Clinical Psychology: Science and Practice

ISSN: 0969-5893

2023, Vol. 30, No. 4, 453–464
https://doi.org/10.1111/cpsp.12375

LITERATURE REVIEW

Family Accommodation in PTSD: Proposed Considerations and Distinctions From the Established Transdiagnostic Literature

Lillian Reuman[1, 2] and Johanna Thompson-Hollands[1, 2]
[1] VA Boston Healthcare System, National Center for PTSD, Boston, MA, USA
[2] School of Medicine, Boston University, Boston, MA, USA

Accommodation is widely documented and studied among internalizing disorders; however, the conceptualization and study of accommodation in the context of posttraumatic stress disorder (PTSD) is relatively nascent. PTSD entails many diagnostic criteria—including exposure to a distinct Criterion A event, emotional numbing, and anger—that may uniquely influence accommodation and merit special consideration. Our aim was to review the impact of accommodation in PTSD, compare and contrast accommodation in PTSD to other disorders with a strong empirical evidence base regarding accommodation, and highlight considerations unique to PTSD and associated implications for accommodation. We conclude by providing considerations for future research and practice.

Public Health Significance Statement
Posttraumatic stress disorder (PTSD) is a public mental health priority that exacts significant interpersonal burden; however, relatively little is known about PTSD-specific symptom accommodation by family members. Unique diagnostic criteria in PTSD highlight the need for updated empirical and clinical considerations regarding symptom accommodation. The paper provides initial support for the need for PTSD-specific approaches to clinically address accommodation and emphasizes the need for further empirical investigation of PTSD-specific accommodation.

Keywords: accommodation, interpersonal involvement, PTSD, relationships, transdiagnostic

Introduction

Emotional disorders exist in an interpersonal context. Indeed, interpersonal involvement across emotional disorders, including anxiety (Thompson-Hollands, Kerns, Pincus, & Comer, 2014), obsessive–compulsive disorder (OCD; Lebowitz, Panza, & Bloch, 2016), hoarding disorder (Drury, Ajmi, de la Cruz, Nordsletten, & Mataix-Cols, 2014), autism (Storch et al., 2015), mood disorders (e.g., bipolar disorder; Goossens, Van Wijngaarden, Knoppert-Van Der Klein, & Van Achterberg, 2008), and eating disorders (EDs; Sepulveda, Kyriacou, & Treasure, 2009), is well-documented. Individuals of varying relationships (e.g., parents, partners) become involved, and this participation takes many forms. For example, family members may adopt various roles previously performed by the affected relative (e.g., dropping children off at school). This involvement makes sense, as family members often feel motivated to aid a loved one in avoiding stressful situations (e.g., traffic, crowds) or find that it is fruitless to engage in arguments about the seeming illogical thoughts and behaviors of the relative. Although well-intentioned, family involvement in symptoms and associated avoidance behaviors is often linked with increased distress and burden and may, in fact, maintain or exacerbate symptoms (Lebowitz et al., 2016; Storch et al., 2007). Without formal clinical training, family members can find it difficult to understand their loved one's symptoms or—know what to do.

One specific type of family involvement is symptom accommodation. Accommodation describes changes that family members or others make to their own behavior to help their loved one who is dealing with a psychological disorder(s) avoid or alleviate distress related to the condition (Calvocoressi et al., 1995; Lebowitz et al., 2016). Accommodation can also serve to help the family member regulate their *own* emotions or decrease tension in the home (Futh, Simonds, & Micali, 2012; Timko, Zucker, Herbert, Rodriguez, & Merwin, 2015). Although the intention is typically to reduce short-

This article was published Online First August 30, 2020.

Lillian Reuman https://orcid.org/0000-0003-4918-6638
Johanna Thompson-Hollands https://orcid.org/0000-0003-3011-8520

National Institute of Mental Health, Grant/Award Number: T32MH0 19836; U.S. Department of Veterans Affairs, Grant/Award Number: IK2 CX001589.

Correspondence concerning this article should be addressed to Lillian Reuman, VA Boston Health Care System, National Center for PTSD (116B-4), 150 S. Huntington Avenue, Boston, MA 02130, USA. Email: lreuman@bu.edu

term distress in the affected relative and to avoid everyday hassles or conflict, accommodation negatively reinforces avoidance and rigid ritualistic behaviors while insulating the affected relative from some of the consequences of those behaviors, ultimately maintaining the disorder and therefore prolonging the problem. Although it is certainly possible for family members to engage with disorder-related distress in a way that is supportive (e.g., encouraging comments that replace reassurance such as "I know this is hard for you; I'm here for you"), true accommodation behaviors are unhelpful given their role in symptom maintenance.

Accommodation was first studied in OCD and has since been widely documented in the OCD and ED literatures (Anastasiadou, Medina-Pradas, Sepulveda, & Treasure, 2014; Wu et al., 2016), among other conditions (e.g., anxiety disorders; Lebowitz et al., 2016). In a prototypical example, a relative of someone with OCD might participate in a decontamination ritual at the request of their loved one. A parent of an adolescent with an eating disorder might adjust the family's weekly menu by omitting certain feared ingredients (e.g., butter) or permitting the adolescent to eat separately from the family. The well-developed literature around accommodation in these disorders serves as a helpful starting point for exploring the construct in other emotional disorders. Diagnosis-specific nuances matter, however, and accommodation cannot be characterized and treated identically across disorders.

A growing body of literature indicates that accommodation also occurs among relatives of individuals with posttraumatic stress disorder (PTSD; Fredman, Vorstenbosch, Wagner, Macdonald, & Monson, 2014). For example, a partner may take over running errands for a spouse so that the spouse can avoid crowded stores. To prevent a feared hostile or angry reaction, a parent may "bite their tongue" (i.e., refrain from bringing up topics of criticism or contention) instead of making a comment to their child. A loved one might steer group conversations away from the patient's traumatic experience (e.g., intentionally avoiding mentioning the patient's military deployment in a social setting) to prevent the patient from being reminded of the event. Table 1 provides examples of some possible accommodation behaviors by PTSD symptom type, although the particular behaviors engaged in will necessarily be idiosyncratic to the patient's individual trauma and resulting PTSD symptoms, as well as to their relationship and history with the accommodating loved one. Regardless of the form accommodation takes in PTSD, the *function* is always to facilitate avoidance of the patient's uncomfortable emotion (whether that involves avoidance of a place, situation, person, or avoidance of unwanted internal experience such as a memory, flashback, or nightmare).

Although research regarding accommodation in PTSD is less developed than in OCD or anorexia nervosa (AN), studies suggest that accommodation among the relatives of individuals with PTSD is widespread, problematic, and worthy of future study (Fredman et al., 2014; Monson, Fredman, & Dekel, 2010). PTSD not only is a prevalent and impairing condition (Kessler, 2000) with significant effects on family members (Ray & Vanstone, 2009; Taft, Watkins, Stafford, Street, & Monson, 2011), but also has distinct features that are worthy of attention. Historically, definitions of accommodation in the context of OCD focused on responses to patients' *fear-based* reactions (Calvocoressi et al., 1995); however, some researchers have extended the construct of accommodation in PTSD beyond fear-related responses to include behaviors that insulate the loved one from the *consequences* of PTSD symptoms, such as anger (Fredman et al., 2014).

The wealth of literature regarding accommodation in OCD offers a prototype and serves as a useful starting point for exploring the phenomena in PTSD. Despite putative overlap among some symptoms and maintenance factors in OCD and PTSD, however, PTSD includes many unique diagnostic criteria—including exposure to a distinct Criterion A event, emotional numbing, and anger—that merit special consideration. Taken together, the PTSD symptom profile can have unique effects on the family (Galovski & Lyons, 2004) and elicit different forms of involvement, including pushing the family member away, isolating, and straining communication (Campbell, Renshaw, Kashdan, Curby, & Carter, 2017). Given these patterns, it is also useful to consult research regarding accommodation in another developed body of work: EDs, specifically AN, which we argue share some interpersonal similarities with PTSD, as described later. Taken together, the aim of the current paper was to clarify the importance of studying accommodation in PTSD, compare and contrast accommodation in PTSD to other disorders with a strong empirical evidence base regarding accommodation (i.e., OCD and AN), highlight considerations unique to PTSD and associated implications for accommodation, and provide recommendations for treatment and research.

