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Couple-based Interventions in the Treatment of Adult Anorexia Nervosa: A Brief Case Example of UCAN

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Abstract

Adult anorexia nervosa (AN) is a serious and often fatal illness that significantly erodes quality of life for both the patient and loved ones. Treatment of adults with AN has focused largely on individual therapy, with recent findings suggesting that improvement is limited and dropout rates are high. In an effort to improve treatment response, we developed a couple-based intervention, Uniting Couples in the treatment of Anorexia Nervosa (UCAN) as an adjunct treatment to standard multidisciplinary care. UCAN leverages the support of a partner and the relationship in treatment by decreasing avoidance around AN, teaching the couple how to effectively address the eating disorder, and helping to foster a more satisfying relationship. This paper presents a case study of a couple who completed UCAN, "Laura and Steve", including their experiences in treatment and outcome measures at pretest, posttest, and three-month follow-up. Laura showed clinically significant change on the Restraint subscale of the EDE at follow-up, and both partners showed clinically significant improvements in relationship satisfaction, as well as on self-reported and observed communication. Both partners reported very high satisfaction with the treatment. A discussion of therapists' experiences in delivering UCAN is provided, including common challenges for therapists with primarily a couple therapy or an individual CBT for eating disorders background, as well as important factors for therapists to consider in order to optimally leverage the benefits of including partners in treatment for AN.

Couple-based Interventions in the Treatment of Adult Anorexia Nervosa: A Brief Case Example of UCAN

Effective treatment options for adults with anorexia nervosa (AN) remain extremely limited (Berkman et al., 2006; NICE, 2004). Treatment for adolescents with AN commonly involves the family (e.g., Lock, 2002), and family members are observed to provide adolescents with essential motivation and support for recovery. As empirical data indicate that adults with AN frequently enter into committed relationships (Maxwell et al., 2011), the possible utility of including these family members in treatment should be considered. Couples in which one partner has AN experience specific problems with sexual functioning, relationship distress,

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and problems with communication (e.g., Bulik, Baucom, & Kirby, 2012b; Pinheiro et al., 2010). Despite these interpersonal complications, partners can provide an important source of support for recovery from AN (Bulik, Baucom, et al., 2012b; Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2003).

Our treatment program Uniting Couples (in the treatment of) Anorexia Nervosa (UCAN; Bulik, Baucom, & Kirby, 2012a; Bulik, Baucom, et al., 2012b; Bulik, Baucom, Kirby, & Pisetsky, 2011) is a couple-based intervention that addresses the above challenges. UCAN integrates cognitive-behavioral therapy (CBT) for AN and cognitive-behavioral couple therapy (CBCT; Epstein & Baucom, 2002) to capitalize on supportive relationships with a partner in a developmentally appropriate fashion. UCAN is not designed to be the sole line of intervention; rather, it is offered as an augmentation treatment along with individual therapy, nutrition counseling, and medication management, providing the multidisciplinary care the patient needs given the severity and complexity of AN. CBCT targets relationship functioning by teaching partners communication and problem-solving skills, helping to enhance understanding of relationship interactions, and addressing emotions in an adaptive manner (Epstein & Baucom, 2002).[1]

Preliminary results of the pilot study of UCAN are promising in terms of weight gain and low dropout rate (Bulik, Baucom, Kirby, & Pisetsky, 2012). The purpose of this case presentation is to demonstrate possible mechanisms of change and core interventions in UCAN with a couple that underwent this treatment program – “Laura” and “Steve.”

Mechanisms of Change in UCAN

The effects of UCAN are proposed to be due to the treatment procedures facilitating three broad mechanisms of change. A common characteristic of AN is the “cloud” of secrecy, deceit, and withdrawal surrounding the disorder, which constitutes a relational problem in itself, and also undermines a couple's ability to work as a team to address AN (Schmidt & Treasure, 2006). Therefore, a primary goal of UCAN is to *bring AN out in the open to be addressed by the couple rather than being a solitary and secretive disorder* (mechanism 1). UCAN interventions also *help the couple to work as a team in a variety of ways to address AN* (mechanism 2). Furthermore, relationship difficulties can serve as chronic stressors exacerbating AN, and AN can be a stressor negatively influencing relationship quality (Bulik et al., 2011). Therefore, we address overall relationship functioning within UCAN as needed in order to *reduce relationship distress as a chronic source of stress for the patient in order to facilitate recovery from AN* (mechanism 3).

UCAN treatment procedures

The following four main interventions are illustrated in this brief case presentation.

