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Anxiety and Relationships: Fear, Communication, and Reciprocal Regulation

Narrative Clinical Review

***Abstract*—**Anxiety and close relationships influence each other through reciprocal patterns of attention, interpretation, behavior, and support. Social anxiety may restrict disclosure and intimacy; generalized worry may recruit repeated reassurance; panic and agoraphobia may narrow shared life; and obsessive-compulsive symptoms may involve partners or relatives in rituals. These responses usually seek short-term relief, yet they can strengthen avoidance and reduce mutuality. This narrative clinical review integrates diagnostic, cognitive-behavioral, interpersonal, and communication-oriented perspectives. Three clinical propositions emerge. First, support should be evaluated by its longer-term function: assistance that restores participation differs from repeated rescue that makes action contingent on another person's response. Second, partner involvement is indicated by an identifiable relational maintenance process, not by diagnosis alone, and requires consent, clear boundaries, and adequate safety. Third, anxiety treatment, relationship repair, and safeguarding are distinct tasks that may require parallel formulations. Assessment should identify the anxiety syndrome, realistic threats, functional impairment, interactional sequences, resources, consent, and safety. Evidence-based individual treatment remains central; selective partner involvement may support exposure, reduce accommodation, clarify boundaries, and restore shared activity. Communication-focused formulation can supplement established care by making threat predictions, needs, choices, and requests explicit and testable. The aim is to preserve agency and connection without making one partner responsible for the other's recovery.

***Index Terms*—**anxiety, relationships, couples, social anxiety, reassurance, accommodation, communication, psychotherapy

I. INTRODUCTION

Close relationships can be both major sources of security and potent contexts for anxiety. A delayed message may be read as rejection; an invitation may evoke fear of scrutiny; a bodily sensation may prompt an urgent request for protection; and disagreement may be interpreted as evidence that the relationship is ending. A trusted person can also help someone tolerate uncertainty, test a prediction, attend treatment, or resume an avoided activity. Anxiety and relationships therefore influence each other: symptoms shape interaction, while the quality and safety of interaction shape symptoms.

Earlier JPPC articles described social anxiety as a constraint on spontaneous communication and argued that anxious responses may organize around avoidance and attempts to obtain certainty (Haverkampf, 2013; Haverkampf, 2017a, 2017b). This accords with literature linking social anxiety to restricted self-disclosure, lower intimacy, and poorer relationship quality, although the effects of emotional expression depend on context (Kashdan et al., 2007; Sparrevohn & Rapee, 2009; Cuming & Rapee, 2010). These are group-level associations, not predictions for an individual relationship. Formulation should identify the particular interactional process rather than infer it from diagnosis.

In this review, relationship refers primarily to intimate partners and, where relevant, relatives or close friends. Reciprocity, boundaries, accommodation, and communication matter across these relationships, while romantic partnerships also involve attachment, sexuality, shared residence, finances, parenting, and long-term decisions. Anxiety models must not obscure actual betrayal, discrimination, incompatibility, violence, or coercive control; apparent hypervigilance may sometimes be an accurate response to danger.

II. SCOPE AND METHOD

This is a narrative clinical review, not a systematic review or treatment guideline. Literature available through 28 February 2023 was considered, prioritizing diagnostic guidance, reviews, controlled treatment research, and studies of anxiety in close relationships. Search concepts included anxiety disorders, social anxiety, generalized anxiety, panic, agoraphobia, relationship satisfaction, intimacy, disclosure, reassurance seeking, accommodation, couple interaction, partner-assisted treatment, exposure, and communication. The

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cited JPPC articles were reviewed directly. Evidence is uneven: social anxiety and obsessive-compulsive family accommodation have been studied more directly than other relational presentations, and many studies are cross-sectional. Causal inferences are therefore limited.

III. A BIDIRECTIONAL SYSTEM

Anxiety alters attention. When threat is expected, ambiguous expressions, silence, or criticism may outweigh signs of warmth. The person may ask what a partner meant, replay an exchange, or monitor shifts in tone. These behaviors can reduce uncertainty briefly, but repeated checking keeps attention fixed on possible threat. The partner may offer further reassurance, become irritated, withdraw, or begin checking in turn. Each response then becomes new information for the other, creating a self-reinforcing cycle.

Close relationships also regulate arousal. A familiar voice, touch, predictable routine, and a history of responsiveness can signal safety; such co-regulation is part of ordinary intimacy, not pathological dependence. Problems arise when one partner can settle only if the other immediately performs a particular act, repeats it despite previous answers, or reorganizes shared life around anxiety. Clinically, the issue is whether support remains flexible, reciprocal, and compatible with each partner's life.