Accommodation as Important and Problematic

Accommodation is well-intentioned and prevalent, yet associated with various negative outcomes. Research in OCD, AN, and PTSD consistently demonstrates that increased accommodation is associated with elevated levels of caregiver burden and caregiver/relationship distress (Amir, Freshman, & Foa, 2000; Anderson, Smith, Nuñez, & Farrell, 2019; Boeding et al., 2013; Fischer, Baucom, Kirby, & Bulik, 2015; Monson et al., 2010; Renshaw, Blais, &

Table 1
PTSD Symptom Clusters and Examples of Associated Accommodation

PTSD symptom cluster	Sample accommodation
Criterion A event	Secrecy; *avoid* direct discussion of the event
Re-experiencing	*Avoid* situations that might bring up memories of the event; agree to unusual sleeping arrangements in order to help the patient *avoid* nightmares
Avoidance	*Avoid* crowded places when with the patient; refrain from addressing problematic substance use that the patient is engaging in to *avoid* memories or emotions
Negative cognitions and mood	Making excuses (i.e., *avoiding*) or managing relationships to compensate for or facilitate detachment/estrangement
Arousal	Bite tongue to *prevent*/*avoid* irritable/angry outbursts; acquiescing to overly burdensome safety rituals

Caska, 2011). For example, Monson et al. (2010) identified decreased relationship satisfaction among spouses of individuals with PTSD due to accommodation-related difficulties in communication and reductions in joint activities.

Accommodation often interferes with treatment and has been associated with poorer treatment outcomes. Like ritualistic behaviors and avoidance performed by the individual with OCD, AN, or PTSD, accommodation by a family member prevents the disconfirmation of feared consequences and therefore maintains the disorder through negative reinforcement. In essence, accommodation contradicts treatment goals of promoting exposure to feared situations and stimuli. Further, an individual whose symptoms are heavily accommodated by a family member may lack motivation for seeking or completing treatment, given the potential relief provided by accommodation or an inability to recognize their symptoms as disruptive. Indeed, empirical research has identified associations between higher levels of family accommodation and poorer treatment outcome (Anderson et al., 2019; Merlo, Lehmkuhl, Geffken, & Storch, 2009; Salerno et al., 2016; Thompson-Hollands, Abramovitch, Tompson, & Barlow, 2015). There is less research regarding the impact of accommodation on treatment outcomes for PTSD, and findings are not definitive (Fredman et al., 2016; Pukay-Martin et al., 2015). Pukay-Martin et al. (2015) observed moderate decreases in partner accommodation over the course of present-focused therapy for PTSD; however, the researchers did not examine the association between accommodation and treatment outcome, and accommodation was not explicitly targeted in treatment. Contrary to expectation, Fredman et al. (2016) found that baseline partner accommodation moderated treatment outcome for PTSD, such that higher levels of partner accommodation at baseline were associated with greater improvements in PTSD symptoms; importantly, these findings were in the context of a relationship-based (conjoint) therapy in which accommodation and other impacts of PTSD on the relationship were a specific focus of treatment. As such, the authors speculated that conjoint treatment may be especially indicated for dyads in which accommodation is high at baseline.

Taken together, the existing literature demonstrates that accommodation is prevalent and often interferes with interpersonal relationships and treatment. The fact that accommodation is modifiable suggests that it is a relevant target for assessment and treatment. Fortunately, validated measures for assessing accommodation exist for OCD (Calvocoressi et al., 1995), EDs (Sepulveda et al., 2009), and PTSD (Fredman et al., 2014). To date, several interventions exist for reducing accommodation in OCD (Thompson-Hollands et al., 2015), as well as for shifting caregiver involvement in EDs (Hoyle, Slater, Williams, Schmidt, & Wade, 2013). In the case of PTSD, at least one fully conjoint protocol that includes interventions meant to reduce accommodation exists [cognitive behavioral conjoint therapy for PTSD (CBCT); Monson et al., 2011], and a more limited, family-only protocol is also currently being tested (Thompson-Hollands et al., 2020). However, although it may be tempting, and to a certain extent useful, to draw directly from the literature regarding assessment of and interventions to reduce accommodation in OCD and EDs, additional consideration is necessary in the case of PTSD for the reasons discussed below. We first discuss diagnostic criteria and associated characteristics that are shared across multiple disorders (OCD, AN, and PTSD) before discussing diagnostic criteria that are unique to PTSD.

Overlapping Diagnostic Characteristics

Three interrelated and overlapping categories of diagnostic criteria/traits in OCD, AN, and PTSD are ritualistic behavior, avoidance, and inflexibility/need for control. Secrecy, which can be prominent in AN and PTSD, is an additional criterion of interest. Each characteristic serves a role in maintaining the disorder and represents a treatment target. After describing each criteria/trait, we discuss each domain's potential effect on accommodation. See Figure 1 for a representation of overlapping and unique diagnostic characteristics.

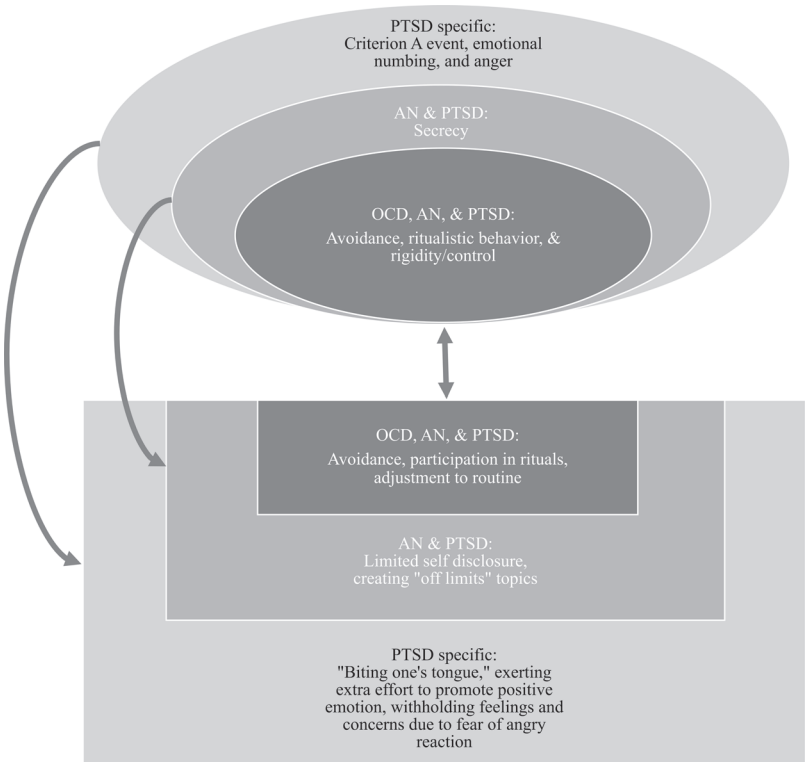
Ritualistic Behaviors

OCD, AN, and PTSD all entail repetitive or ritualistic behaviors designed to reduce anxiety or to prevent feared consequences from occurring. Although rituals functionally serve to relieve distress in the short term, they are often time-consuming and lead to the maintenance of the condition in the long term. In OCD, rituals may include behaviors such as excessive cleaning, checking, mental "un-doing," or other behaviors meant to prevent dire consequences. Individuals with AN typically engage in rituals related to feared weight gain and dyscontrol (e.g., checking or measuring body parts for fat, manipulating food; Engel et al., 2005). Typically related to hypervigilance, ritualistic checking behaviors in PTSD can be present and may involve checking that the doors are locked or checking the roadside for explosive devices. These rituals may serve to address feared beliefs about danger and promote safety, yet can become time-consuming and disruptive to one's daily routine (Tuerk, Grubaugh, Hamner, & Foa, 2009). At times, individuals with OCD, AN, or PTSD may enlist their loved ones to help with rituals when possible and may be quite resistant to complaints that these behaviors are unnecessary. These ritualistic behaviors wield interpersonal consequences. The time-consuming nature of rituals (e.g., spending an hour to check the perimeter of one's property before leaving home) can delay or derail the family routine. Additionally, rituals may lead to frustration or exhaustion on behalf of family members who feel obligated to wait for or participate in said behaviors.

Avoidance

Avoidance is prominent in OCD, AN, and PTSD. Like ritualistic behavior, avoidance serves to reduce anxiety associated with feared stimuli. Individuals may avoid external stimuli (e.g., people, situations) and internal stimuli (e.g., emotions, sensations, memories). Avoidance behavior is negatively reinforced (i.e., individuals receive temporary relief following avoidance behavior), increasing the likelihood of future avoidance. Individuals with OCD typically avoid situations that will bring them in contact with their obsessive thoughts. In AN, patients may avoid certain foods or situations involving food (e.g., family gatherings, holidays) to regulate or avoid unwanted emotions (Wildes, Ringham, & Marcus, 2010). With the implementation of DSM-5, avoidance is a separate PTSD symptom cluster and the presence of either internal or external avoidance is required to meet diagnostic criteria. In PTSD, this can include emotional avoidance (e.g., forcing oneself to think about something else when thoughts of past sexual assault arise) and behavioral avoidance (e.g., turning off the news when coverage of the war comes on television). Behavioral and emotional avoidance are natural responses to unpleasant stimuli; however, persistent avoidance behaviors inhibit

Figure 1
Interrelationships Between Overlapping and Unique Characteristics of OCD, AN, and PTSD and Associated Accommodation Behaviors



trauma processing and, in turn, may contribute to increased symptomatology over time while precluding opportunities for corrective learning (Foa & Kozak, 1986).

