

Online Intervention for Couples Affected by Generalized Anxiety Disorder

Lisa A. Benson^{*a}, Brian D. Doss^b, Andrew Christensen^c

[a] Department of Psychiatry, Harbor-UCLA Medical Center, Torrance, CA, USA. [b] Department of Psychology, University of Miami, Miami, FL, USA. [c] Department of Psychology, University of California, Los Angeles, CA, USA.

Abstract

This article describes recent developments in online interventions for distressed couples, with a focus on an adaptation of an online program to address the needs of couples in which one partner has Generalized Anxiety Disorder (GAD). This program, OurRelationship.com, is based on Integrative Behavioral Couple Therapy, an empirically supported treatment which builds closeness between partners through empathy and acceptance of one another's differences rather than emphasizing short-term change. We review the rationale for adapting the OurRelationship.com program to focus on couples affected by GAD, the structure of this intervention, and a brief case study illustrating our clinical approach. In this case study, a couple who participated in the online intervention reported that by the end of the program, they had been able to recognize the patterns of communication they had developed related to the female partner's generalized anxiety. Moreover, they reported they had been able to develop new strategies for responding to these issues that improved the quality of their relationship.

Keywords: integrative behavioral couple therapy, internet, online intervention, couples, anxiety, generalized anxiety disorder

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*Corresponding author at: Lisa A. Benson is now with the Los Angeles County Department of Mental Health, Office of Clinical Informatics, Los Angeles, CA, USA. 695 S. Vermont Avenue, 9th Fl., Los Angeles, California 90005, USA. E-mail: lbenson@dmh.lacounty.gov



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This article describes recent developments in online interventions for distressed couples, with a focus on adaptation of an online program to address the needs of couples in which one partner has Generalized Anxiety Disorder. We review the rationale for this adaptation, the structure of the intervention, and a brief case study illustrating our clinical approach.

Online Treatment for Relationship Distress

Although approximately one third of couples meet criteria for relationship distress, less than 15% of couples choose to participate in couple therapy. Even among couples who went on to divorce, only 40% attempted to use therapy to prevent the divorce (Johnson, 2002). Although couples' reasons for avoiding in-person therapy vary, many of these reasons such as lack of funds, long driving distances to mental health clinics, desire for privacy could be less of a barrier to a self-help or Internet-based treatment. Many couples do read self-help books as a strategy for improving their relationships (Doss et al., 2009). However, a major limitation of these books is their lack of flexibility to meet the particular needs of each couple.

Internet-based interventions have been successful in providing a flexible, targeted treatment for mood and anxiety disorders (Andersson & Cuijpers, 2009; Cuijpers et al., 2009). Treatment using the Internet has become in-

creasingly well-established as an alternative mode of intervention that can use the same principles as face-to-face therapy (Andrews et al., 2010) and has been rated as highly acceptable by consumers (Gun, Titov, & Andrews, 2011). There is evidence that an online premarital education program can increase relationship satisfaction for as long as 10 months, and a short program providing feedback about the relationship also improves satisfaction (Braithwaite & Fincham, 2011; Larson, Vatter, Galbraith, Holman, & Stahmann, 2007). However, these programs targeted couples with relatively high levels of relationship satisfaction, and it is unknown whether they would have similar effects on distressed couples.

In an attempt to reach distressed couples with an online program, Doss et al. (2013) developed an online program, OurRelationship.com, based on the empirically-supported Integrative Behavioral Couple Therapy (IBCT; Christensen et al., 2004). IBCT encourages couples to accept their differing personalities and emotional responses by promoting unified detachment from relationship patterns and more empathic communication in sessions. In three clinical trials with a total of 172 couples, IBCT has been shown to be efficacious for serious relationship distress, producing larger improvements through two-year follow-up than traditional behavioral couple therapy (Christensen et al., 2004; Christensen et al., 2010; Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000; Wimberly, 1998). Participants in the largest study also reported changes in overall mental health in association with changes in marital satisfaction (Christensen et al., 2004).

OurRelationship.com is a comprehensive, approximately eight-hour program that involves videos and animations of example couples, psychoeducation from relationship experts, tailored feedback based on the data the couple enters, and interactive activities using input from both partners (Doss et al., 2013). The program is structured as a series of modules, some completed independently, and others completed with both partners in front of the same screen. The content of the modules follows the principles of IBCT, with a focus on increasing couples' acceptance of their differences, helping them empathize with each other, and promoting mindful awareness of their interaction patterns in order to begin changing these patterns.