Cross-sectional studies cannot establish whether anxiety precedes relationship difficulty, follows it, or shares causes with it. Longitudinal and observational findings nevertheless support a transactional account: anxiety may constrain disclosure, warmth, and constructive conflict; negative or unpredictable interaction may heighten threat anticipation; and both may be shaped by depression, attachment history, financial stress, illness, discrimination, or trauma. In a daily-process study of 33 couples in which the wife had an anxiety disorder, wives' anxiety was associated with both partners' relationship quality, and accommodation strengthened the association between wives' anxiety and husbands' distress (Zaider et al., 2010). These group findings do not determine the experience of any particular couple.

Epidemiologic reviews show that anxiety disorders are common and often begin early, but they do not predict the course of an individual relationship (Kessler et al., 2005; Bandelow & Michaelis, 2015). Models of anticipatory uncertainty and defensive responding can help explain reciprocal vigilance within a broader psychological and relational formulation (Grupe & Nitschke, 2013; LeDoux & Pine, 2016).

Table 1. Common anxiety–relationship cycles (author-developed narrative synthesis; nonvalidated)

Starting condition	Anxious response	Partner response	Immediate effect	Possible longer-term cost
Unanswered message	Repeated messages, status checks, catastrophic interpretation	Provides immediate reassurance or becomes less responsive	Brief certainty or restored contact	More monitoring, resentment, and reduced tolerance of ordinary delay
Fear of negative evaluation	Avoids disclosure, eye contact, affection, or social events	Takes over, guesses, or reads distance as disinterest	Less exposure to feared judgment	Reduced intimacy and apparent confirmation of inadequacy
Panic sensations	Requests escape, accompaniment, or medical checking	Cancels plans or remains continuously available	Rapid fall in distress	Shared life contracts and bodily sensations remain feared
Persistent worry	Reviews adverse possibilities and asks for guarantees	Debates each scenario or dismisses the worry	Temporary engagement or shutdown	More hypothetical discussion; less problem-solving
Obsessive doubt	Seeks certainty or asks others to participate in rituals	Answers, checks, cleans, or avoids triggers	Brief reduction in anxiety	Accommodation strengthens the compulsive rule
Conflict sensitivity	Withdraws, appeases, or escalates to force resolution	Pursues, criticizes, or withdraws in return	Conflict pauses or forced reassurance follows	Issues remain unresolved; future disagreement feels more dangerous

IV. SOCIAL ANXIETY, INTIMACY, AND DISCLOSURE

Social anxiety centers on anticipated scrutiny, humiliation, rejection, or visible inadequacy. Dating and partnership involve repeated moments of evaluation: initiating contact, expressing attraction, tolerating silence, meeting friends, discussing sexuality, disagreeing, and revealing needs. Because connection matters, the perceived stakes may be especially high. Haverkampf (2013) described how fear of others' judgments can restrict communication even when closeness is desired.

People with social anxiety may speak less, over-rehearse, conceal preferences, use alcohol before social contact, avoid eye contact, or monitor their performance during interaction. Self-focused attention reduces access to information that might revise the threat prediction, so a neutral pause may later be remembered as evidence of failure. Kashdan et al. (2007) found that the relational effects of expressing or withholding negative emotion varied by social anxiety and context.

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Participants with social phobia also reported less self-disclosure, emotional expression, and intimacy than controls (Sparrevohn & Rapee, 2009). These findings identify modifiable processes—concealment, safety behaviors, and restricted approach—rather than an absence of relational capacity.

Daily-process research further links social anxiety to differences in positive emotion and everyday social experience, indicating that assessment should extend beyond visible distress (Kashdan et al., 2013). Sexual activity and satisfaction may also be affected by social anxiety, depressive symptoms, avoidance, and self-monitoring, although direction and personal meaning require individual assessment (Kashdan et al., 2011).

Intimacy depends on disclosure that is both genuine and appropriately paced. Persistent postponement prevents a partner from responding to actual preferences and needs, while indiscriminate disclosure may disregard context and boundaries. Treatment can support graded, values-consistent disclosure and observation of its consequences. Success is defined by flexible participation, not flawless performance or certainty about evaluation.

Safety behaviors warrant close attention. Rehearsing an opening sentence may be a practical aid; memorizing every line and refusing to speak unless it can be delivered exactly may prevent learning that spontaneous imperfection is tolerable. Asking a partner to speak on one's behalf may be appropriate in a crisis but limiting as a default. Cuming and Rapee (2010) associated higher social anxiety with less self-disclosure and, among women, indirectly with poorer romantic relationship quality. The finding supports attention to self-protective communication in formulation, but does not show that symptom improvement alone will repair relationship functioning.