In an interpersonal context, individuals may avoid discussing content related to feared stimuli (leading to strained communication patterns over time). If an individual is isolating or independently avoiding situations with little to no explanation, family members may feel confused or frustrated. Alternatively, individuals with OCD, AN, or PTSD may require that their relatives comply with avoidance behaviors (whether or not they choose to disclose the reason for their avoidance). Across disorders, family members may "collude" with avoidance, further promoting the individual's avoidance behaviors and interfering with recommended treatment goals (e.g., approach-oriented exposure tasks). Over time, this pervasively limits or dictates what the couple or family can do (e.g., can no longer attend public events or crowded sporting games, cannot attend social events that center around food). Decreased engagement in such shared rewarding behaviors can contribute to further relationship dissatisfaction (Monson & Fredman, 2012).

Need for Control

Characteristics such as rigidity and need for control are prominent in OCD, AN, and PTSD. Beliefs about control—and the deleterious consequences that could result from losing control—are common and well-documented (Moulding & Kyrios, 2006). Metacognitive beliefs regarding the need for control of thoughts are key maintenance factors of OCD (Clark, 2004). In AN, a combination of a low sense of control combined with a high desire for control may serve as a maintaining factor and be expressed through various rituals designed to maximize control (Surgenor, Horn, & Hudson, 2003; Tiggemann & Raven, 1998). In PTSD, research suggests that psychological inflexibility predicts unique variance in symptom severity (Meyer et al., 2019). Indeed, difficulties with appropriately managing power and control are a central tenet in cognitive processing therapy for PTSD (Resick, Monson, & Chard, 2016). Potentially related to these control-oriented beliefs are inflexible or rigid behaviors and documented set-shifting difficulties in OCD (Lawrence et al., 2006), AN (for a review see Roberts, Tchanturia, Stahl, Southgate, & Treasure, 2007), and PTSD (Aupperle, Melrose, Stein, & Paulus, 2012).

In an interpersonal context, inflexibility, rigidity, and beliefs about control can impact various aspects of the relationship. In addition to affecting the family routine/schedule and dictating avoidance (as described above; e.g., a need for order and control precluding family outings to "unpredictable" crowded places), inflexibility and rigidity can stifle openness and warmth in the relationship. Family members frequently grow frustrated with their loved one's rigidity or need for control; qualitative findings suggest that among individuals with PTSD, a need for control

induced neither empathy nor concern, but increased fear and anxiety (Gerlock, Grimesey, & Sayre, 2014).

Secrecy

Thus far, we have discussed commonly present diagnostic criteria and associated clinical phenomena in OCD, AN, and PTSD, as well as associated implications for family involvement. Although not a DSM diagnostic criterion, secrecy is a trait worthy of consideration in the context of accommodation. Although some individuals with OCD may hide taboo thoughts from others given associated shame (e.g., ego-dystonic thoughts of harming children), individuals with OCD often draw *in* trusted individuals in a quest for reassurance. In contrast, clinical observations and research findings suggest that both AN and PTSD often involve a significant degree of secrecy or "shutting out," which can strain communication and ultimately push a loved one away. Although the reasons for secrecy may differ, the behavior functionally has similar consequences for family. Family members remain in the dark about the affected person's experience and how to help.

Secrecy in AN is well-documented (Huke & Slade, 2006; Loeb, Lock, Greif, & Le Grange, 2012), and individuals with AN often hide their disordered eating behaviors and avoid discussing their concerns with loved ones. Secrecy can also be associated with PTSD (Nelson, Carter-Vassol, Yorgason, Wangsgaard, & Kessler, 2002) and trauma (e.g., sexual trauma; Monteith, Gerber, Brownstone, Soberay, & Bahraini, 2019). Similar to AN, shame and (self-)stigma around PTSD may hinder individuals' openness regarding the disorder and the extent of distress they are experiencing. A further distinction from AN, however, is the presence of a Criterion A traumatic event, which is unique to PTSD. A Criterion A event is defined as direct or indirect (e.g., witnessing) exposure to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence. As a result of feelings and thoughts associated with the event itself (e.g., "It's too painful to discuss") or one's reaction to it (e.g., "It's my fault this happened," "I should be over this by now"), individuals with PTSD may keep their relative in the dark about the content of what actually happened. They may also maintain secrecy out of fear that learning about the event could be traumatic for their family member ("vicarious traumatization" or "secondary traumatic stress;" Diehle, Brooks, & Greenberg, 2017).

Unlike reassurance-seeking in OCD, secrecy associated with PTSD, like secrecy in AN, may push relatives away. Further, secrecy contributes to low levels of self-disclosure, which can lead to decreased intimacy in relationships where one partner has PTSD (Solomon, Dekel, & Zerach, 2008). Strained communication naturally follows. Secrecy may occur within a relationship (e.g., a wife withholding details of a past trauma from her husband in a way that is problematic for the relationship and leads to decreased closeness) or may occur between a dyad and other relationships. For example, an "in-the-know" partner or parent may "collude" with their affected loved one and help patients to keep their symptoms or traumatic event secret from *others*. The latter may not be problematic however, but rather may help to maintain respect for the individual's privacy.

This is neither to say that reassurance-seeking is preferable, nor to say that providing reassurance is adaptive; reassurance-seeking is driven by anxiety and may be quite wearing on family members in and of itself (and providing reassurance functionally maintains the OCD symptoms no matter how unlikely or illogical the affected person's fears are). The effect of secrecy on the relationship and the closeness of the individuals in question, however, may be quite different compared to the "shutting out" of AN and PTSD.

PTSD-Specific Considerations and Concerns

Secrecy (and, relatedly, a Criterion A event) is not the only element that potentially distinguishes family involvement in PTSD from that of OCD. Additional diagnostic criteria and characteristics unique to PTSD potentially serve to further complicate relationships with family members. These include anger and emotional numbing (Ray & Vanstone, 2009). Each characteristic —and the potential consequences related to accommodation—will be discussed in turn.

Anger

Anger is an affective state that shares many features with anxiety, such as threat-based appraisals and shifts in physiology (e.g., increased heart rate). Indeed, anger is a multidimensional construct that includes physiological, cognitive, subjective, and behavioral components. Anger can be described as a state (e.g., current feelings) and a trait (e.g., anger over time; Spielberger, Krasner, & Solomon, 1988). Theoretical models also suggest that anger can present as a tendency to suppress angry feelings (*anger in*), a tendency to express anger outwardly toward individuals or objects through physically or verbally aggressive behavior (*anger out*), or difficulty moderating the occurrence of angry feelings (*anger control*; Spielberger et al., 1988).

A meta-analysis by Olatunji, Ciesielski, and Tolin (2010) revealed that a PTSD diagnosis was associated with significantly greater difficulties with anger than other anxiety disorder diagnoses. In addition to the consequences that an individual with PTSD might experience due to "anger in" (e.g., increased blood pressure, poorer PTSD treatment outcome; Foa, Riggs, Massie, & Yarczower, 1995), "anger out" can yield relational consequences. One prominent example is aggressive behavior toward romantic partners ("intimate partner violence;" IPV). Among both veteran/military (Taft, Walling, Walling, Howard, & Monson, 2011) and civilian samples (Jakupcak & Tull, 2005; Rosenbaum & Leisring, 2003), a diagnosis of PTSD is associated with higher rates and severity of IPV compared to men without PTSD. Although much of the literature around IPV perpetration focuses on men, several studies have also found that women with PTSD have higher rates of IPV perpetration than those without PTSD (Kirby et al., 2012; Taft, Watkins, et al., 2011), although this association tends to be weaker for women than for men. Risk for IPV or other forms of relationship violence (e.g., child abuse) must be a focus of assessment when working with individuals with PTSD and their loved ones. Individuals with PTSD who do not engage in IPV, however, may still experience levels of anger that negatively impact their relationships. Many studies of individuals with PTSD have documented elevated rates of anger and aggressivity compared to those without the disorder (Beckham, Moore, & Reynolds, 2000; Jakupcak & Tull, 2005; Rosenbaum & Leisring, 2003). Due to fear of anger or violent outbursts, relatives may be hesitant to promote