The program has three phases: Observe (O), Understand (U), and Respond (R). In the Observe phase, couples are oriented to the program, complete an assessment battery, receive feedback about their relationship, and identify one or two core relationship issues they would like to focus on. In the Understand phase, participants learn about a new way to conceptualize relationship difficulties and apply what they have learned to their core issue/s. This new conceptualization is called a "DEEP Understanding" in which DEEP is an acronym for how natural *differences* (D) such as personality are at the root of couples' problems, how *emotional* sensitivities (E) such as a fear of abandonment or a fear of being smothered make these differences more difficult to manage, how circumstances such as *external* stressors (E) exacerbate the difficulties, and how couples often respond to these DEE factors with maladaptive *patterns* of communication (P) that can make the problem worse (such as one partner demanding change and the other withdrawing from the conversation). After developing these new conceptualizations, couples meet for a joint conversation in which they share what they learned. Then, in the Respond phase, couples learn about what aspects of their relationships are best accepted versus changed and develop self-change plans for dealing with stress, changing their patterns of communication, sharing positive activities with each other, and improving their self-care. They then meet for a final conversation to share these plans and receive feedback about their progress. We recently completed a randomized clinical trial of the OurRelationship.com program; 300 couples were randomly assigned to begin the program immediately or after spending 1.5 months on a waitlist. At post-treatment, couples reported significant improvements in rela-

tionship satisfaction, as well as individual variables such as quality of life, as compared to waitlist control (Doss et al., 2016).

Treatment for Relationship Distress and Generalized Anxiety

Another key goal of the OurRelationship program was to make a website program flexible enough to be modified to focus on specific problems affecting relationships: for example, parenting, depression, and anxiety. This paper addresses the modifications for anxiety: specifically, for Generalized Anxiety Disorder (GAD). While cognitive-behavioral therapy (CBT) is efficacious for GAD, on average, only about 60% of GAD patients treated with CBT or SSRIs have a 70% reduction in symptoms (Rynn & Brawman-Mintzer, 2004). In an effort to address the more treatment-resistant GAD cases, a growing literature has targeted the improvement of empirically-supported treatments in two directions: (a) mindfulness and acceptance-based treatment and (b) interpersonally-oriented treatment.

Acceptance, Mindfulness, and Interpersonally-Based Treatment of GAD

Although the literature on mindfulness and acceptance-based (or third-wave) behavioral interventions for GAD is relatively new, their efficacy has been supported in four studies of two treatment protocols. Mindfulness-based cognitive therapy (MBCT), which emphasizes mindfulness meditation as well as cognitive exercises, produced large effect sizes for change in pathological worry, quality of life, and other GAD symptoms in one uncontrolled trial (Craigie, Rees, Marsh, & Nathan, 2008). In another small open trial of MBCT, half of clients with clinically significant pathological worry scores reported that these scores had dropped below cutoff by the end of treatment (Evans et al., 2008).

Acceptance-based behavior therapy (ABBT) uses acceptance and mindfulness to target the experiential avoidance theorized to be central to GAD (Orsillo, Roemer, & Barlow, 2003). In a small open trial, participants reported large effect sizes for change in GAD symptoms and quality of life at post-treatment follow-up (Roemer & Orsillo, 2007). In a randomized clinical trial with waitlist control, GAD symptoms improved significantly in the ABBT group, with 77% of ABBT participants no longer meeting criteria for GAD at the end of treatment, compared to 17% on the waitlist (Roemer, Orsillo, & Salters-Pedneault, 2008). Research on mechanisms of change in ABBT has demonstrated that treatment increases acceptance of internal experience and engagement in valued action, and that changes in these variables predicts change in GAD symptoms over and above change in trait worry (Hayes, Orsillo, & Roemer, 2010). These findings suggest that acceptance- and mindfulness-based behavioral interventions are appropriate treatments for GAD symptoms.