A. ***Dating-specific decisions***

Dating entails genuine uncertainty: interest may not be reciprocated, compatibility may be absent, and rejection remains possible. Therapy cannot promise a desired response, but it can distinguish controllable actions—sending a respectful invitation, listening, stating a boundary—from outcomes outside the person's control. A useful behavioral experiment tests a specific prediction, such as “If I pause, the other person will think I am incompetent,” rather than the global demand “Make this date go well.” Outcomes may include remaining present, expressing one genuine preference, and recovering after discomfort.

Digital communication adds read receipts, online status, profile metrics, and abundant alternatives, all of which may invite monitoring. Rather than prescribing a universal messaging rule, assessment should determine whether checking provides actionable information or repeatedly regulates distress without resolving uncertainty. Mutually agreed expectations about frequency and urgency can reduce ambiguity, provided the agreement does not become a ritual whose breach is treated as catastrophic.

V. **GENERALIZED WORRY AND REASSURANCE**

Generalized anxiety often enters relationships as chains of hypothetical questions about finances, health, work, children, or the relationship itself. Some concerns permit planning; others cannot be solved because the missing element is certainty about the future. Partners may spend long periods arguing against each feared outcome, yet no argument can prove that an uncertain event will never occur. Relief therefore fades and a new variation appears.

Reassurance is not inherently maladaptive. A new medical symptom, an unclear plan, or a misunderstanding may require information. Its function becomes clinically important when the same question returns despite a clear answer, the required certainty escalates, or action is postponed until the partner removes all doubt. Refusing every request in the name of treatment can feel abandoning; answering every iteration can exhaust the partner and maintain the cycle. A negotiated response can validate distress, refer to an agreed coping plan, answer genuinely new information once, and decline repetitive certainty-seeking.

Validation without endorsing the feared conclusion (author-developed summary; nonvalidated)

- Acknowledge the experience: “I can see that the uncertainty is frightening.”
- Clarify whether the request is for information, comfort, practical help, or a guarantee.
- Provide relevant new information once and state honestly what remains uncertain.
- Support one chosen action: wait, make one call, follow the care plan, or return to the present task.
- Avoid prolonged debate over each hypothetical possibility.
- Review the strategy after arousal subsides and revise it collaboratively.

Irritability may be an underrecognized expression of chronic anxiety. A worried person can sound controlling while trying to prevent an adverse outcome; after repeated cycles, the partner may sound dismissive. Slowing the exchange can reveal the concern beneath the command: “Leave now” may express fear of lateness and judgment; “Stop asking” may express an inability to provide the certainty being sought. Identifying the underlying concern supports negotiation without excusing disrespect.

VI. **PANIC, AGORAPHOBIA, AND SHARED RESTRICTION**

Panic attacks may recruit a partner urgently. The partner may drive, remain on the telephone, check pulse or breathing, accompany every journey, or arrange rapid escape. New,

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atypical, severe, or medically concerning symptoms require appropriate assessment. After recurrent panic or agoraphobia has been assessed and relevant medical causes considered, however, guaranteed rescue can impede independent exposure. Shared life may then contract around safe routes, nearby exits, and activities the support person can attend.

Partner support can be incorporated into an evidence-based plan. The clinician, patient, and partner can agree what constitutes an emergency, which language supports the exposure rationale, when the partner will remain present, and when independent practice is expected. The partner should neither intensify exposure secretly nor prevent escape by force. Exposure must be collaborative and graduated, with learning about sensations, uncertainty, coping, and feared outcomes—not compliance with a partner-imposed test—as its purpose.

Haverkampf (2017a) examined anxiety and panic through communication-focused questions about how internal sensations and external messages acquire meaning. This perspective may clarify why a particular setting becomes threatening, but it should supplement rather than replace disorder-specific cognitive-behavioral treatment and guideline-informed medication decisions. Communication hypotheses should remain testable elements of formulation, not explanations imposed on the patient.

VII. OBSESSIVE-COMPULSIVE SYMPTOMS AND ACCOMMODATION

Obsessive-compulsive symptoms can reorganize household life. Relatives may wash, check, answer questions, avoid words, change routes, or wait while rituals are completed. Accommodation usually begins as compassionate help: it lowers visible distress and allows the day to continue. Repetition may nevertheless reinforce the belief that danger is intolerable unless the ritual is completed, while resistance can provoke conflict as the required procedure expands.

Consistent with exposure-and-response-prevention principles, accommodation may be reduced gradually, by agreement, and as part of diagnosis-specific treatment rather than as punishment. This is a reasoned clinical extrapolation in this review; it does not establish the independent efficacy of a partner-led protocol. Abrupt refusal without preparation may increase distress and conflict, while continued participation may undermine treatment. The patient retains ownership of goals. A partner can support an agreed plan, recognize effort without demanding immediate calm, and maintain reasonable household boundaries. Escalating anger, coercion, or risk requires safety assessment and specialist input.