exposure to a feared stimulus, engage in response prevention (e.g., withholding reassurance), or bring up difficult topics. That is, they may accommodate in order avoid the feared consequence of a PTSD-related angry outburst. Indeed, the original validation study for the Significant Others' Responses to Trauma Scale (SORTS; Fredman et al., 2014), the only validated measure of accommodation in PTSD, indicated that three items related to avoiding the individual with PTSD's anger ("How often do you 'bite your tongue' or hold back from trying to discuss any relationship issues with [THE PATIENT]?" "How often do you 'tiptoe' around [THE PATIENT] so as not to anger him/her?," and "How often do you not share your own feelings or concerns with [THE PATIENT] due to concerns that he/she would become upset?") were the most frequently endorsed by family members and also the most distressing. This type of accommodation centers around avoiding a "blow up" or "explosion," or even lower-level hostility or irritation on the part of the individual with PTSD. Although this suppression on the part of the family member may entail a fair amount of effort and engender substantial resentment, the individual with PTSD may not even be aware that such accommodation is occurring. Family members may simply refrain from bringing up topics of criticism or contention, and otherwise hide aspects of their personality or behavior that are likely to cause conflict with their loved one. Because of the relative prominence of anger among individuals with PTSD in comparison with OCD and AN, accommodation related to this aspect of their presentation is likely to be much more common in these families than in the families of individuals with OCD or AN. As the Fredman et al.'s (2014) data show, anger-related accommodation is perceived as highly distressing relative to other types of accommodation.

Emotional Numbing

Emotional numbing is yet another criterion that distinguishes PTSD from OCD and AN. Numbing results in a number of adverse consequences for family members and interpersonal relationships. Unlike the PTSD symptoms that focus on the presence of negative affect (e.g., re-experiencing, hyperarousal), emotional numbing relates to the absence of positive affect (Litz, 1992). The construct reflects a persistent inability to experience positive emotions, feeling detached from others, and a restricted range of emotional expressiveness.

As a result of emotional numbing, relatives may perceive their loved one with PTSD to be flat, preoccupied, and distant. Perhaps not surprisingly, the emotional numbing symptom (in which factor analyses of PTSD symptoms have frequently separated out as a distinct cluster [Armour et al., 2012; King, Leskin, King, & Weathers, 1998; Pietrzak, Tsai, Harpaz-Rotem, Whealin, & Southwick, 2012], despite it having been subsumed within larger criteria in both DSM-IV-TR and DSM-5) has been most frequently associated with marital distress by veterans (Cook, Riggs, Thompson, Coyne, & Sheikh, 2004; Lunney & Schnurr, 2007; Taft, Schumm, Panuzio, & Proctor, 2008) and their spouses (Evans, McHugh, Hopwood, & Watt, 2003; Riggs, Byrne, Weathers, & Litz, 1998). With regard to accommodation, Campbell et al. (2017) found a positive, significant path linking earlier emotional numbing to later accommodation among female spouses of male service members with clinically significant PTSD symptoms. Although future research is needed to further explore this relationship, we hypothesize several potential ways that such a process may unfold based on clinical observations and theory. Emotional numbing may simply serve to maintain estrangement; however, emotional numbing could also potentially engender accommodation by prompting a family member to exert effort to try to elicit positive emotional reactions from a loved one (e.g., being especially careful not to upset the affected individual or being very solicitous about always allowing the affected individual to sit in his/her preferred seat [which, of course, faces the door, to allow for more effective hypervigilance]).

Recommendations for Clinicians

Due to their inherent properties, these aforementioned PTSD-related tendencies—secrecy, anger, and emotional numbing—make treating accommodation in PTSD especially difficult. Combined, the symptoms present specific challenges for relationships and prompt/elicit unique forms of responding on behalf of family members. It is therefore important to consider family treatment strategies for reducing accommodation from the OCD and AN treatment literature, while also acknowledging unique PTSD-related concerns when providing psychoeducation to family members and making clinical suggestions regarding interpersonal interactions and potential behavior change. Several interventions in OCD or AN focus on the reduction of family accommodation as an explicit treatment objective and as a possible mediator of treatment outcomes within a larger treatment framework (Grover et al., 2011; Lebowitz et al., 2016). Further, some approaches to reducing accommodation adopt a unilateral approach (i.e., family-member only). For example, Thompson-Hollands et al. (2015) developed a brief intervention for family members that includes a discussion of how to make behavioral changes to accommodation and role-playing how to respond to the patient's possible reactions. The primary focus of Lebowitz and colleagues' intervention (SPACE; Lebowitz, Omer, Hermes, & Scahill, 2014) is on parent change rather than on direct child change. Parents are guided to reduce unhelpful accommodation as a way to strengthen the child's ability to cope independently. Although further empirical work will be needed to definitively establish the necessary elements for adequately addressing accommodation in PTSD, clinical observation and theory suggest that multiple components such as psychoeducation, provision of support for PTSD-focused treatment, and skills training (to address anger and communication) may all be useful. What follows are our clinical recommendations for addressing family involvement and accommodation in PTSD.

Psychoeducation and Support for Treatment Engagement

Psychoeducation, which entails offering disorder-specific information about the symptoms, conceptualization, and treatment of a given disorder, is a powerful tool that can help to provide accurate knowledge about PTSD, normalize the experience of PTSD, reduce stigma, and absolve blame (Gould, Greenberg, & Hetherton, 2007). For clinicians who treat family members of individuals with PTSD, psychoeducation regarding symptoms such as irritability/anger, avoidance, and emotional numbing may be particularly important. With an improved understanding, family members may be better able to label/identify PTSD symptoms and have

compassion for their origin. Knowing the label (i.e., "PTSD") could facilitate both insight into the psychological consequences of trauma *and* an ability to interpret typical symptoms in a nonblaming way (Barrowclough, Gregg, & Tarrier, 2008). Further, psychoeducation about PTSD symptoms can not only help to normalize and validate the family members' experience, but also depersonalize some of the behaviors (e.g., allow the family member to realize that the interpersonal sequelae of emotional numbing are not specific to the marriage, per se, but rather a function of PTSD more broadly). Finally and perhaps most significantly, orientation to the functional model of PTSD, the role of avoidance and cognitive distortions in maintaining the disorder, and the goals of trauma-focused treatment may all contribute to family members becoming more willing to reduce accommodation over time.

Notably, researchers have found that less psychological understanding among family members was associated with increased hostility toward a loved one with PTSD (Barrowclough et al., 2008). Family members perceived irritability and anger as more controllable and personal than any other problem. If psychoeducation can promote psychological understanding and debunk myths about the controllability of behavior, these findings suggest that the technique may help relatives to reappraise the impact of PTSD and, in turn, improve interpersonal functioning.

Accommodation is typically well-intentioned, and its deleterious functional effects may not be intuitive. Without understanding the rationale (i.e., "the why") for changing behavior and reducing accommodation, family members may not understand the need for such a change and may not be able to generalize the skills covered in session to the various settings they encounter with their loved one. Thus, psychoeducation about accommodation is necessary for relatives to understand the function of a given behavior and reduce accommodation across multiple domains, beyond those covered in a brief skills-based intervention. Indeed, multiple psychoeducation-based interventions to reduce accommodation have demonstrated benefit (Albert, Maina, Saracco, & Bogetto, 2006; Thompson-Hollands et al., 2015).

Following psychoeducation, family members of individuals with PTSD may be in a better position to provide support for their loved ones (and, eventually, learn skills). Research suggests that family members can be helpful by providing support to enter/stay in psychological treatment and to encourage them to be courageous in the face of distress (Meis et al., 2019). As such, Meis et al. (2019) propose that "outreach to loved ones that provides (a) a compelling case that confronting distress is essential for PTSD recovery, and (b) simple instruction to encourage veterans to confront distress" may facilitate trauma-focused treatment adherence (p. 253).