1. Psychoeducation is a crucial step in beginning to bring AN out in the open (mechanism 1) and sets the stage for the partner to be a well-informed, sensitive

[1]For a more detailed presentation of the case, see the *Casebook of Evidence-Based Therapy for Eating Disorders*, Thompson-Brenner (Ed.), 2015. The relevant chapter by Fischer, Kirby, Raney, Baucom, and Bulik (2015) is presented more briefly in this special section, with additional material concerning therapist experience. See also Epstein and Baucom (2002) for a detailed discussion of CBCT; and Baucom, Epstein, Kirby, and LaTaillade (2015) for an introductory overview of couple-based interventions.

member of the recovery team (mechanism 2). Furthermore, if the partner is able to correctly attribute symptoms and behaviors to AN (rather than an inherent trait of the patient), this may increase understanding, decrease relationship distress in the partner, and reduce conflict, criticism, and hostility (mechanism 3).

2. Communication training facilitates couples' sharing their thoughts and feelings with each other, along with developing strategies for making effective decisions. More open, skillful communication about AN counters secrecy surrounding AN (mechanism 1), enables the couple to work together more effectively to address ED-related issues (mechanism 2), and helps to improve the couple's overall relationship quality (mechanism 3). Discussing the issues related to AN helps the partner understand the patient's experience, and builds empathy. It is crucial that partners learn to respond in a non-punishing manner in order to create a safe, reinforcing environment for the patient to talk about her or his experiences.

3. Addressing eating-disordered (ED) behavior. A substantial proportion of the treatment is spent helping the couple to address ED behavior in a practical way (mechanism 2). The partner helps to promote healthful eating and exercise, and to change unhelpful couple interaction patterns. For example, partners may move from trying to monitor and control patient's behaviors to problem-solving around how to respond if ED behaviors occur.

4. Body image, sexuality, and affection are often areas of significant difficulty. Body dissatisfaction can lead to shame, disgust, and discomfort with being touched. Problems in sexual functioning secondary to malnutrition are also common. Partners often do not understand the patient's withdrawal and feel rejected. By addressing these issues and working towards a mutually satisfying physical and sexual relationship, UCAN counters the pattern of withdrawal and isolation around AN (mechanism 1) and promotes relationship satisfaction (mechanism 3).

5. Relapse prevention. In the final sessions, the therapist and couple discuss what to expect for recovery, remaining areas that need to be addressed, and how the couple will continue to work on the areas described above as a team. What is unique in this context is that these discussions explore possible slips and relapses focal to (a) the patient's eating-disordered behaviors and related symptoms, as well as (b) the couple's approach to addressing the disorder.

Method

Participants[2]

The therapist, Dr. Kirby, was a Caucasian 32-year-old female clinical psychologist with extensive background in couple therapy and training in the treatment of AN. The couple,

[2]Prior to assessment and therapy, the couple provided written informed consent to participate in the study, including consent for therapy sessions to be recorded. Prior to the publication of this case, the couple signed a separate informed consent for their data and session content to be published individually, including excerpts of session transcripts. Their names and identifying information have been changed to protect their confidentiality.

Laura and Steve, presented for treatment eager for help with Laura's eating disorder (ED). Both partners were Caucasian, college educated, and worked as professionals. Laura was in her early 40s and Steve in his late 30s. They had been married for 15 years and had two children when they began UCAN treatment. Both partners were warm, friendly, and talkative. Despite the love and commitment they felt toward each other, they described struggling to connect emotionally and to refrain from arguing, most frequently about Laura's ED as well as the demands of children, home, and finances. In arguments they often raised their voices and made hurtful criticisms and judgments. Apart from arguments about overt ED symptoms such as restricting and binge eating, Laura and Steve had never talked about some of the more internal, private experiences Laura had surrounding the ED, such as the extent of her body dissatisfaction and shame about her ED-related behaviors. This left the couple feeling distant, and Steve struggled to understand why Laura could not simply “quit” her ED behaviors.

Laura presented to the UCAN treatment trial after achieving weight restoration in residential, individual, and group therapy. Intensive treatment had been disruptive to the family, with Steve having to take on a full load of caregiving tasks alongside his full time employment. Steve had been supportive of her recovery, but he struggled with each slip because he was afraid that they were “going back to square one” or that “treatment isn't working.” Laura blamed herself for the family disruptions and their financial difficulties, adding to her guilt and shame. Despite Steve's extensive efforts, he felt he could not help Laura to see how wonderful and beautiful she was. He described “hating the disease” and, as a result, lashing out at Laura due to his frustration that she was not improving quickly enough. Laura felt that Steve's glowing evaluations did not conform to her own reality or to his more negative communications. The couple reported general difficulty communicating effectively about Laura's AN.