Comparable accommodation occurs outside OCD. A relative may make every telephone call for a person with social anxiety or cancel all travel because of panic. The relevant distinction is functional and longitudinal: does assistance meet a temporary need while increasing autonomy, or does action become contingent on its continued provision? Disability, culture, and practical resources must be considered before help is judged excessive.

VIII. ATTACHMENT, LEARNING, AND INTERPRETATION

Attachment concepts can illuminate expectations of availability, rejection, and self-worth, but are often applied too broadly. An attachment-style questionnaire does not explain an entire relationship, and anxious behavior during a stressful period does not establish a fixed identity. Developmental experience may shape predictions, while current relationships can provide new learning. Formulation should specify what the person expects in this relationship, the evidence for that expectation, and the behavior it organizes.

Learning occurs through interaction. Mockery following vulnerable disclosure makes later concealment understandable. Repeated pursuit and reassurance after withdrawal may give withdrawal a regulatory function. Disagreement followed by repair can make future conflict less threatening. These contingencies locate opportunities for new learning without assigning moral blame.

Cognitive biases also have interpersonal effects. Threat-focused attention may privilege one frown over repeated signs of support; interpretation bias may turn “I need quiet” into “I no longer love you”; memory may preferentially retrieve earlier rejection. Cognitive restructuring can examine alternatives, but the partner should not be recruited into continuous thought disputation. Independent evaluation of evidence and tolerance of residual ambiguity remain important. Threat-biased attention, intolerance of uncertainty, and experiential avoidance therefore provide testable process hypotheses for checking, withdrawal, and constrained disclosure (Cisler & Koster, 2010; Carleton, 2016; Hayes et al., 1996).

IX. SEXUALITY, AFFECTION, AND BODILY ANXIETY

Anxiety can affect desire, arousal, orgasm, pain, body image, and the ability to remain present during intimacy. Performance monitoring shifts attention from sensation and connection to evaluation, while fear of rejection may inhibit either initiating or declining contact. Medication, depression, trauma, medical illness, menopause, pregnancy, pain, and relationship conflict may also contribute and require assessment.

Sexual communication should be specific, consensual, and free from pressure. No exposure rationale justifies unwanted sexual activity. When chosen, safe, and clinically appropriate, an appropriately trained clinician may consider non-demand

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affection, discussion of preferences, attention shifting, or sensate-focus exercises. This is a practice-based extrapolation rather than anxiety-specific efficacy evidence in the studies reviewed here. Clinicians should not assume heterosexuality, monogamy, a particular gender role, or a universal meaning of sexual frequency.

Bodily sensations during intimacy can resemble anxiety sensations. Palpitations, warmth, breathlessness, and a sense of losing control may be interpreted as danger. Psychoeducation can normalize this overlap while respecting medical warning signs and trauma responses. Clinical success is greater freedom to choose, communicate, consent, and experience closeness rather than achievement of a prescribed level of sexual activity.

X. CONFLICT, WITHDRAWAL, AND REPAIR

Anxiety may produce pursuit, appeasement, defensiveness, or withdrawal. One partner may press for immediate resolution because delay feels catastrophic, while the other needs a pause because arousal impairs thinking. Without an agreement, pursuit confirms the need to escape and withdrawal confirms the fear of abandonment. A structured pause can interrupt this cycle when it includes a credible time for return; indefinite disappearance cannot serve the same regulatory function.

During conflict, the first question is whether either partner can process information effectively. High arousal narrows attention and favors habitual responses, so a brief, agreed pause may need to precede problem-solving. On returning, each partner can describe the observable event, its meaning, the associated emotion, a need or boundary, and one specific request. Global claims—"you always," "you never," or "if you cared"—make clarification and repair more difficult.

Repair extends beyond reassurance. It may require acknowledgment of impact, responsibility for behavior, a concrete change, and time. Anxiety provides context but does not remove accountability; accountability need not deny anxiety. "I was frightened and spoke harshly; the fear explains the urgency but does not make the words acceptable" holds both elements together.