Individual treatment including a focus on interpersonal relationships also has been successful for GAD. Newman and colleagues developed an integrative therapy for GAD consisting of alternating CBT sessions and Interpersonal/Emotional Processing (I/EP) sessions; the latter focuses on exposing clients to their avoided emotions and helping them develop strategies for handling their interpersonal relationships more effectively (Newman, Castonguay, Borkovec, & Molnar, 2004). Participants in an open trial of this therapy reported significant changes from baseline in GAD symptoms, with effect sizes larger than those usually seen in CBT studies (Newman, Castonguay, Borkovec, Fisher, & Nordberg, 2008). Interpersonal issues may be relevant to treatment-resistant GAD in part because controlling for sociodemographic variables, for every increase of one unit of marital distress, the odds of having GAD increase by a multiplicative factor of 2.54 (Whisman, 2007).

Online treatments have also demonstrated efficacy for GAD. A randomized controlled trial of an online mindfulness-based stress reduction protocol found that it produced significantly greater improvements in GAD symptoms and well-being than the waitlist control (Houghton, 2008). Three users of an online CBT for GAD reported significant improvement in GAD symptoms; all met criteria for GAD at pre-treatment but no longer met criteria at post-treatment (Draper, Rees, & Nathan, 2008). Another online CBT program demonstrated significantly greater improvements in GAD symptoms in the treatment group than the waitlist control group in a randomized clinical trial (Titov et al., 2009).

Acceptance, Mindfulness, and Relationship Distress

In the GAD treatment literature, interventions based on acceptance and mindfulness principles, as well as interventions addressing interpersonal relationships, have only been examined separately. However, outside the area of GAD, there have also been successful interventions based on acceptance and mindfulness principles and designed specifically for relationship issues. Although research on mindfulness and couples is a relatively recent development, trait mindfulness has been shown to predict relationship satisfaction concurrently and 10 weeks later (Barnes, Warren Brown, Krusemark, Campbell, & Rogge, 2007; Wachs & Cordova, 2007). Mindfulness-based relationship enhancement, a program focused on teaching couples general mindfulness meditation skills, produced greater increases in relationship satisfaction and decreases in psychological distress than a waitlist control among a non-distressed group of couples (Carson, Carson, Gil, & Baucom, 2004). Two case studies of couples that completed a version of Acceptance and Commitment Therapy modified to focus on dyadic problems reported scores that moved from the distressed to the non-distressed range for both relationship satisfaction and psychological distress (Peterson, Eifert, Feingold, & Davidson, 2009). As stated above, IBCT is also an empirically-supported acceptance-based treatment. Although IBCT is not explicitly mindfulness-based, its objective of unified detachment is considered dyadic mindfulness (McGinn, Benson, & Christensen, 2010).

The targets of acceptance and mindfulness work are not identical for treatment of individual versus dyadic problems. However, both involve the skills of becoming more aware and accepting of internal experience (such as anxiety or frustration), delaying any automatic reactions to that internal experience (such as worrying or criticizing), and consciously choosing how to react in the way that best suits the individual's goals for their own life or for their relationship (such as doing something that will please the other partner).

Dyadic Treatment for GAD and Relationship Distress

Given the literature reviewed above, we expected conjoint treatment based on mindfulness and acceptance principles, modified to have a particular focus on GAD, to simultaneously influence GAD symptoms directly and alter dyadic interaction patterns that maintain GAD. For individuals who are interested in addressing both of these areas of difficulty, an integrated treatment may be appealing. Also, it has been previously suggested that obtaining support from a partner who is involved in the treatment process may contribute to a patient's ability to complete treatment (Jacobson, Holtzworth-Munroe, & Schmalings, 1989).

Another option is to sequence a couple-focused treatment and a separate individual treatment of the GAD. However, it seems unlikely that a GAD-linked interaction pattern could be fully altered while GAD symptoms are still present in the relationship; similarly, the GAD may not fully remit until any maintaining factors in the relationship have been eliminated. The most promising option seems to be a treatment in which individual and dyadic elements are integrated in both when and how they are presented, so that practice with mindfulness of

anxious feelings and practice with mindfulness of couple interactions can be mutually reinforcing. The treatment would emphasize the benefits for both partners if they help one another pursue valued goals rather than engaging in anxiety-driven behavior. If successful, the relationship may become one that no longer maintains the individual's GAD but instead promotes symptom remission. To date, however, no couple-focused or couple-based therapy has been described for the treatment of GAD. Therefore, the treatment developed in this study combined strategies for promoting mindfulness and acceptance of internal experience in GAD patients with strategies for promoting joint mindfulness of interpersonal patterns and acceptance of one another's experiences and emotions.