When she started UCAN, Laura continued to experience significant eating disorder symptoms. Her initial diagnosis was AN, binge/purge subtype; at the UCAN intake, although recently weight restored, she continued to experience strong urges to restrict and self-harm, binge eating, severe body dissatisfaction, and general low self-esteem. Laura continued with individual therapy and psychiatric care while participating in UCAN.

Procedure

Assessment and treatment—After the couple consented to treatment, trained clinicians conducted structured clinical interviews and collected self-report measures at intake, termination, and three-months follow-up. The couple received 20 conjoint UCAN treatment sessions, each lasting 60-75 minutes. All sessions were audio- and video-taped for study and supervision purposes. Dr. Baucom reviewed all sessions, which were then discussed in weekly group supervision with Drs. Kirby, Baucom, and Bulik. After treatment and follow-up were completed, Laura and Steve were contacted by Dr. Bulik, who explained the purpose and content of the current case report. Both partners consented to the use of their data and session recordings. For the purpose of this case report, selected session recordings were transcribed by a research assistant and checked for accuracy by a graduate student.

Excerpts of session transcripts were selected to demonstrate core interventions and proposed mechanisms of change.

Analyses—Clinically significant change analyses were applied as described by Jacobson and Truax (1991), and defined by reliable improvement and crossover from the clinical into the normal range. Reliable improvement was assessed using the reliable change index (RC; Jacobson & Truax, 1991). For some of the measures, cutoffs and RC could not be calculated due to a lack of available norms, and only descriptive data are provided for these measures.

Measures

Eating disorder symptoms—The Eating Disorders Examination (EDE; Fairburn, Cooper, & O'Connor, 2008) is a standardized interview assessment used to assess ED pathology and establish a diagnosis. Nonclinical normative data were obtained from Fairburn et al. (2008) and clinical normative data from Darcy et al. (2012) on the four subscales and the Global Score: Dietary Restraint (nonclinical $M = .94$ ($SD = 1.10$), clinical $M = 2.24$ ($SD = 1.52$)), Eating Concern (nonclinical $M = .27$ ($SD = .59$), clinical $M = 1.46$ ($SD = 1.52$)), Shape Concern (nonclinical $M = 1.34$ ($SD = 1.09$), clinical $M = 2.47$ ($SD = 1.91$)), and Weight Concern (nonclinical $M = 1.81$ ($SD = .93$), clinical $M = 2.32$ ($SD = 1.78$)), as well as a Global Score (nonclinical $M = .93$ ($SD = .81$), clinical $M = 2.23$ ($SD = 1.60$)). Test-retest reliability ranges from $r = .71$ - .76 (Rizvi, Peterson, Crow, & Agras, 2000).

Relationship factors—The Dyadic Adjustment Scale – 4 (DAS - 4; Sabourin, Valois, & Lussier, 2005) is a widely used, valid and reliable self-report measure of relationship satisfaction. Norms are available from a community sample (women $M = 15.81$ ($SD = 3.45$), men $M = 15.96$ ($SD = 3.23$)) and from couples receiving couples therapy (clinical norms, women $M = 10.18$ ($SD = 3.48$), men $M = 10.41$ ($SD = 3.38$)), reliability is $r = .87$ for men and $r = .83$ for women (Sabourin et al., 2005). A version of the Brief Index of Sexual Functioning (BISF; Mazer, Leiblum, & Rosen, 2000; Taylor, Rosen, & Leiblum, 1994) revised for the purpose of the study (R-BISF) was used to measure the self-reported frequency of sexual thoughts/desire and activity, arousal, pleasure, and problems affecting sexual functioning in both partners. Norms for the R-BISF are not available. The Problem-Solving Communication subscale of the Marital Satisfaction Inventory-Revised (MSI-R; Snyder, 1997) assessed self-reported quality with problem-solving communication; norms are available for nonclinical ($M = 47.3$ ($SD = 9.4$)) and clinical ($M = 62.5$ ($SD = 7.8$)) groups, with test-retest reliability $r = .82$ (Snyder, 1997). The Couples Interaction Rating System (CIRS; Heavey, Gill, & Christensen, 2002) is an observational coding system assessing whether partners engage, avoid, or withdraw, accept, and attempt to influence each other, based on 10-minute conversations completed at each assessment. For thee videotaped interactions, the couple was asked to share their thoughts and feelings about an aspect of the patient's AN. The CIRS allows computation of total scores for Demand and Withdraw, unpublished norms based on a large clinical trial of couples therapy were obtained for these scores (B. Baucom, personal communication, September 20, 2012). Test-retest reliability was not available.