Table 2. Translating anxious interaction into assessable communication (author-developed narrative synthesis; nonvalidated)

Surface behavior	Possible function to assess	Clearer message	Boundary-preserving response
Repeated questioning	Seeking certainty, closeness, or permission	"I want reassurance, although I know no answer can remove all doubt."	Provide new information once; support the agreed plan for uncertainty
Withdrawal	Avoiding evaluation, conflict, or overwhelming arousal	"I am overloaded and need twenty minutes. I will return at 19:30."	Respect the bounded pause; address non-return separately
Control of plans	Preventing lateness, panic, embarrassment, or unpredictability	"Unexpected changes raise my anxiety; can we agree what is flexible?"	Negotiate useful predictability without surrendering autonomy
Appeasement	Preventing rejection or anger	"I disagree and fear that saying so will damage us."	Invite a genuine preference and tolerate difference
Irritability	Expressing threat under cognitive load	"I am worried about the bill and need a plan, not a guarantee."	Set limits on hostility while engaging the solvable problem
Partner takeover	Reducing distress or keeping life moving	"I can help with the first step, but I do not want to replace your action."	Define the support, transfer of responsibility, and review point

XI. ASSESSMENT

Assessment begins with the anxiety presentation rather than a generic relationship label. The clinician asks what is feared, when symptoms began, how often they occur, what is avoided, which safety behaviors are used, and how work, sleep, health, and social life are affected. Differential diagnosis should consider social anxiety disorder, generalized anxiety disorder, panic disorder, agoraphobia, OCD, trauma-related disorders, depression, substance use disorders, neurodevelopmental conditions, medical illness, and medication effects (American Psychiatric Association, 2022; National Institute for Health and Care Excellence, 2020).

Relationship assessment then maps sequence: what occurred before anxiety rose, which prediction appeared, how each partner responded, and what changed over the next minute and the next week. The same behavior can serve different functions. A telephone call may be ordinary connection, an agreed safety check, or compulsive reassurance; frequency alone does not distinguish them.

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Each partner should be able to describe the cycle without receiving a fixed role. Separate interviews may be needed to assess violence, coercive control, stalking, sexual coercion, financial restriction, or fear of retaliation. Joint work is unsafe when a person cannot speak freely or disclosures may be used against them. Abuse requires safeguarding and specialist domestic-abuse support, not negotiation in couple therapy.

Relationship distress should not automatically be attributed to anxiety. Incompatibility, infidelity, unequal labor, discrimination, poverty, caregiving burden, chronic pain, infertility, or bereavement may be central. Conversely, exclusive attention to relationship content can obscure a treatable anxiety disorder. Diagnostic, functional, relational, medical, and social formulations should therefore proceed in parallel rather than compete for a single explanation.

Table 3. A dyadic assessment map (author-developed narrative synthesis; nonvalidated)

Domain	Questions	Why it matters
Symptoms and diagnosis	Which syndrome, duration, severity, impairment, comorbidity, substance use, medication effects, and medical contributors are present?	Treatment and risk management differ by diagnosis
Threat and meaning	What exactly is predicted about self, partner, or future? What would it mean if it occurred?	Turns diffuse anxiety into testable propositions
Individual response	Which avoidance, checking, reassurance, rumination, appeasement, escape, or overpreparation occurs?	Identifies short-term relief and longer-term maintenance
Partner response	Does the partner offer comfort, debate, takeover, criticism, withdrawal, accommodation, or collaborative support?	Shows how the cycle continues or changes
Relationship resources	What warmth, humor, repair, shared values, practical support, and successful coping are available?	Prevents a deficit-only formulation
Context and equity	How do workload, money, housing, care responsibilities, culture, discrimination, health, and power shape the problem?	Locates realistic stress and unequal constraints
Safety	Are violence, coercion, stalking, sexual pressure, self-harm, intoxication, or fear of disclosure present?	Determines whether joint work is appropriate
Preference and consent	Does each partner want involvement, and what information may be shared?	Preserves autonomy and confidentiality

XII. TREATMENT PLANNING

Treatment should follow diagnosis, formulation, severity, preference, and risk. Evidence-based individual cognitive-behavioral treatment, including exposure when indicated, remains central for anxiety disorders (Carpenter et al., 2018). Pharmacotherapy may also be appropriate within disorder-specific, guideline-informed care (National Institute for Health and Care Excellence, 2020). Partner involvement is an adjunct when a clinically relevant interactional process has been identified and both partners consent; it should neither delay effective individual treatment nor imply that the partner is responsible for recovery.

A treatment plan can address three linked targets: the patient's symptoms and maintaining behaviors, the responses exchanged between partners, and valued activities lost from shared life. For panic, interoceptive and situational exposure may be paired with a partner response that does not guarantee rescue. For social anxiety, attention work and behavioral experiments may include graded disclosure and shared activity. Worry-focused CBT may set limits on repetitive reassurance, while OCD treatment may combine exposure and response prevention with planned reduction of family accommodation.

Goals should be behavioral and observable. “Be less anxious” is difficult to coordinate; “attend one meal without asking whether I embarrassed myself,” “take the train for two stops while my partner remains available only for a genuine emergency,” or “discuss the budget for twenty minutes and record decisions rather than reviewing catastrophes all evening” can be monitored. Anxiety may initially rise as safety behavior decreases, and both partners should understand that temporary discomfort does not by itself indicate treatment failure.