The goal of this program, therefore, was to develop an adapted form of the OurRelationship.com program for couples affected by GAD ("IBCT-GAD"). The online program was rewritten to include extensive additional materials for the treatment of GAD and relationship patterns related to the GAD. In the beginning of the program, couples are taught how to complete mindfulness exercises and are asked to do one together. In the DEEP Understanding sections, content was added to help participants link their relationship difficulties to GAD. For example, the program highlights natural *Differences* in neuroticism and anxiety sensitivity, *Emotional* sensitivities such as what worrying meant in each partner's family of origin, and *Patterns* of communication typical in couples affected by GAD, such as hostile criticism of anxiety leading to more anxiety. Just as in the original OurRelationship program, both partners then meet together to share what they wrote about their relationships earlier in the program in the hopes of facilitating unified detachment.

In the next part of the program, in which individuals develop a plan for changing their own behavior in a way that may improve the relationship, the IBCT-GAD program places greater emphasis on changes that may be relevant to GAD symptoms. Regardless of their level of anxiety, both partners are encouraged to become more accepting of internal experiences such as anxiety and then to increase behaviors that are consistent with their values rather than their emotions. For example, an individual with GAD might value sharing his emotions with his partner, even while he fears that if he does so, his partner will leave him because he has demonstrated himself to be inadequate. He might choose to follow his value and share his emotions while taking a mindful and accepting stance toward the anxiety he is likely to experience during this behavior. Similarly, a non-GAD partner may need to accept emotions, such as anger or sadness while engaging in value-driven behavior, such as being less critical of the other partner.

In this section of the program, participants are encouraged to identify new value-driven behavior in which they could engage for both the domain of the relationship and in other areas of their lives. Then, participants share these conclusions with their partners and identify joint values for the relationship they would like to work toward together. In this way, the GAD program mirrors the OurRelationship program's focus on individual behavior change, but with added emphasis on variables thought to be associated with change in GAD symptoms.

Method

Case Illustration

The following is a case study of a composite couple representing several couples who completed the program to preserve confidentiality. It includes the couples' responses to self-report measures as well as qualitative material from the couples' typed entries over the course of the intervention. The study in which these couples par-

ticipated was approved by the Institutional Review Board (North General) of the University of California, Los Angeles. Couples gave informed consent to participate through electronic signatures.

“Elizabeth and Trevor” (names given as pseudonyms to maintain confidentiality) are in their mid-twenties, have been in a relationship for 3 years and are not married. Both are Caucasian and have high school degrees. Both completed an online screening tool including the *Overall Anxiety Severity and Impairment Scale* (OASIS; Campbell-Sills et al., 2009), a measure which successfully classifies individuals with and without anxiety disorders 88% of the time. At least one member of the couple needed to score above the clinical cut-off for the assessment to proceed. Her anxiety appeared to be much higher than his, with her score falling above the cutoff and his below (Elizabeth: OASIS = 11; Trevor: OASIS = 5). Therefore, Elizabeth was asked to complete the *Anxiety Disorders Interview Schedule* (ADIS-IV-L; Brown, Di Nardo, Lehman, & Campbell, 2001) to assess for presence of GAD or other anxiety disorders; the ADIS-IV-L is a highly reliable and valid interview that follows DSM-IV diagnostic criteria. Elizabeth received a score of 7, indicating fairly severe GAD. Both partners also completed the 16-item *Couples Satisfaction Inventory* (CSI-16; Funk & Rogge, 2007), a measure of relationship satisfaction consisting of the most informative items from more established measures such as the Dyadic Attachment Scale and Marital Adjustment Test. At least one member of the couple needed to score below the clinical cut-off of 51.5 for the couple to participate in the program. Both Elizabeth and Trevor scored below the clinical cutoff, indicating mild distress (Elizabeth: CSI = 42; Trevor: CSI = 47). Therefore, they were admitted into the program and spent 3 months completing it.

Participation in the Program

Elizabeth’s initial description of how their relationship is impacted by GAD was lengthy and very anxious in tone. She stated that they have a strong relationship but she has frequent thoughts that perhaps it was not strong enough. She feared that if they were to try to stay together for life, they would fall out of love and be unhappy. Elizabeth also expressed concerns that the frequency of her worry indicated a problem in the relationship. Trevor’s description of the relationship referred to Elizabeth’s anxiety about the future, although he did not share it. He believed they would be able to have a strong marriage but noted that sometimes he felt lonely and hurt when she expressed so much anxiety about the relationship.