Treatment evaluation—The couple completed a 10-item service evaluation questionnaire at the post-assessment with a 4-point Likert scale and questions such as “How would you rate the quality of UCAN?” and “To what degree did UCAN help you and your partner support each other through the anorexia nervosa experience?” Normative data are not available for this questionnaire.

Results

Treatment Description

Initial Phase of Treatment—The focus of early sessions was making sure that the couple had a consistent and accurate understanding of AN and of each other's personal experience of the disorder. In addition, treatment focused on building the couple's understanding of their adaptive and maladaptive interactions around AN, and enhancing their communication patterns. Initial UCAN sessions were spent assessing Laura's AN-related thoughts, feelings, and behaviors, along with her overall low self-worth. For example, Laura frequently engaged in all-or-nothing thinking, seeing certain foods as “good” or “bad”, or her progress in treatment as insufficient because she was not yet fully recovered. Also, she reported binge eating in the car on her way home from work or when Steve was out of the home. Psychoeducation concerning the symptoms of AN that Laura experienced and the variable nature of the course, treatment, and recovery process from AN were presented in a manner that engaged both partners and addressed both partner's concerns that Laura was not progressing quickly enough (i.e., recovery from AN is not linear, it is a trial of ups and downs). By providing this information to the couple jointly and engaging in shared dialogue, a safe and supportive context was created for Laura to disclose her AN-related experiences and for Steve to more effectively understand Laura's struggles. In this way, detailed and tailored psychoeducation helped to bring Laura's AN out of “hiding” (mechanism 1) and provided Steve with a better appreciation of AN-related symptoms. This set the stage for them to work more effectively as a team in the UCAN treatment (mechanism 2).

Communication Training—To bolster the couple's ability to work as a team (mechanism 2) and have a more satisfying relationship overall (mechanism 3), the next phase of UCAN treatment addressed the couple's communication. These sessions introduced the couple to well-established communication guidelines regarding: (a) how to be open and share their emotional experiences with one another in a subjective, effective manner as well as how to listen actively to each another, and (b) how to make decisions effectively as a team (Epstein & Baucom, 2002). The therapist worked hard to help Laura share her feelings more freely and to assist Steve in accepting and trusting Laura's disclosures—communication strategies that were challenging for both of them. The following transcript reflects one of Laura and Steve's early, in-session discussions of Laura's struggles stemming from AN and illustrates the therapist working to foster Laura's disclosures by shaping Steve's responses. The therapist directs the couple to follow the guidelines for sharing thoughts and feelings, such as remaining in their respective roles (speaker/listener), with the listener focused only on understanding and accepting what the speaker is saying, and reflecting this understanding by summarizing the main points.

LAURA: But I also feel very humiliated when I don't have a job because of the reasons that I don't have a job (*looks down*). I'm embarrassed that three times now I've screwed up (*looks up*). And I feel like a failure to you because I'm not pulling my weight financially and you're having to do that. And it's frustrating to me that the issues that I'm causing for the family and for you are tangible because there is no money coming in. Therefore all that entails is tangible, and you can see it…And you can't see what's in my head, you can't see how I'm, what I'm up against and what I am trying to surmount. Because it's not a tangible thing. It's not like I've broken my leg and you can see that I can't work. Okay? And I also feel frustrated when I feel like my saying that it is difficult for me to overcome some of these things is automatically taken as if I'm embracing the disease and I can't work and I'm disabled. That's not what I'm saying…My efforts are probably not as fast as you, you need them to be, but I am trying. My goal is to find some way that I can take care of my responsibilities without going nuts and be able to take care of the kids, you, the house, everything, *and* work and keep my stability.

(…)

THERAPIST: Steve, what are some main things that she is telling you? I know that there was a fair amount in there, but tell her what she is telling you. Not whether or not you agree with it or disagree with it, or comment on it.

STEVE (*to therapist*): I hear what she is telling me. It's not that I don't agree or disagree.

THERAPIST: Yes, but tell her what she is telling you.

STEVE (*to Laura*): I hear what you're telling me. I hear that you say that.

THERAPIST (*interrupting*): What is that?

STEVE: I hear you say that … I agree that you're, that that is frustrating for me and stuff. And I agree (*sighs and stops*).

THERAPIST: What's it like for her? How is she doing with this?

STEVE: (*to therapist*) She's not doing well with it. Okay, (*to Laura*) and I understand that you aren't doing well with it. Okay? … (*to therapist*) It's hard because you say you don't have to agree with it, okay? It's not that I don't agree with what she said, it's that I don't believe it.

THERAPIST: Mm, that means you're—that's the part about working on accepting it. That's it. That's good that you're articulating that, because that's important for us to know…what you are saying about trust. You know that in terms of things that either Laura has said or done in the past or whatever or the eating disorder and the patterns you guys have gotten into, that it is hard for you to believe or know what you can believe.