*A. **Psychoeducation for both partners***

Shared psychoeducation can reduce blame. The anxious partner is not choosing physiological arousal, and the other partner is not uncaring because certainty cannot be supplied. A functional model explains how short-term relief can reinforce avoidance or reassurance and clarifies the distinction between support and accommodation. Support helps the person approach a chosen goal or tolerate emotion; accommodation primarily reorganizes another person's behavior to reduce anxiety, often reinforcing avoidance or compulsive rules.

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The distinction is contextual and temporal. Driving someone to a first appointment may enable treatment; driving every short route indefinitely because panic is assumed dangerous may maintain avoidance. Proofreading an important application once may be collaborative; proofreading every message until no doubt remains may reinforce a compulsive standard. Across these examples, support increases the person's capacity to act over time, whereas accommodation makes action increasingly contingent on another person's anxiety-reducing response.

Partners also require workable limits. Chronic anxiety may affect sleep, spontaneity, finances, sexuality, social life, and caregiving; compassion and fatigue can coexist. A planned boundary is safer than assistance continued until resentment erupts. The boundary should describe the partner's own action rather than attempt to control emotion: "I will discuss the test result after the appointment, but I will not search the internet with you repeatedly tonight."

B. ***Exposure and behavioral experiments***

Exposure is most useful when it tests a feared prediction or builds willingness to experience uncertainty while pursuing meaningful action. Contemporary inhibitory-learning accounts emphasize variability, expectancy violation, and learning that can coexist with residual fear (Craske et al., 2014). A partner may help identify safety behaviors, support entry into the situation, and review observations afterward, but should not become the safety signal without which exposure is considered impossible.

Before an exercise, the person states the prediction, the action, the safety behaviors to be reduced or omitted, and the partner's role. During the exercise, the partner avoids repeated reassurance unless the agreed plan includes brief coaching. Afterward, both review what occurred rather than judging success only by anxiety reduction. Expressing a preference while visibly nervous, for example, may constitute a successful social-anxiety experiment despite an imperfect interaction.

Couple-based experiments can also test communication predictions. A person who expects respectful disagreement to end the relationship might undertake a bounded discussion in which each partner states a different preference and, if needed, returns after a planned pause. The relevant learning is that difference can be expressed, survived, understood, and repaired; disappearance of conflict is not required.

C. ***Reassurance reduction***

Reassurance reduction works best as a protocol agreed outside acute distress. The couple identifies repetitive questions, specifies which information will be answered once, chooses a validating phrase, and defines an alternative action. The person seeking reassurance practices naming and delaying the urge; the partner practices warmth without entering a prolonged attempt to prove safety. Brief records can show whether distress rises and subsides without another answer.

Rigid non-reassurance can itself become unhelpful. New facts deserve discussion, and legitimate relationship questions require honest answers. Where trust has been broken, requests for information cannot automatically be labeled anxiety. The clinician must distinguish compulsive certainty-seeking from accountability and repair.

D. ***Individual, couple, and family formats***

Individual treatment provides privacy and direct symptom work. Couple or family sessions can reveal interactional patterns, align responses, and restore shared activities. A blended format may be practical: individual assessment and core treatment, with selected joint sessions for psychoeducation, accommodation, communication, or relapse planning. Confidentiality arrangements should be explicit, especially when the clinician sees more than one person.

Evidence for partner-assisted or couple-enhanced approaches varies by problem. Individual CBT has a larger evidence base than relationship interventions, whose components and populations differ. A cancer-dyad review reported improvements in communication, intimacy, satisfaction, and some psychosocial outcomes, but mainly Western oncology findings cannot establish efficacy for anxiety disorders or couples generally (Zhou et al., 2023). Partner involvement is therefore best treated as a process-based indication: it is warranted when a specific interaction maintains symptoms or obstructs recovery, the relationship is sufficiently safe, both partners consent, and progress can be measured.

XIII. COMMUNICATION-FOCUSED FORMULATION

Anxiety-related information is processed within the individual and exchanged between partners. A communication-focused formulation asks which signal anxiety amplifies, how each person interprets the other's behavior, which need or boundary remains difficult to express, and which responses restrict or expand new information. Haverkampf (2017a) proposed Communication-Focused Therapy (CFT) as a framework for examining such exchanges. Because it is author-developed, CFT should supplement rather than displace established cognitive-behavioral treatment.