Elizabeth and Trevor participated in psycho-educational activities about the DEEP Understanding model, then described how this framework applies to their relationship. Elizabeth identified the key *Difference* in their relationship as Emotional Reactivity, saying that Trevor has less strong emotions than she does, so she sometimes comes across as “crazy.” Trevor chose a more specific difference, stating that it does not bother him that his work demands long hours but he recognizes that this is anxiety-provoking for her. He also mentioned that his sex drive is higher than hers.

In the *Emotional Sensitivities* section, Elizabeth stated that her typical surface emotion during disagreements is anger, while her hidden emotion is anxiety or hurt. Given her many fears about the future, this hidden emotion is understandable. Trevor stated that he rarely shows any surface emotion but has a hidden emotion of “helpless”. When they argue, he wants to solve the problem but is unable to do so, which distresses him. For *External Stressors*, both noted that work and extended family make these emotional sensitivities more difficult to deal with. For the *Pattern* of Communication, Elizabeth and Trevor agreed that they tend to engage in a de-

mand/withdraw pattern. When they disagree, she pushes him to agree with her and he withdraws from the conversation.

After discussing their responses to the first part of the program, they each wrote that developing this DEEP Understanding of their relationship helped them feel more accepting toward one another. Elizabeth said it was particularly helpful to her to learn more about what Trevor was experiencing when she became anxious. Trevor stated he did not learn as much from the program but liked having a common vocabulary for discussing their issues.

In the second, change-focused part of the program, Elizabeth wrote that she would like to work toward the values of being caring, patient, and affectionate. In her relationship, she would like to be caring even when she feels anxious, and she decided to practice counting to 10 when she notices her anxiety increasing. She stated she would let Trevor know she was feeling anxious and accept her own anxiety, but choose to take some time to distract herself with counting so she would not try to convince him to agree with her worries.

Trevor endorsed the values of hard work and caring for others. He stated he would like to find a way to express his love to Elizabeth every day. When he experiences strong emotions, he wants to let her know that he needs a few minutes away from her to calm down and then he will return to their conversation. In other words, both Trevor and Elizabeth want to address their more challenging moments as a team, communicating openly about them and taking whatever steps they need to avoid making the situation worse.

After Trevor and Elizabeth completed the material on how they can each change their behavior to interrupt their *Pattern* of communication, Trevor wrote that he would like to notice when they are heading toward a conflict (in other words, he would like to increase his mindfulness). Instead of withdrawing as he usually does, he would like to address the issue directly. Elizabeth wrote that she would like to tell Trevor explicitly when she is feeling anxious rather than simply asking questions in an anxious way.

Results of the Program

At the end of the program, both wrote that they believe they have made significant changes in their communication pattern. Elizabeth stated that although they are not always able to talk exactly as the program suggested, they are much more open about their feelings. She said they often begin laughing during a discussion because they realize they are using language from the program! She also noted she has more compassion for Trevor's experience. He agreed they both acknowledge their anxiety more often and recognize when they need to be honest with each other. In other words, both expressed acceptance of anxiety without being governed by it.

At the beginning, middle, and end of the program, Elizabeth and Trevor completed measures of their anxiety and relationship distress, the credibility of the program, and several other constructs expected to be associated with changes in anxiety and distress (see [Figure 1](#)). The primary measure of change in GAD symptoms was the GAD-7 scale ([Spitzer, Kroenke, Williams, & Lowe, 2006](#)), which has been used in the literature as an outcome measure for intervention studies ([Titov et al., 2009](#)). It also appears to be a good severity measure, as increasing scores on the GAD-7 are associated with increasing numbers of disability days. As is indicated in [Figure 1](#), Elizabeth's scores on the GAD-7 suggested substantial change in symptoms. Her score at pre-treatment was 16, above the clinical cutoff of 10. However, by mid-treatment this score had declined to 6, and at post-treat-

ment it had remained stable at 7. Additional information about GAD status was gathered with the *Penn State Worry Questionnaire* (PSWQ; Meyer, Miller, Metzger, & Borkovec, 1990), a standard measure of the frequency and perceived uncontrollability of worry behavior. Elizabeth's scores on the PSWQ did not decline over the course of the intervention (pre = 63, mid = 64, post = 63), but this measure is considerably less sensitive to change, with items such as "I have been a worrier all my life."