(…)

STEVE: It really is.

THERAPIST: But you know what you told me last time was that you don't check, you don't follow her to the bathroom anymore. That you're not checking on her food intake anymore, because you're letting go of some of that.

STEVE: Yeah. (*foot twitching*)

THERAPIST: And maybe this is going to be … the next step in that? When she's telling you this is my internal experience, and this is not the eating disorder talking, this is me talking about my battle with the eating disorder, and my work on trying to make a healthy life for me and you and the family. This is it. I think maybe the next step is you practice believing that.

STEVE: That's going to be hard. (*folds arms behind head*)

THERAPIST: I know, I know, but, look, we can do it in little bits, you know?

This transcript reflects how the UCAN treatment utilized communication training as a key process by which the couple was assisted in bringing AN out in the open (mechanism 1) and enhancing their ways of communicating and relating more broadly in the relationship (mechanism 3). The goal was not that the couple be in agreement or that each person only communicated positive statements to the other individual; instead, it was critical that the couple be open, honest, and respectful regarding the AN and its implications.

Addressing eating-disordered behavior—The next phase of UCAN focused on helping Laura and Steve approach specific AN-related challenges as a team (mechanism 2). They discussed developing a plan for food purchase and preparation, improving the experience of meals at home and in social situations, and incorporating higher risk foods back into the home. For example, the couple had disagreed about “binge foods” being in the home as Steve believed it was too risky, and Laura wanted to practice being around these foods without binge eating (i.e., can she have Oreos in the home without eating the entire package). Using their decision-making skills, the couple developed a plan in which certain high risk foods would be kept in the home, and they would frequently check-in with each other regarding Laura's ability to tolerate these foods being in the home without binge eating. These conversations allowed Laura to continue being open about her ED (mechanism 1) while Steve worked on being supportive and non-judgmental in response; thus, the couple developed collaborative approaches to aid in Laura's recovery (mechanism 2).

Body image concerns, sexuality, and affection—The final domains that the couple addressed in UCAN related to Laura's negative body image, the struggles the couple had with their physical relationship, and their difficulty communicating effectively around these domains. Laura felt reluctant to share the extent of her body dissatisfaction and negative self-image, which in part was due to Steve's responses that she was “beautiful; the most wonderful woman in the world” and that he “couldn't understand why she didn't just see that.” Laura reported having little interest in sexual intimacy; Steve described feeling as if he was negotiating to have sex with Laura and was consistently rejected by her. By helping the couple discuss experiences they typically avoided, Laura's AN-related struggles were brought out into the open (mechanism 1); the couple felt more connected as a team against

the ED (mechanism 2), and the connection and effective communication promoted closer and more hopeful feelings as a couple (mechanism 3).

These influences can be seen in the following transcript from near the end of treatment. The couple had just concluded a discussion of the difficulties in their physical relationship, described briefly above. The therapist checked in with both partners regarding their thoughts on just having had this conversation, one they would usually avoid. This exchange led the couple to discuss extremely private topics about intimacy and sexuality that they had never discussed with each other in the many years they had been together. The interlude was a turning point in therapy, especially for Steve, who felt he had gained a whole new appreciation of who his wife was.

THERAPIST: It's a lot, isn't it? How are you doing talking about all this?

LAURA: I feel like I'm gonna puke *(buries her face in her hands)*.

THERAPIST: Okay.

STEVE: Why? I mean…

LAURA: I don't mean that I want to puke, I just feel gross.

STEVE: I know, I know. You just feel gross, but you wanna know what I think? I think you're doing great. Ha ha, honestly.

THERAPIST[3]: Tell her a bit more about what it's been like for you.

STEVE: It's the most I've ever heard you talk about this, and *(hesitates)*

THERAPIST: And? What is that like for you?

STEVE: And it's like there's lightening; it makes me feel good; it makes me get to know you in ways that I've never known you before, and I thought I knew you.

(…)

THERAPIST: Here's the thing that I want us to really look at, and then we'll bring this session to a close and we'll take a break. Okay? You've started, you two together have been sharing different feelings, complex feelings, uncomfortable feelings, and you've really taken that lead in there, Laura, and shared all that. And what I really want … Steve to say again, what it was about what you just shared, about what it's like for you to hear this from her. (*To Laura*) Because it's hard, I know there's that part of you that just wants to "Oh, stop, close it down, run away." This is uncomfortable, and you are really in there, coming through the other side of this conversation. And Steve wants to tell you how much this means to him that you did that. And I want you to hear that and then we'll wrap up, okay?