Communication Skills

Communication skills training for the individual with PTSD and the family member can assist in addressing accommodation behaviors such as secrecy, which may be related to the Criterion A event, stigma, shame/guilt, or other factors. Additionally, communication skills can be beneficial for teaching relatives to replace reassurance-related accommodation with more specific, direct supportive statements. A consistent predictor of overall, long-term relationship functioning, effective communication, can offer both instrumental and emotional support. In their study describing couple treatment for AN (Uniting Couples [in the treatment of] Anorexia Nervosa [UCAN]), Bulik, Baucom, and Kirby (2012) emphasize communication as central in the provision of a support from a partner. The UCAN treatment involves didactic instruction regarding communication (e.g., how to make decisions, how to share feelings) as well as practice in and out of session. The protocol also aims to help the patient become more open about the disorder and encourages the couple to work together around eating-disordered behavior and related symptoms (Bulik et al., 2012); a similar approach may be necessary in PTSD. Sautter, Armelie, Glynn, and Wielt (2011) have described and tested empathic communication training, which specifically focuses on skills to communicate about traumatic experiences. This type of communication facilitates a family member taking the perspective of the traumatized person. During in-session empathic communication practice, the couple receives feedback and encouragement from the therapist. Knowing that their loved one has skills for empathically talking about trauma, an individual with PTSD may be more inclined to reduce secrecy. Of course, given its dyadic nature, this communication training was conducted in a joint manner. Findings suggest that veterans receiving training showed significantly greater reductions in self- and clinician-rated PTSD compared with veterans receiving a couple-focused educational intervention (Sautter, Glynn, Cretu, Senturk, & Vaught, 2015). Given the prominence of anger in PTSD, skills for communication, not only with regard to the trauma/secrecy, but also with regard to high emotionality, are warranted. For example, Sherman, Perlick, and Straits-Tröster (2012) suggest "providing a structure in which the veteran can achieve the distance he or she needs, but simultaneously be encouraged to communicate with the spouse and "check in" at a specified later point in time" (p. 356).

Directly Addressing Accommodating Behaviors

At this time, there is little empirical evidence regarding how to most effectively structure family-inclusive interventions toward reducing accommodation. As previously discussed, CBCT does include attention to accommodation as a core treatment component; however, there are many cases in which conjoint approaches may be difficult or impossible (e.g., when there are scheduling difficulties or when the individual with PTSD is resistant to engaging in treatment at all). In other disorders, "unilateral" approaches that solely target family members have been used (Reuman & Abramowitz, under review; Thompson-Hollands et al., 2015), but such formats have not been directly tested in comparison with conjoint delivery; thus, clinicians must be guided by patient and family member preferences in terms of delivery of accommodation-focused interventions.

Following adequate psychoeducation about the function of avoidance in PTSD and the rationale for trauma-focused treatment, the clinician can then identify specific types of accommodation in which the family member is engaging (via both the SORTS and further clinical interview) and discuss appropriate changes. These changes might be introduced in a gradual way, as a sort of hierarchy, or be implemented more immediately. Attention should always be paid to the function of the accommodation behavior, and how the behavior can be shifted in a way that the affected individual experiences it as supportive and empathic, rather than punitive.

Because accommodation related to anger/irritability is so common, clinicians will likely need to address this type of behavior in almost all cases. We recommend an explicit assessment of IPV whenever one is working with an individual with PTSD or their family member(s). If there is ongoing severe violence or other coercive behavior, this should be a primary focus and the safety of all parties paramount. Assuming no ongoing severe violence or other threats are present, assessment of anger-related accommodation can proceed. As we have noted above, the SORTS has items that explicitly identify accommodation related to (fear of) anger from the individual with PTSD. If the relative endorses engaging in such behaviors, more specific behavioral examples should be elicited.

Determining how to proceed in the context of anger-related accommodation depends somewhat on the format of treatment. In a conjoint treatment, the focus can be on getting both parties to agree to commit to managing anger in a healthier way, in order to allow both parties to raise concerns constructively without feeling the need to suppress all conflict. In CBCT, skills for managing anger (including slowed breathing and time-outs) are intentionally a part of safety-building in the first phase of treatment (Monson & Fredman, 2012). However, in family interventions where the individual with PTSD is not present, addressing anger-related accommodation becomes more difficult. Without explicit buy-in from the affected individual, as well as skills training focused on helping that individual cope with anger in a more constructive way, it may not be safe to encourage the family member to stop all anger-related accommodation. Even if the person with PTSD is engaged in individual trauma-focused treatment, this does not typically include any skills focused on anger specifically. Although we might hope that the skills of cognitive reappraisal or tolerating intense emotion that are emphasized in trauma-focused treatment would generalize to the experience of irritation or anger within a close relationship, it is not clinically responsible to encourage family members to unilaterally cease being cautious about their loved one's potential for anger. Instead, the focus might need to remain on addressing other forms of accommodation that are more fear-oriented, and on improving relationship quality more generally by engaging in pleasant activities together.

Necessary Future Research Directions

We conclude by outlining a research agenda for the study of accommodation in PTSD. First, we encourage nuanced work (likely including a heavy emphasis on qualitative approaches) to better understand family members' perceptions and experiences of PTSD symptoms, knowledge about PTSD treatment, and desires for involvement in treatment. Preliminary work suggests that family members understand little about trauma-focused treatment and are not routinely involved, but that they are quite willing to play a more active role if given the opportunity by patients and clinicians (Thompson-Hollands et al., 2019). Clarifying specific deficits, needs, and preferences among family members will help to ensure that intervention strategies are appropriate. In addition to conducting qualitative interviews to better understand accommodation patterns and to develop interventions to shift accommodation-related behaviors in PTSD, researchers should solicit feedback during and following the interventions to make further iterations and flexibly adapt interventions accordingly.

Relatedly, we recommend more multimethod assessment into the specific impact of PTSD symptoms such as anger and emotional numbing on accommodation, including exploration of bidirectional effects. Campbell et al. (2017), for example, conducted a daily diary study of posttraumatic stress symptoms and romantic partner accommodation. To date, little is known about the bidirectional effects of accommodation and its attempted alteration in PTSD treatment. Although PTSD symptoms and accommodation are clearly linked, there has been little longitudinal research focused on how shifting one impacts the other. Basic research in this area is still needed.

Accommodation in PTSD could be further assessed through qualitative interviews with stakeholders (e.g., individuals with PTSD, family members). For example, researchers might ask family members, "what do you fear might happen when your loved one becomes visibly angry?" and "How do you respond as your loved one becomes visibly angry?" Additionally, researchers should study the ways in which accommodation could offer potential benefits to the relationship (e.g., "After a loved one helps you to avoid a feared situation, how do you feel towards them?"). Studies that include written or video vignette methodologies may be helpful to further researchers' understanding of the ways in which PTSD symptoms such as anger may elicit hypothetical responses in family members. To further study partner-specific accommodation patterns or responses to PTSD symptoms, observational ratings of recorded interactions may be useful (Kerig & Baucom, 2004).

We also emphasize the need for empirical research into the hypotheses proposed within this paper. For example, future research should systematically examine the presence of compulsive behaviors and secrecy in PTSD and compare the prominence and presentation of anger in PTSD relative to other diagnoses (e.g., AN). This empirical research will also bolster the clinical recommendations outlined above.

We encourage thoughtful intervention research that specifically focuses on accommodation. This would include examining the effectiveness of existing treatments (both family-inclusive and not) on accommodation, as well as the development of additional approaches. The latter would most likely take the form of adjunctive interventions, delivered alongside standard trauma-focused therapy, or family-member only approaches for cases in which the individual with PTSD is not currently participating in treatment. Eventually, dismantling studies can be useful for examining which, if any, components of family involvement to reduce accommodation are helpful or necessary.

The issue of format (e.g., whether an intervention is delivered to the family member alone or jointly with the affected individual) must also be a focus of study in order to determine what approach is most effective and acceptable to participants. Research can help to clarify which treatment components might successfully be administered without the individual with PTSD present versus a joint/couple approach. Researchers should consider tracking factors such PTSD symptoms (e.g., anger) and each participants' sense of safety, self-efficacy, and perceived support over the course of unilateral and joint interventions to determine how and for who such interventions might be most helpful.

It is particularly important that such assessment and intervention effectiveness research not only focus on the overall mean outcome from the intervention, but also explore key moderating variables

that can further guide treatment choices. Clinical observations suggest that recommendations for shifting accommodation may differ by trauma/PTSD characteristics (e.g., trauma type, timing of trauma, prominent symptoms) and relationship characteristics (e.g., degree of hostility and support, length, presence of IPV); therefore, it is crucial that researchers thoughtfully explore the impact of these potentially key variables in shifting family accommodation behaviors in PTSD.

Various trauma- and PTSD-related factors could affect accommodation; however, research is needed to determine which variables are relevant and how they influence accommodation. For example, trauma type may affect symptom accommodation. An interpersonal trauma (e.g., sexual assault marked by high levels of self-blame), in comparison with a past motor vehicle accident (MVA), may differentially affect communication patterns (e.g., secrecy, empathic responding) between a couple. Accommodation within a dyad that jointly experienced a MVA may be different than avoidance behaviors in a situation where only one partner experienced the MVA. In the latter case, for example, one partner may take on additional responsibilities with regard to driving, and there may be increased resentment and hostility over time (e.g., "Why can't you just get over it?"). The timing of the event may also affect accommodation behaviors. For example, if a veteran experienced combat trauma before meeting their partner, there may be added barriers to changing behaviors that have existed since the inception of the relationship. Alternatively, family members who have known "before and after versions" of their loved one may be readily able to identify shifts in the family routine and motivated to change said accommodation behaviors. Accommodation may also vary by PTSD symptom presentation, as partners or parents might respond differently to individuals that are more overtly angry than to someone who is predominately anhedonic.