The formulation can be organized as a six-step communication map: (1) observable event ("No reply for two hours"); (2) interpretation ("I am being abandoned"); (3) action tendency (repeated messages, withdrawal, or accusation); (4) message actually transmitted, perhaps urgency or anger rather than vulnerability; (5) the partner's interpretation and response; and (6) a clearer message with a proportionate request ("The silence triggered fear. I know you may be busy; could we discuss our usual expectations later?").

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The map does not determine whether the relationship is secure; it separates observation, prediction, emotion, action, and request so that each can be assessed.

Internal communication also matters. Bodily arousal may be translated as "danger," an intrusive image as "intention," or uncertainty as "proof." Within a safe therapeutic relationship, dialogue can help the patient notice these translations, voice difficult material, and hold interpretations as hypotheses. The same process may clarify what is communicated to a partner. This approach is compatible with cognitive restructuring, exposure, acceptance-based work, and relational inquiry, but does not assume that every symptom conceals a message or every disagreement reflects failed communication.

XIV. **TRUST, JEALOUSY, AND RELATIONSHIP UNCERTAINTY**

Relationship anxiety is not necessarily irrational. Trust rests partly on observed reliability, honesty, and repair, so the clinician should establish what occurred before treating checking as a symptom. After deception, requests for information may be part of accountability and repair. In the absence of new evidence, however, repeated checking that never produces durable certainty may be maintained by anxiety.

Jealousy ranges from ordinary emotion to obsessive checking, delusional conviction, stalking, coercion, and violence. Assessment should cover belief strength, evidence, behavior, substance use, access to a partner's devices, threats, and capacity to tolerate separation. Couple work is unsafe when either person cannot decline surveillance or speak freely. Delusional or violent presentations require appropriate psychiatric assessment and risk management.

Relationship-focused obsessive doubt may involve repeated checking of feelings, comparison of partners, certainty-seeking about compatibility, or confession of every internal fluctuation. Although the content concerns the relationship, the maintaining process may be obsessive-compulsive. Specialist OCD assessment and, when indicated, exposure and response prevention may be more appropriate than repeated compatibility analysis. This is a disorder-specific clinical extrapolation rather than efficacy evidence established by the relationship studies reviewed here.

Attachment insecurity may heighten sensitivity to ambiguity, but attachment language should not become a total explanation or accusation. The label "anxiously attached" can imply a fixed defect and obscure a partner's actual inconsistency. A more useful formulation identifies the current prediction and asks which response would generate reliable information while preserving boundaries.

Trust repair and anxiety treatment address different mechanisms. Trust repair builds warranted confidence through truthful disclosure, responsibility, changed behavior, and time. Anxiety treatment reduces checking or analysis that cannot create certainty. The two processes may proceed in parallel, but neither can substitute for the other.

XV. **WHEN INDIVIDUAL WORK SHOULD COME FIRST**

Joint sessions are not always the appropriate starting point. The patient may need privacy to disclose obsessions, trauma, sexuality, substance use, or uncertainty about the relationship. Severe panic or social anxiety may require individual assessment and initial skills work before a complex joint exchange. The partner may also need independent support for burden or safety.

Individual work is particularly important when the patient does not want partner involvement, confidentiality cannot be managed, one person dominates the session, or the relationship itself is being evaluated. Consent may be revisited later; partner involvement is neither obligatory nor evidence of commitment.

When joint work occurs, the clinician should not treat the partner merely as a source of collateral information. The partner's well-being and autonomy matter, while the patient remains the identified patient unless the contract is explicitly for couple therapy. Clear policies on the client, goals, records, and separately disclosed information help prevent ethical confusion.

XVI. **RESPONDING TO AN ACUTE ANXIETY EPISODE TOGETHER**

Acute anxiety is a poor setting in which to devise a response policy. A couple benefits from a plan agreed when both can think clearly. The plan distinguishes familiar anxiety from new medical or safety concerns, identifies the first response, and limits improvised reassurance. It should also specify when the partner needs sleep, work, or distance and which other supports can be contacted.

During a familiar episode, the partner can orient the person to the present, speak calmly, ask which part of the plan applies, and support one chosen action. Repeatedly arguing that everything is safe is often unhelpful when no new warning sign is present. "I can see this is intense; shall we follow the ten-minute plan or contact the clinician if this feels different?" validates distress while preserving choice.

The patient can name the help requested: presence, transport, one factual answer, assistance with a coping card, or emergency evaluation. A specific request reduces guessing and disappointment when the wrong form of help is offered. It remains negotiable; a partner is not required to provide unlimited availability.

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Review should wait until arousal has settled. The pair can then ask which response addressed genuine risk, which produced only brief relief, and what should change. Because repeated debriefing can itself become reassurance, a scheduled review may be more informative than continuous analysis.