[3]Therapists working in other theoretical orientations might hear Laura's reference to "puking" while talking about intimacy and note a possible connection between eating disorder symptoms and the subject matter. In UCAN, however, the focus here was on facilitating communication between the couple, and the therapist uses the opportunity to create a different, more positive experience of open communication.

(…)

STEVE: All right, I love you; I do love you. This is great, okay? This is great because I'm getting to know you in ways that I never knew you before, and we've been together for eighteen years…I'm not gonna be judgmental with you …I really do wanna know your feelings…Like we've said, you don't have to agree with my feelings, just like I don't have to agree with yours. You don't have to agree with my feelings, but I am biased, and I do think you are a beautiful and loving and caring, kind-hearted girl. *(Reaches over, pats Laura's knee)* I love you.

Relapse prevention and termination—The relapse prevention sessions focused on a number of areas. For example, Laura and Steve discussed how they would handle situations in which Steve suspects that the eating disorder is driving particular behaviors (e.g., wanting to exercise), but Laura perceives the behavior to be healthy. In these situations, they agreed to share their expectations and concerns with one another directly, rather than resume arguing or avoiding potentially sensitive conversations. In their final session, Steve and Laura reflected on their experience in UCAN. Laura stated that they had learned to make decisions, and "now they are the team they always were but couldn't be." She said understanding Steve's feelings about intimacy had been very important. Steve said he learned to "listen, listen, listen," and that he did not have to agree with Laura's feelings but needed to acknowledge them. The couple was noted they felt more united in their work against the ED and more satisfied with their broader relationship.

Outcome Measures

Tables 1 and 2 show Laura and Steve's scores on the outcome measures and indices of clinically significant change on measures for which adequate normative data were available. These empirical findings largely reflect the more subjective presentation provided above. Laura maintained her weight over the study period. Her score on the Restraint subscale of the EDE dropped from pretest to 3-months follow-up and went below the cutoff into the normal functioning range, this was a clinically significant decrease as well. Despite improvement, changes on all other EDE scores were not reliably improved, and not significantly different from scores of patients with current AN (see Table 1).

In terms of relationship functioning, both Laura and Steve's scores on the DAS-4 (overall relationship adjustment, Table 1) increased beyond what would be expected by chance, and both crossed well past the cutoff for non-distressed couples (13), indicating clinically significant change into high relationship satisfaction. Scores on problem-solving communication (MSI) were reliably improved at follow up for both partners, and Steve's scores also crossed into the normal range (see Table 1). Demand behaviors for Laura and Withdraw behaviors for both partners also crossed into the healthy range; reliable improvement could not be tested due to lacking psychometric data (see Table 1).

Sexual functioning scores for both Laura and Steve are shown in Table 2. Both partners demonstrated improvement. Steve reported considerably higher sexual satisfaction and functioning than Laura. The largest increase in scores for Laura was "Pleasure/Orgasm," indicating that sexual activities had become more enjoyable.

Treatment Evaluation from the Couple's Perspective

Laura and Steve's responses on the evaluation questionnaire were very positive, with all responses at a 3 or 4 on the 4-point scale, resulting in an average rating of 3.7 from Steve and 4.0 from Laura. Both partners rated the overall quality of UCAN as “excellent”, and both said that UCAN helped them to deal with AN “a great deal” more effectively (scores of 4).

Laura and Steve volunteered to share the following comments with a professional audience years after the treatment had ended:

STEVE: And there is a massive amount prior to UCAN, there is a massive amount of mistrust on my part, okay? “She's going to the bathroom; she's going to purge. I've got to stop this; I've got to do something,” okay? And I would literally follow her to the bathroom. And what UCAN did was, UCAN taught us to therapeutically be able to communicate, to list the thoughts and feelings about what is going on. And be able to get the trust factor back to where I trust Laura enough now for her to say, “Hey, there is a problem; I need help. Let's talk about this.”

LAURA: And he'll come back with, you know, “Okay you're saying that you are feeling fat; let's talk about it, or that must really be awful to feel that way.”

(…)

LAURA: It's really been a life-saver. It helped me realize that other people were involved in this, and other people were feeling the effects of it, not just me… I think it helped Steve separate the disease from me, and I really appreciated that… [The eating disorder] is still there, but even now when my “evil twin” gets tweaked a little bit about things, I can see now what is at stake. And that keeps me from falling back into it.