Relationship characteristics may also moderate the frequency and form of accommodation behaviors in PTSD; however, empirical examination is necessary. For example, the degree of accommodation may affect the extent to which an individual feels supported in the relationship; however, this may differentially impact relationship satisfaction among members of the dyad. For example, the individual with PTSD may describe increased satisfaction, whereas the family member may feel resentful, burnt out, and dissatisfied. The length of the relationship could not only affect degree of accommodation but also influence willingness or motivation to engage in an intervention to change accommodation. Hypothetically, a partner in a 30-year marriage may question "what's the point of changing?" whereas a partner in a newer relationship may be more optimistic that the relationship patterns can shift.

Conclusion

Although the well-developed literature in accommodation for OCD and AN offers a starting point for understanding and treating this behavior in PTSD, additional considerations are warranted given PTSD-specific symptoms. In particular, the presence of a Criterion A event, anger, and emotional numbing can differentially impact the family member's experience of PTSD and the characteristics of accommodation-related involvement. Such differences require unique approaches to intervention and further research investigation.

References

Albert, U., Maina, G., Saracco, P., & Bogetto, F. (2006). Multifamily psycho educational intervention (MPI) for obsessive-compulsive disorder: A pilot study. *Epidemiology and Psychiatric Sciences*, *15*(1), 71–76. https://doi.org/10.1017/S1121189X00002050

Amir, N., Freshman, M., & Foa, E. B. (2000). Family distress and involvement in relatives of obsessive-compulsive disorder patients. *Journal of Anxiety Disorders*, *14*(3), 209–217. https://doi.org/10.1016/S0887-6185(99)00032-8

Anastasiadou, D., Medina-Pradas, C., Sepulveda, A. R., & Treasure, J. (2014). A systematic review of family caregiving in eating disorders. *Eating Behaviors*, *15*(3), 464–477. https://doi.org/10.1016/j.eatbeh.2014.06.001

Anderson, L. M., Smith, K. E., Nuñez, M. C., & Farrell, N. R. (2019). Family accommodation in eating disorders: A preliminary examination of correlates with familial burden and cognitive-behavioral treatment outcome. *Eating Disorders*, 1–17. https://doi.org/10.1080/10640266.2019.1652473

Armour, C., Elhai, J. D., Richardson, D., Ractliffe, K., Wang, L., & Elklit, A. (2012). Assessing a five factor model of PTSD: Is dysphoric arousal a unique PTSD construct showing differential relationships with anxiety and depression? *Journal of Anxiety Disorders*, *26*(2), 368–376. https://doi.org/10.1016/j.janxdis.2011.12.002

Aupperle, R. L., Melrose, A. J., Stein, M. B., & Paulus, M. P. (2012). Executive function and PTSD: Disengaging from trauma. *Neuropharmacology*, *62*(2), 686–694. https://doi.org/10.1016/j.neuropharm.2011.02.008

Barrowclough, C., Gregg, L., & Tarrier, N. (2008). Expressed emotion and causal attributions in relatives of post-traumatic stress disorder patients. *Behaviour Research and Therapy*, *46*(2), 207–218. https://doi.org/10.1016/j.brat.2007.11.005

Beckham, J. C., Moore, S. D., & Reynolds, V. (2000). Interpersonal hostility and violence in Vietnam combat veterans with chronic posttraumatic stress disorder: A review of theoretical models and empirical evidence. *Aggression and Violent Behavior*, *5*(5), 451–466. https://doi.org/10.1016/S1359-1789(98)00018-4

Boeding, S. E., Paprocki, C. M., Baucom, D. H., Abramowitz, J. S., Wheaton, M. G., Fabricant, L. E., & Fischer, M. S. (2013). Let me check that for you: Symptom accommodation in romantic partners of adults with obsessive–compulsive disorder. *Behaviour Research and Therapy*, *51*(6), 316–322. https://doi.org/10.1016/j.brat.2013.03.002

Bulik, C. M., Baucom, D. H., & Kirby, J. S. (2012). Treating anorexia nervosa in the couple context. *Journal of Cognitive Psychotherapy*, *26*(1), 19–33. https://doi.org/10.1891/0889-8391.26.1.19

Calvocoressi, L., Lewis, B., Harris, M., Trufan, S. J., Goodman, W. K., McDougle, C. J., & Price, L. H. (1995). Family accommodation in obsessive-compulsive disorder. *The American Journal of Psychiatry*, *152*(3), 441–443. https://doi.org/10.1176/ajp.152.3.441

Campbell, S. B., Renshaw, K. D., Kashdan, T. B., Curby, T. W., & Carter, S. P. (2017). A daily diary study of posttraumatic stress symptoms and romantic partner accommodation. *Behavior Therapy*, *48*(2), 222–234. https://doi.org/10.1016/j.beth.2016.04.006

Clark, D. A. (2004). *Cognitive-behavioral therapy for OCD*. New York, NY: Guilford Press.

Cook, J. M., Riggs, D. S., Thompson, R., Coyne, J. C., & Sheikh, J. I. (2004). Posttraumatic stress disorder and current relationship functioning among World War II ex-prisoners of war. *Journal of Family Psychology*, *18*(1), 36–45. https://doi.org/10.1037/0893-3200.18.1.36

Diehle, J., Brooks, S. K., & Greenberg, N. (2017). Veterans are not the only ones suffering from posttraumatic stress symptoms: What do we know about dependents' secondary traumatic stress? *Social Psychiatry and Psychiatric Epidemiology*, *52*(1), 35–44. https://doi.org/10.1007/s00127-016-1292-6

Drury, H., Ajmi, S., de la Cruz, L. F., Nordsletten, A. E., & Mataix-Cols, D. (2014). Caregiver burden, family accommodation, health, and well-being in relatives of individuals with hoarding disorder. *Journal of Affective Disorders*, *159*, 7–14. https://doi.org/10.1016/j.jad.2014.01.023

Engel, S. G., Wonderlich, S. A., Crosby, R. D., Wright, T. L., Mitchell, J. E., Crow, S. J., & Venegoni, E. E. (2005). A study of patients with anorexia nervosa using ecologic momentary assessment. *International Journal of Eating Disorders*, *38*(4), 335–339. https://doi.org/10.1002/eat.20184

Evans, L., McHugh, T., Hopwood, M., & Watt, C. (2003). Chronic posttraumatic stress disorder and family functioning of Vietnam veterans and their partners. *Australian & New Zealand Journal of Psychiatry*, *37*(6), 765–772. https://doi.org/10.1080/j.1440-1614.2003.01267.x

Fischer, M. S., Baucom, D. H., Kirby, J. S., & Bulik, C. M. (2015). Partner distress in the context of adult anorexia nervosa: The role of patients' perceived negative consequences of AN and partner behaviors. *International Journal of Eating Disorders*, *48*(1), 67–71. https://doi.org/10.1002/eat.22338

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin*, *99*(1), 20–35. https://doi.org/10.1037/0033-2909.99.1.20

Foa, E. B., Riggs, D. S., Massie, E. D., & Yarczower, M. (1995). The impact of fear activation and anger on the efficacy of exposure treatment for posttraumatic stress disorder. *Behavior Therapy*, *26*(3), 487–499. https://doi.org/10.1016/S0005-7894(05)80096-6

Fredman, S. J., Pukay-Martin, N. D., Macdonald, A., Wagner, A. C., Vorstenbosch, V., & Monson, C. M. (2016). Partner accommodation moderates treatment outcomes for couple therapy for posttraumatic stress disorder. *Journal of Consulting and Clinical Psychology*, *84*(1), 79–87. https://doi.org/10.1037/ccp0000061

Fredman, S. J., Vorstenbosch, V., Wagner, A. C., Macdonald, A., & Monson, C. M. (2014). Partner accommodation in posttraumatic stress disorder: Initial testing of the Significant Others' Responses to Trauma Scale (SORTS). *Journal of Anxiety Disorders*, *28*(4), 372–381. https://doi.org/10.1016/j.janxdis.2014.04.001

Futh, A., Simonds, L. M., & Micali, N. (2012). Obsessive-compulsive disorder in children and adolescents: Parental understanding, accommodation, coping and distress. *Journal of Anxiety Disorders*, *26*(5), 624–632. https://doi.org/10.1016/j.janxdis.2012.02.012

