility of the intervention. Additionally, participant feedback (e.g., total scores on measures of acceptability and written comments) suggested that the intervention was both credible and acceptable. Despite these promising initial findings, two participants did not complete the intervention. Both attritors were female partners. Although this observation is based on a small sample and may be spurious, this attrition might suggest that modifications are needed to enhance the acceptability of this type of group intervention for partners. Alternatively, factors unrelated to the participants’ relationship may have contributed to the attritors’ decisions to discontinue the intervention.

The second hypothesis was partially supported, as participants’ self-reported SA scores (FAS-A) significantly decreased between baseline and the follow-up period. Although participants consistently exhibited decreases in SA, unique participant characteristics and study methodology may help to explain the observed effect sizes. First, the current study was relatively brief in comparison to a standard course of CBT (i.e., 5 versus 10–12 sessions). Although this abbreviated length may have fostered the current study’s feasibility, it may have been an “insufficient dose” or prematurely stifled participants’ opportunities to further reduce accommodation across repeated sessions. Indeed, participants in the current study, on average, appeared to continually report reduced SA behaviors during the 1MFU period. Second, accommodation was not particularly high/frequent among all participants. Although all participants responded to the study advertisement to “learn skills for living with an anxious loved one,” the inclusion criteria did not specify a cutoff for relationship distress or accommodation frequency. Studies suggest that a FAS-A score above 13 indicates significant family accommodation; 6 participants (30%) scored at or below this cutoff (at baseline) in the current study. This floor effect limits variability and the extent to which individuals who accommodate infrequently can further decrease their behaviors as a result of the intervention.

Taken together, study findings provide preliminary evidence that a transdiagnostic, relative-only group intervention to reduce SA is feasible and acceptable; however, modifications to improve the effectiveness of the intervention are warranted. A number of study limitations related to study design and sample characteristics temper the conclusions drawn from this study. Study limitations and future directions are discussed in turn.

The pre-post, single-group design facilitated an examination of the study’s primary aims but precluded conclusions about causality. The current study also lacked a comparison condition. Accordingly, it may be nonspecific factors such as the camaraderie of the groups or the increased attention to the problem of SA that contributed to the observed changes observed. A randomized control trial would permit a direct comparison of the current intervention to existing family-based interventions that include the identified patient or other relative-only interventions for SA.

Relatively, the small sample size was not sufficient to detect moderators of change. Certain individuals may have benefited more or less from the intervention; a larger sample size would permit moderation analyses. Such analyses could explore which relative characteristics (e.g., insight, motivation to change, baseline level of SA) make someone the best fit for a group intervention and which group compositions are ideal with regard to participant characteristics. For example, researchers could explore whether group homogeneity
(i.e., the presence of fellow participants with a very similar identity/role) influences improvement at posttreatment.

Somewhat relatedly, the inclusion of parents and partners in the same group is novel, yet it also may serve as a potential limitation of the intervention. The cognitive behavioral theories of anxiety maintenance and treatment are similar for children and adults, and the group leader provided various examples of SA among parents and partners. The issues that parents and partners may face in dealing with their loved ones, however, can differ (e.g., navigating sibling conflict versus issues with sexual intimacy) as does the equity (partners vs. parent–child). Future research could explore family members' preferences for groups composed of members with similar roles (i.e., all parents).

The intervention’s relative brevity may have compromised its effectiveness. A five-session intervention may not permit enough time to learn, practice, and implement new dyadic behavioral patterns. Indeed, participants exhibited continued decreases in SA between the posttreatment and IMFU assessment time points. Further, multiple participants commented upon the potential value of an added “booster session” to promote accountability and maintain gains.

Although the assessment measures included in the study exhibited sound psychometric properties, it is possible that the instruments did not capture features of change as identified by participants’ verbal feedback (e.g., knowledge about anxiety, self-efficacy). Measures that address related constructs of interest (e.g., self-efficacy) may help to capture the intervention’s secondary benefits. Further, the dichotomous measurement of constructs of interest (e.g., homework compliance) minimized variability in the data. Continuous measurement (e.g., percentage of homework completed) or assessments of the quality of homework may improve the nuanced conclusions that can be drawn from the study findings. Further, the primary outcome measure (FAS-A) asks respondents to rate the frequency of accommodation behaviors during the past month and may not sensitively capture shifts within the past week. Such temporal sensitivity may be crucial given the intervention’s brief duration. Measuring accommodation frequency alone may not sufficiently capture the scope and interference associated with SA. Additionally, the psychometric properties of the FAS-A when used with adults have not been published.

The study sample was rather homogeneous (i.e., primarily well-educated White women); thus, findings may not generalize to demographically diverse family contexts. Recruitment materials did not include culturally sensitive anxiety-related lingo (e.g., ataques de nervios), which may have unintentionally limited interest in the intervention. Additionally, the intervention did not include any cultural adaptations (e.g., culturally specific proverbs about anxiety; Hinton & Patel, 2017). Further, the intervention may not be accessible for single parents or individuals of lower socioeconomic status who might rely upon childcare or subsidized transportation.

Numerous improvements may strengthen future iterations of the intervention. For example, in-session experiential practice of exposure might improve participants’ understanding of the purpose of exposure and what their loved one is tasked with, and, ultimately, bolster support for exposure treatment. Additionally, the use of technology via app-based lessons or online platforms may address some of the aforementioned limitations, facilitate broader dissemination to harder-to-reach populations (e.g., rural areas), and promote further reductions in SA. For example, a single parent without 3 hours of evening childcare to cover the time required to commute to and attend the group might be able to attend the session virtually instead. Additionally, several participants suggested the use of technology (e.g., automated text-based prompts and reminders) to enhance accountability for homework practice between sessions. Specifically, participants noted that frequent reminders could help enhance daily awareness of the accommodation behaviors, offer insight into daily fluctuations in behavior (e.g., via experience sampling methodology), and improve compliance with behavioral skills practice.

Conclusion

Study findings suggest that a transdiagnostic, relative-only group intervention to reduce SA is feasible and acceptable; however, modifications to improve the effectiveness and reach of the intervention are warranted. Further, subsequent studies should adopt an iterative evaluation approach to incorporate participant feedback and verify findings across varied settings.

References


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