Conclusion

Laura and Steve presented to UCAN as a loving and caring couple who were experiencing significant distress due to Steve's worry and frustration surrounding Laura's AN and its treatment, their difficulties communicating about and addressing Laura's AN effectively, and, more generally, their intense arguments and feelings of disconnection. Through their participation in UCAN, the couple gained a shared understanding of AN and the recovery process; they brought the AN out of “hiding” through repeated discussions of both partners' experiences of AN and they learned to work more effectively as a team in Laura's recovery. More broadly, Laura and Steve discovered that they could experience negative emotions and face difficult experiences together as a couple, as evident by their discussions of the challenges in their sexual relationship, using their relationship as a source of support. Laura and Steve's experiences and progress, as shown in the qualitative data and empirical findings, hopefully serve to demonstrate the proposed benefits and mechanisms of the UCAN treatment.

Therapist Comments[4]

For individual therapists trained in the treatment of eating disorders, learning to become a UCAN couple therapist can bring a number of challenges and rewards. Switching from the role of individual therapist to couple therapist requires a significant paradigm shift; addressing the eating disorder from a couples' perspective as adopted in UCAN consists of facilitating the couple's understanding and addressing of the eating disorder as a team rather than targeting the patient's eating disorders symptoms more directly. For example, if the patient were struggling with negative body image, the therapist could focus on helping him or her share these struggles in a clear and subjective manner (versus stating them as absolute truths such as, “I am fat, disgusting, etc.”) so that the partner can better understand and empathize with the patient's feelings. The goal would be increased acceptance from the partner facilitating the patient in feeling less isolated and overwhelmed by the negative feelings. This is an important outcome for the patient but would also facilitate the couple's ability to address the patient's struggles with body image more effectively. Notably, the therapist does not have the patient evaluate his or her thoughts or feelings, but helps to share them in the best way that he or she can. (This couple approach does not mean that the patient's distorted cognitions are ignored. Given that our comprehensive treatment includes individual therapy as well, these issues are more likely addressed in individual therapy).

For individual therapists well versed in eating disorders treatment learning to do UCAN, the pull to address the eating disorder directly rather than focusing on the couple dynamic can be quite strong. They may worry or feel frustrated that they are not intervening on the psychopathology present in the room (i.e., the patient's eating disordered thoughts). With extensive couple therapy training and ongoing supervision, therapists are able to adopt a couple's mindset, seeing the role of the relationship dynamics in the patient's recovery more clearly, and readily identifying opportunities in session to shift the couple's interactions so that they can work as a team more effectively. For example, rather than target the patient's all-or-nothing thinking present in the statement of “No one cares about me anyway, so why do I need to get better?”, the UCAN therapist can help the patient express her feelings of loneliness and insecurity to her partner, and assist the partner in understanding the patient and expressing his own feelings of care and concern for her. With such experiences and continued training, the UCAN therapist appreciates more fully how building the communication, respect, and closeness a couple experiences can create a more effective context for the patient's recovery, and is able to rely more comfortably on the patient's individual therapist to address the eating disorder more directly.

Once fully trained and adept in the role of UCAN therapist, addressing the eating disorder from this perspective can be highly rewarding. First and perhaps most importantly, preliminary results suggest that having the partner involved in UCAN significantly reduces treatment drop-out, which is not only a detrimental result for the patient but also for the therapist. Having an ally (i.e., the partner) in keeping the patient coming to treatment is a

[4]Editor's note: As part of the special section on approaches to improving the treatment of AN, the authors were requested to write a section reflecting on the experience of treating patients with AN using the innovative adjunct approach, including the particular quality of the relationship, and particular satisfactions and challenges relative to customary treatment approaches.

huge advantage and may be one of the fundamental mechanisms through which UCAN operates—we can't succeed in treating patients with anorexia nervosa if they do not come to treatment. With the partner engaged as a member of the team, the couple therapist also has the benefit of their support, motivation, and accountability relative to keeping the patient engaged in the therapeutic process and commitment to recovery. As in family based treatment of eating disorders in which parents provide collateral reports and offer structure and support, partners can provide significant insight into success and challenges during the week, and often facilitate behavior change. Rather than relying solely on the patient's report, the UCAN therapist is able to talk directly with the partner and observe the couple interact in session, gaining a more accurate and richer understanding of the patient's relationships and home environment. In addition, the therapist can utilize the partner as a readily available safety net and support for the patient in between sessions. This not only helps the patient maintain treatment gains but also helps calibrate the therapist's concerns about the patient's progress. For example, if a patient is demonstrating an ongoing pattern of weight loss, the treatment team might consider admitting the patient to a higher level of care. The UCAN therapist is well situated to work with the couple to address this critical situation in hopes of avoiding the treatment transition and interruption of UCAN. By bringing the partner into the discussion, the couple, UCAN therapist, and full treatment team are better equipped to respond to this critical juncture in the patient's care.