Galovski, T., & Lyons, J. A. (2004). Psychological sequelae of combat violence: A review of the impact of PTSD on the veteran's family and possible interventions. *Aggression and Violent Behavior*, *9*(5), 477–501. https://doi.org/10.1016/S1359-1789(03)00045-4

Gerlock, A. A., Grimesey, J., & Sayre, G. (2014). Military-related posttraumatic stress disorder and intimate relationship behaviors: A developing dyadic relationship model. *Journal of Marital and Family Therapy*, *40*(3), 344–356. https://doi.org/10.1111/jmft.12017

Goossens, P. J., Van Wijngaarden, B., Knoppert-Van Der Klein, E. A., & Van Achterberg, T. (2008). Family caregiving in bipolar disorder: Caregiver consequences, caregiver coping styles, and caregiver distress. *International Journal of Social Psychiatry*, *54*(4), 303–316. https://doi.org/10.1177/0020764008090284

Gould, M., Greenberg, N., & Hetherton, J. (2007). Stigma and the military: Evaluation of a PTSD psychoeducational program. *Journal of Traumatic Stress*, *20*(4), 505–515. https://doi.org/10.1002/jts.20233

Grover, M., Naumann, U., Mohammad-Dar, L., Glennon, D., Ringwood, S., Eisler, I., . . . Schmidt, U. (2011). A randomized controlled trial of an Internet-based cognitive-behavioural skills package for carers of people with anorexia nervosa. *Psychological Medicine*, *41*(12), 2581–2591. https://doi.org/10.1017/S0033291711000766

Hoyle, D., Slater, J., Williams, C., Schmidt, U., & Wade, T. D. (2013). Evaluation of a web-based skills intervention for carers of people with anorexia nervosa: A randomized controlled trial. *International Journal of Eating Disorders*, *46*(6), 634–638. https://doi.org/10.1002/eat.22144

Huke, K., & Slade, P. (2006). An exploratory investigation of the experiences of partners living with people who have bulimia nervosa. *European Eating Disorders Review*, *14*(6), 436–447. https://doi.org/10.1002/erv.744

Jakupcak, M., & Tull, M. T. (2005). Effects of trauma exposure on anger, aggression, and violence in a nonclinical sample of men. *Violence and Victims*, *20*(5), 589–598. https://doi.org/10.1891/vivi.2005.20.5.589

Kerig, P. K., & Baucom, D. H. (2004). *Couple observational coding systems*. Mahwah, NJ: Taylor & Francis.

Kessler, R. C. (2000). Posttraumatic stress disorder: The burden to the individual and to society. *The Journal of Clinical Psychiatry*, *61*(Suppl 5), 4–14.

King, D. W., Leskin, G. A., King, L. A., & Weathers, F. W. (1998). Confirmatory factor analysis of the clinician-administered PTSD Scale: Evidence for the dimensionality of posttraumatic stress disorder. *Psychological Assessment*, *10*(2), 90–96. https://doi.org/10.1037/1040-3590.10.2.90

Kirby, A. C., Beckham, J. C., Calhoun, P. S., Roberts, S. T., Taft, C. T., Elbogen, E. B., & Dennis, M. F. (2012). An examination of general aggression and intimate partner violence in women with posttraumatic stress disorder. *Violence and Victims*, *27*(5), 777–792. https://doi.org/10.1891/0886-6708.27.5.777

Lawrence, N. S., Wooderson, S., Mataix-Cols, D., David, R., Speckens, A., & Phillips, M. L. (2006). Decision making and set shifting impairments are associated with distinct symptom dimensions in obsessive-compulsive disorder. *Neuropsychology*, *20*(4), 409–419. https://doi.org/10.1037/0894-4105.20.4.409

Lebowitz, E. R., Omer, H., Hermes, H., & Scahill, L. (2014). Parent training for childhood anxiety disorders: The SPACE program. *Cognitive and Behavioral Practice*, *21*(4), 456–469. https://doi.org/10.1016/j.cbpra.2013.10.004

Lebowitz, E. R., Panza, K. E., & Bloch, M. H. (2016). Family accommodation in obsessive-compulsive and anxiety disorders: A five-year update. *Expert Review of Neurotherapeutics*, *16*(1), 45–53. https://doi.org/10.1586/14737175.2016.1126181

Litz, B. T. (1992). Emotional numbing in combat-related post-traumatic stress disorder: A critical review and reformulation. *Clinical Psychology Review*, *12*(4), 417–432. https://doi.org/10.1016/0272-7358(92)90125-R

Loeb, K. L., Lock, J., Greif, R., & Le Grange, D. (2012). Transdiagnostic theory and application of family-based treatment for youth with eating disorders. *Cognitive and Behavioral Practice*, *19*(1), 17–30. https://doi.org/10.1016/j.cbpra.2010.04.005

Lunney, C. A., & Schnurr, P. P. (2007). Domains of quality of life and symptoms in male veterans treated for posttraumatic stress disorder. *Journal of Traumatic Stress*, *20*(6), 955–964. https://doi.org/10.1002/jts.20269

Meis, L. A., Noorbaloochi, S., Hagel Campbell, E. M., Erbes, C. R., Polusny, M. A., Velasquez, T. L., . . . Spoont, M. (2019). Sticking it out in trauma-focused treatment for PTSD: It takes a village. *Journal of Consulting and Clinical Psychology*, *87*(3), 246–256. https://doi.org/10.1037/ccp0000386

Merlo, L. J., Lehmkuhl, H. D., Geffken, G. R., & Storch, E. A. (2009). Decreased family accommodation associated with improved therapy outcome in pediatric obsessive–compulsive disorder. *Journal of Consulting and Clinical Psychology*, *77*(2), 355–360. https://doi.org/10.1037/a0012652

Meyer, E. C., La Bash, H., DeBeer, B. B., Kimbrel, N. A., Gulliver, S. B., & Morissette, S. B. (2019). Psychological inflexibility predicts PTSD symptom severity in war veterans after accounting for established PTSD risk factors and personality. *Psychological Trauma: Theory, Research, Practice, and Policy*, *11*(4), 383–390. https://doi.org/10.1037/tra0000358

Monson, C. M., & Fredman, S. J. (2012). *Cognitive-behavioral conjoint therapy for posttraumatic stress disorder: Harnessing the healing power of relationships*. New York: Guilford.

Monson, C. M., Fredman, S. J., Adair, K. C., Stevens, S. P., Resick, P. A., Schnurr, P. P., . . . Macdonald, A. (2011). Cognitive–behavioral conjoint therapy for PTSD: Pilot results from a community sample. *Journal of Traumatic Stress*, *24*(1), 97–101. https://doi.org/10.1002/jts.20604

Monson, C. M., Fredman, S. J., & Dekel, R. (2010). Posttraumatic stress disorder in an interpersonal context. In J. G. Beck (Ed.), *Interpersonal processes in the anxiety disorders: Implications for understanding psychopathology and treatment* (pp. 179–208). Washington, D.C.: American Psychological Association.

Monteith, L. L., Gerber, H. R., Brownstone, L. M., Soberay, K. A., & Bahraini, N. H. (2019). The phenomenology of military sexual trauma among male veterans. *Psychology of Men & Masculinities*, *20*(1), 115–127. https://doi.org/10.1037/men0000153

Moulding, R., & Kyrios, M. (2006). Anxiety disorders and control related beliefs: The exemplar of obsessive–compulsive disorder (OCD). *Clinical Psychology Review*, *26*(5), 573–583. https://doi.org/10.1016/j.cpr.2006.01.009

Nelson, B. S., Carter-Vassol, E., Yorgason, J., Wangsgaard, S., & Kessler, M. H. (2002). Single-and dual-trauma couples: Clinical observations of relational characteristics and dynamics. *American Journal of Orthopsychiatry*, *72*(1), 58–69. https://doi.org/10.1037/0002-9432.72.1.58

Olatunji, B. O., Ciesielski, B. G., & Tolin, D. F. (2010). Fear and loating: A meta-analytic review of the specificity of anger in PTSD. *Behavior Therapy*, *41*(1), 93–105.