Composite Outcome Measures

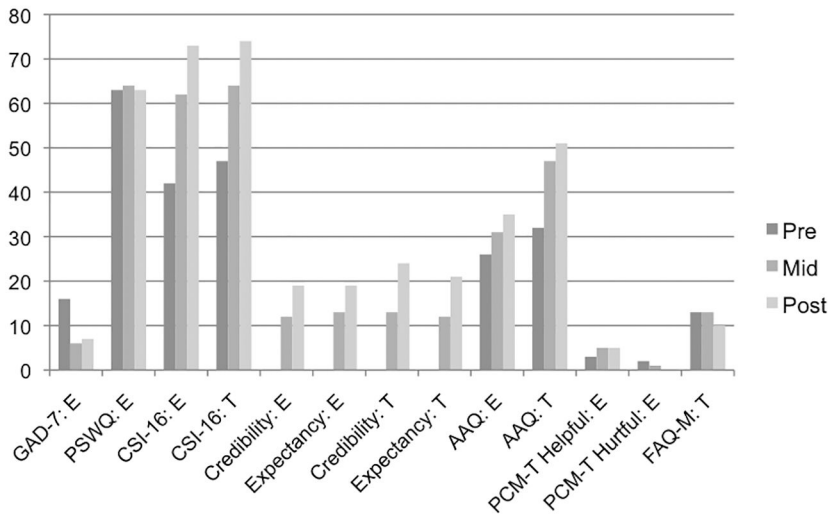


Figure 1. Composite values of self-report outcome measures for case study couple as measured at pre-treatment, mid-treatment, and post-treatment.

Note. E = Elizabeth; T = Trevor. GAD-7 = 7-item Generalized Anxiety Disorder Scale (Spitzer, Kroenke, Williams, & Lowe, 2006); PSWQ = Penn State Worry Questionnaire (Meyer, Miller, Metzger, & Borkovec, 1990); CSI-16 = Couples Satisfaction Inventory (Funk & Rogge, 2007); Credibility = CEQ Credibility factor, Expectancy = CEQ Expectancy factor, CEQ = Credibility and Expectancy Questionnaire (Devilley & Borkovec, 2000); AAQ = Acceptance and Action Questionnaire (Hayes et al., 2004); PCM-T Helpful and PCM-T Hurtful = Perceived Criticism Measure-Type (Renshaw, Blais, & Caska, 2010); FAQ-M = Family Accommodation Questionnaire-Modified (Zaider, Heimberg, & Iida, 2010).

At pre-treatment, Elizabeth's CSI-16 (relationship distress) score had been 42. At mid-treatment, her CSI had increased to 62, in the non-distressed range. By post-treatment, score had further increased to 73. Similarly, at pre-treatment, Trevor's CSI score had been 47. At mid-treatment, it had increased considerably to 64, in the non-distressed range. At post-treatment it increased again to 74. These results indicate that in addition to improving GAD symptoms, the intervention was extremely successful at increasing relationship satisfaction for both partners.

Credibility of the treatment method and users' expectancy of treatment success were measured using the *Credibility and Expectancy Questionnaire* (CEQ; Devilly & Borkovec, 2000); this measure has demonstrated reliability and validity with a GAD sample. Both Trevor and Elizabeth appear to have found the intervention credible and expected it to be fairly effective. At mid-treatment, Elizabeth's score on the credibility portion of the Credibility and Expectancy Questionnaire was 12, which represents being approximately 40% confident the program is credible, averaging across items. On the expectancy portion, her score was 13, also about 40% confident the program would help her improve. At post-treatment, Elizabeth's scores on both the credibility and expectancy portions had increased to 19, or approximately 60% confident the program would be helpful. At mid-treatment,

Trevor's score on the credibility portion of the Credibility and Expectancy Questionnaire was 13, which represents being approximately 50% confident the program is credible, averaging across items. On the expectancy portion, his score was 12, or about 40% confident the program would help him improve. At post-treatment, Trevor's score on the credibility portion had increased to 24; similarly, his score for expectancy increased to 21, or approximately 70% confident. These increases suggest Trevor and Elizabeth may have attributed a considerable portion of the improvements in their relationship and symptoms to this online program.