Table 4. Acute dyadic response plan (author-developed narrative synthesis; nonvalidated)

Situation	Patient action	Partner action	Escalation
Familiar anxiety with no new warning sign	Name the feared outcome and choose the agreed coping step	Validate, remain briefly if agreed, and avoid repeated reassurance	Review later if episodes become more frequent or impairing
Panic during planned exposure	Continue or modify the exercise according to the exposure plan	Coach within the exposure rationale without guaranteeing rescue	Stop for a genuine medical or safety concern
Urge for reassurance	Ask once for the agreed support or delay the question	Give new information once and warmly decline repeated analysis	Review the protocol with the clinician if conflict increases
New or atypical physical symptom	Describe what differs rather than assuming the symptom is panic	Support appropriate medical triage	Use urgent or emergency services according to local guidance
Threat of self-harm, violence, or inability to maintain safety	Communicate the risk if able and move toward safety	Do not manage the risk alone or accept responsibility under coercion	Contact emergency, crisis, or safeguarding services

This plan should never require a partner to diagnose an emergency. Local clinical guidance and individualized medical advice take precedence. Its purpose is to reduce confusion around familiar anxiety while preserving a direct route to appropriate care.

XVII. SAFETY AND ETHICS

Anxiety does not make coercion acceptable. Threats of self-harm to prevent separation, surveillance, control of money or movement, sexual pressure, and intimidation require risk assessment. A partner should not be asked to conduct exposure without consent, withhold needed medication, ignore medical emergencies, or endure abuse. Joint therapy may be contraindicated when power and safety prevent honest participation.

Suicidal thinking, severe depression, substance use disorders, psychosis, mania, escalating aggression, and severe self-neglect require appropriate assessment and escalation. Anxiety may coexist with any of them. Relationship-focused intervention must not obscure the need for individual care or emergency action.

Therapists must also maintain role boundaries. A partner is not a co-therapist and should not be expected to monitor every behavior. The patient controls which clinical information is shared, within legal and safety limits. When a clinician treats both partners, consent, record access, policies on separately disclosed information, and conflicts of interest should be discussed before difficult material arises.

XVIII. RELAPSE PREVENTION AND OUTCOME

Outcome assessment should cover symptom change and recovery of everyday life. Relevant indicators include independent travel, social participation, sleep, sexual choice, division of responsibilities, time spent in reassurance cycles, capacity to disagree, and return to valued shared activities. Relationship satisfaction should be measured separately from anxiety because their trajectories may differ; greater honesty may initially produce more conflict as avoidance declines.

Relapse planning identifies early signs such as increased checking, narrowed plans, partner takeover, concealment, alcohol use before social contact, or urgent demands for certainty. The plan specifies each partner's response, when professional support will be sought, and which situations require medical or safety assessment. A lapse provides information rather than proof that all progress has been lost.

Maintenance also requires experiences not organized around symptoms. When every conversation concerns anxiety, the relationship can become an extension of treatment. Ordinary pleasure, affection, friendship, individual interests, and shared projects restore identities beyond patient and helper and form part of the life that treatment is intended to reopen.

XIX. LIMITATIONS AND RESEARCH NEEDS

Much relationship research relies on self-report and cross-sectional designs. Samples may underrepresent diverse cultures, relationship structures, severe comorbidity, and unsafe relationships. Diagnostic groups are heterogeneous, and an associated interaction pattern cannot establish why a particular couple is struggling. Trials of partner involvement also differ in format, therapist training, comparators, and outcome measures, limiting general conclusions.

The communication-oriented synthesis offered here is clinically plausible but has not been validated as a mechanism across anxiety disorders. It should generate observable hypotheses and be discarded when it does not fit. Priorities for research include identifying who benefits from partner involvement, reducing accommodation without increasing conflict, clarifying the effects of digital monitoring, and

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adapting interventions to disability, minority stress, and varied relationship forms.

XX. **CONCLUSION**

Anxiety and close relationships influence one another through reciprocal patterns of anticipation, avoidance, reassurance, and support. Help should be judged by what it does over time: effective support expands the anxious person's capacity to act, whereas accommodation may make action increasingly dependent on another person's response. Partner involvement is appropriate when a specific interaction maintains symptoms or obstructs recovery, both partners consent, and adequate safety and boundaries are in place. Because anxiety treatment, trust repair, and safeguarding address different mechanisms, they may need parallel formulations. Evidence-based individual care remains central, with selective joint work used to support exposure, reduce accommodation, clarify communication, or restore valued shared activity without making either partner responsible for the other's recovery.

XXI. **DISCLOSURES**

Conflicts of interest—The author developed Communication-Focused Therapy and has related publications. It is identified here as an author-developed supplementary framework and is not presented as a replacement for established evidence-based treatment. No other conflicts were reported.

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XXII. **REFERENCES**

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