Pietrzak, R. H., Tsai, J., Harpaz-Rotem, I., Whealin, J. M., & Southwick, S. M. (2012). Support for a novel five-factor model of posttraumatic stress symptoms in three independent samples of Iraq/Afghanistan veterans: A confirmatory factor analytic study. *Journal of Psychiatric Research*, *46*(3), 317–322. https://doi.org/10.1016/j.jpsychires.2011.11.013

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. *Journal of Clinical Psychology*, *71*(4), 302–312. https://doi.org/10.1002/jclp.22166

Ray, S. L., & Vanstone, M. (2009). The impact of PTSD on veterans' family relationships: An interpretative phenomenological inquiry. *International Journal of Nursing Studies*, *46*, 838–847. https://doi.org/10.1016/j.ijnurstu.2009.01.002

Renshaw, K. D., Blais, R. K., & Caska, C. M. (2011). Distress in spouses of combat veterans with PTSD: The importance of interpersonally based cognitions and behaviors. In S. M. Wadsworth & D. Riggs (Eds.), *Risk and resilience in US military families* (pp. 69–84). New York: Springer.

Resick, P. A., Monson, C. M., & Chard, K. M. (2016). *Cognitive processing therapy for PTSD: A comprehensive manual*. New York, NY: Guilford Press.

Reuman, L., & Abramowitz, J. S. (under review). GIV CARE: A group intervention to reduce accommodation among relatives of individuals with fear-based disorders.

Riggs, D. S., Byrne, C. A., Weathers, F. W., & Litz, B. T. (1998). The quality of the intimate relationships of male Vietnam veterans: Problems associated with posttraumatic stress disorder. *Journal of Traumatic Stress*, *11*(1), 87–101. https://doi.org/10.1023/A:1024409200155

Roberts, M. E., Tchanturia, K., Stahl, D., Southgate, L., & Treasure, J. (2007). A systematic review and meta-analysis of set-shifting ability in eating disorders. *Psychological Medicine*, *37*(8), 1075–1084. https://doi.org/10.1017/S0033291707009877

Rosenbaum, A., & Leisring, P. A. (2003). Beyond power and control: Towards an understanding of partner abusive men. *Journal of Comparative Family Studies*, *34*(1), 7–22. https://doi.org/10.3138/jcfs.34.1.7

Salerno, L., Rhind, C., Hibbs, R., Micali, N., Schmidt, U., Gowers, S., . . . Treasure, J. (2016). An examination of the impact of care giving styles (accommodation and skillful communication and support) on the one year outcome of adolescent anorexia nervosa: Testing the assumptions of the cognitive interpersonal model in anorexia nervosa. *Journal of Affective Disorders*, *191*, 230–236.

Sautter, F. J., Armelie, A. P., Glynn, S. M., & Wielt, D. B. (2011). The development of a couple-based treatment for PTSD in returning veterans. *Professional Psychology: Research and Practice*, *42*(1), 63–69. https://doi.org/10.1037/a0022323

Sautter, F. J., Glynn, S. M., Cretu, J. B., Senturk, D., & Vaught, A. S. (2015). Efficacy of structured approach therapy in reducing PTSD in returning veterans: A randomized clinical trial. *Psychological Services*, *12*(3), 199–212. https://doi.org/10.1037/ser0000032

Sepulveda, A. R., Kyriacou, O., & Treasure, J. (2009). Development and validation of the accommodation and enabling scale for eating disorders (AESED) for caregivers in eating disorders. *BMC Health Services Research*, *9*, 1–13. https://doi.org/10.1186/1472-6963-9-171

Sherman, M. D., Perlick, D. A., & Straits-Tröster, K. (2012). Adapting the multifamily group model for treating veterans with posttraumatic stress disorder. *Psychological Services*, *9*(4), 349–360. https://doi.org/10.1037/a0028963

Solomon, Z., Dekel, R., & Zerach, G. (2008). The relationships between posttraumatic stress symptom clusters and marital intimacy among war veterans. *Journal of Family Psychology*, *22*(5), 659–666. https://doi.org/10.1037/a0013596

Spielberger, C. D., Krasner, S. S., & Solomon, E. P. (1988). The experience, expression, and control of anger. In M. P. Janisse (Ed.), *Individual differences, stress, and health psychology* (pp. 89–108). New York: Springer.

Storch, E. A., Geffken, G. R., Merlo, L. J., Jacob, M. L., Murphy, T. K., Goodman, W. K., . . . Grabill, K. (2007). Family accommodation in pediatric obsessive–compulsive disorder. *Journal of Clinical Child and Adolescent Psychology*, *36*(2), 207–216. https://doi.org/10.1080/15374410701277929

Storch, E. A., Zavrou, S., Collier, A. B., Ung, D., Arnold, E. B., Mutch, P. J., . . . Murphy, T. K. (2015). Preliminary study of family accommodation in youth with autism spectrum disorders and anxiety: Incidence, clinical correlates, and behavioral treatment response. *Journal of Anxiety Disorders*, *34*, 94–99. https://doi.org/10.1016/j.janxdis.2015.06.007

Surgenor, L. J., Horn, J., & Hudson, S. M. (2003). Empirical scrutiny of a familiar narrative: Sense of control in anorexia nervosa. *European Eating Disorders Review*, *11*(4), 291–305. https://doi.org/10.1002/erv.499

Taft, C. T., Schumm, J. A., Panuzio, J., & Proctor, S. P. (2008). An examination of family adjustment among Operation Desert Storm veterans. *Journal of Consulting and Clinical Psychology*, *76*(4), 648–656. https://doi.org/10.1037/a0012576

Taft, C. T., Walling, S. M., Howard, J. M., & Monson, C. (2011). Trauma, PTSD, and partner violence in military families. In S. M. Wadsworth & D. Riggs (Eds.), *Risk and resilience in US military families* (pp. 195–212). New York: Springer.

Taft, C. T., Watkins, L. E., Stafford, J., Street, A. E., & Monson, C. M. (2011). Posttraumatic stress disorder and intimate relationship problems: A meta-analysis. *Journal of Consulting and Clinical Psychology*, *79*(1), 22–33. https://doi.org/10.1037/a0022196

Thompson-Hollands, J., Abramovitch, A., Tompson, M. C., & Barlow, D. H. (2015). A randomized clinical trial of a brief family intervention to reduce accommodation in obsessive-compulsive disorder: A preliminary study. *Behavior Therapy*, *46*(2), 218–229. https://doi.org/10.1016/j.beth.2014.11.001

Thompson-Hollands, J., Burmeister, L. B., Rosen, C. S., O'Dougherty, M., Erickson, E. P., & Meis, L. A. (2019). Veterans with poor PTSD treatment adherence: Exploring their loved ones' experience of PTSD and

understanding of PTSD treatment. *Psychological Services*. https://doi.org/10.1037/ser0000389

Thompson-Hollands, J., Kerns, C. E., Pincus, D. B., & Comer, J. S. (2014). Parental accommodation of child anxiety and related symptoms: Range, impact, and correlates. *Journal of Anxiety Disorders*, *28*(8), 765–773. https://doi.org/10.1016/j.janxdis.2014.09.007

Thompson-Hollands, J., Strage, M., DeVoe, E. R., Beidas, R. S., & Sloan, D. M. (2020). Development of a brief adjunctive intervention for family members of veterans in individual PTSD treatment. *Cognitive and Behavioral Practice*. https://doi.org/10.1016/j.cbpra.2020.06.007

Tiggemann, M., & Raven, M. (1998). Dimensions of control in bulimia and anorexia nervosa: Internal control, desire for control, or fear of losing self-control? *Eating Disorders*, *6*, 65–71. https://doi.org/10.1186/s40337-016-0104-4

Timko, C. A., Zucker, N. L., Herbert, J. D., Rodriguez, D., & Merwin, R. M. (2015). An open trial of Acceptance-based Separated Family Treatment (ASFT) for adolescents with anorexia nervosa. *Behaviour Research and Therapy*, *69*, 63–74. https://doi.org/10.1016/j.brat.2015.03.011

Tuerk, P. W., Grubaugh, A. L., Hamner, M. B., & Foa, E. B. (2009). Diagnosis and treatment of PTSD-related compulsive checking behaviors in veterans of the Iraq war: The influence of military context on the expression of PTSD symptoms. *American Journal of Psychiatry*, *166*, 762–767. https://doi.org/10.1176/appi.ajp.2009.08091315

Wildes, J. E., Ringham, R. M., & Marcus, M. D. (2010). Emotion avoidance in patients with anorexia nervosa: Initial test of a functional model. *International Journal of Eating Disorders*, *43*(5), 398–404. https://doi.org/10.1002/eat.20730

Wu, M. S., McGuire, J. F., Martino, C., Phares, V., Selles, R. R., & Storch, E. A. (2016). A meta-analysis of family accommodation and OCD symptom severity. *Clinical Psychology Review*, *45*, 34–44. https://doi.org/10.1016/j.cpr.2016.03.003

Received February 18, 2020
Revision received June 26, 2020
Accepted July 7, 2020 ■