Several other measures were administered to capture possible predictors or mediators of therapeutic change. Both partners completed the *Acceptance and Action Questionnaire* (AAQ; Hayes et al., 2004), a measure of experiential avoidance and its opposite, acceptance. Elizabeth's scores on the Acceptance and Action Questionnaire increased during the intervention (with higher scores indicating greater acceptance). She scored 26 at pre-treatment, 31 at mid-treatment, and 35 at post-treatment. This finding is in accordance with her reductions in GAD symptoms. At pre-treatment, Trevor's AAQ score was 32. It increased substantially to 47 at mid-treatment and increased again to 51 at post-treatment.

Participants with GAD also rated their partners' hostile criticism of them using the *Perceived Criticism Measure-Type* (PCM-T; Renshaw, Blais, & Caska, 2010), which distinguishes between hostile and non-hostile forms of criticism. At pre-treatment, Elizabeth reported on the Perceived Criticism Measure-Type (PCM-T) that Trevor criticizes her in a "helpful, constructive way" at the level of 3 out of 7, while he criticizes her in a "harsh, hurtful way" at 2 out of 7. At mid-treatment, she reported that he criticizes her in a "helpful, constructive way" at the level of 5 out of 7, while he criticizes her in a "harsh, hurtful way" at 1 out of 7. At post-treatment, her report of "helpful, constructive" was also 5 out of 7, while "harsh, hurtful" became 0 out of 7. These reductions in hurtful criticism and increases in helpful criticism fit their report of improvements in satisfaction.

Partners of those members with GAD also completed the *Family Accommodation Questionnaire-Modified* (FAQ-M; Zaider, Heimberg, & Iida, 2010), a measure of accommodation of their partners' symptoms. This measure was originally developed for use with obsessive-compulsive disorder but was successfully modified by Zaider, Heimberg, and Iida (2010) for use with any anxiety disorder. At pre-treatment, Trevor's score on the FAQ-M was 13; this indicates endorsing each accommodation-related item "one to three times per month" on average. At mid-treatment, his self-reported accommodation remained steady at 13. However, at post-treatment it declined slightly to 10. This finding is in accordance with Trevor and Elizabeth's statements suggesting they had both become less accommodating of anxiety symptoms.

Discussion

The overarching goal of this project was to develop the IBCT-GAD online intervention and conduct a preliminary evaluation of feasibility. The experiences of the couples on which this case study was based suggest that a combined web-based intervention for relationship difficulties and GAD is feasible and may be effective for some couples.

Many more individuals will need to participate in the program before more definitive conclusions can be drawn. However, the patterns described here are somewhat informative. Elizabeth and Trevor appeared to have made major changes in their pattern of interacting with one another. Both recognized the way their parts in the pattern were ineffective responses to Elizabeth's anxiety. Elizabeth committed to alerting Trevor to her anxiety and then

returning to valued activities, rather than engaging in anxiety-driven behavior. Trevor also expressed a desire to describe unhelpful anxiety-driven patterns and “break” them rather than continue engaging in them. Both reported that at the end of the program, they had been successful in these goals of both openly acknowledging and responding differently to anxiety. Their self-reported acceptance and avoidance were also in accordance with these changes. Moreover, her report of his harsh criticism decreased, while his report of his accommodation also decreased. Perhaps as a result, Elizabeth’s GAD symptoms decreased, and both partners’ relationship satisfaction increased.

These findings suggest it may be helpful for the IBCT-GAD intervention content to be modified to add more explanations and examples of how acceptance and accommodation are related to communication patterns and GAD symptoms. If the results of these cases were replicated in a larger pilot sample, they would have significant implications for the treatment of GAD. Nearly all the research on couples and GAD has focused on partners’ hostility, with the notable exception of Zaider, Heimberg, and Lida’s (2010) work. Partners’ accommodation may be found to be a factor predicting lack of response to individual treatment, as was hostility (Zinbarg, Lee, & Yoon, 2007). Addressing accommodation may be an important strategy for improving the efficacy of interventions for GAD. Additional research and modification of this intervention may make the IBCT-GAD program a valuable resource for a particularly treatment-resistant segment of the GAD population.

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Competing Interests

Brian D. Doss and Andrew Christensen hold the intellectual property of the OurRelationship program and earn royalties from it.

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