UCAN couple therapists also report it to be particularly rewarding to be able to address the eating disorder from within its interpersonal context in real time. In comparison to individual therapy where session time can be mostly spent processing what occurred or will occur in the inter-session intervals, UCAN therapy, like family therapy, focuses on within-session dynamics such as helping the couple better understand and support each other during the recovery process. For example, couples who have presented for UCAN treatment have commonly avoided discussions of difficult topics for fear of conflict or upsetting one another. For the members of our UCAN team with expertise in couple therapy (co-authors JK, MF, and DB), the extent of this avoidance has been surprising and at times shocking. For example, one of our first UCAN couples who had been married for >20 years had their very first conversation about the eating disorder on the way to admitting the patient into the hospital despite the fact that her eating disorder had been active for the entire duration of their marriage (i.e., the couple never ate meals together and this was simply part of their routine). Once in UCAN, this same couple struggled to discuss what we (as couple therapists) would perceive to be a very mild relationship topic, stating that was it the hardest conversation they had ever had as a couple. By working with this couple and many others like them, we (the couple therapy members of the team) now have a much richer appreciation of the communication challenges present in couples facing anorexia nervosa.

This extensive avoidance of addressing difficult topics and how it factors into the maintenance of the patient's eating disorder is a primary target of the UCAN treatment. By actively guiding a couple with an avoidant style through the steps of talking with one another more openly and directly in session, the therapist has the opportunity to directly influence a chronic, maladaptive interaction pattern that may contribute both to the eating disorder and to couple distress, and in so doing observe steps toward recovery occurring in real time. Patients often report this process to be very frightening in the beginning, but many

comment on how important this process has been to them by the end of treatment. Addressing these dynamics within session requires the therapist to be fully present, nimble, quick, and focused in the room—a demanding experience that can also be incredibly rich and stimulating.

These same rewards can pose challenges for a UCAN therapist. The therapist must balance two people's needs and experiences concurrently while managing the dynamics between them, and addressing psychopathology that may be present in either partner (including but not limited to the eating disorder). This requires the ability to conceptualize and choose directions quickly and the ability to tolerate demanding and often emotional sessions. If one's personal style is not a good fit for such work, the UCAN therapist can find him or herself feeling drained and overwhelmed. However, if the fit is right, training and supervision is strong, and great emphasis is put on ongoing case conceptualization, therapists seem to navigate these challenges quite well.

Effective UCAN therapy, like all good couple therapy, consists of a strong therapeutic alliance between the therapist and each partner, but the most important alliance in the room is between the members of the couple. Fostering the alliance between the partners is a primary emphasis of UCAN and represents the scaffolding upon which all the eating disorder-related interventions are built. The UCAN therapist demonstrates a warm, respectful, and accepting manner toward each partner; this approach is both implicitly and explicitly modeled to the couple in hopes that they will treat each other similarly. By emphasizing the importance of accepting each other's experience (although not necessarily agreeing with it) and making room for subjectivity rather than aiming toward finding one objective truth, the therapist creates a safe therapeutic milieu that allows both partners to feel validated and understood. While this is an important component to any couple therapy, this takes a particularly central role in UCAN given how differently the two partners often perceive many issues related to anorexia nervosa (e.g., body image). They are then encouraged to incorporate these principles into their communication and ways of relating in general. The safety and acceptance exhibited by the UCAN therapist supports the couple as they take risks of being more open and vulnerable with one another, and try new ways of interacting around the eating disorder and within their relationship in general.

Maintaining a therapeutic alliance with the couple most commonly becomes challenging when the patient, partner, and/or clinical team have noncongruent treatment goals. Frequently, the patient is ambivalent about changing eating disordered behaviors, whereas the partner presents as more eager to delve into this work while still being apprehensive about how to do this without upsetting the patient. As the UCAN therapist focuses on helping the couple address the eating disorder, the patient may feel anxious and outnumbered in the room, and may balk at specific treatment suggestions (i.e., the patient is to begin eating around others more often and attending a family reunion cook-out is proposed). To avoid such a dynamic, it is imperative that the UCAN therapist work closely with the patient's individual therapist and dietitian who are setting regular treatment goals with the patient. Ideally, the patient experiences UCAN as “coming alongside” or supporting her or his efforts in these other treatment modalities, and thus less threatening (i.e., knowing

that family gatherings are very stressful, can the couple eat at a restaurant so the patient is challenged to eat around others but not overwhelmed by the exercise).

Although often ambivalent towards addressing the eating disorder, the patient is frequently more committed to improving the relationship with her or his partner. The patient's desire to have a more open and intimate connection with the partner can increase buy-in relative to the UCAN therapy and to eating disorder treatment as a whole. More specifically, patients commonly report wanting their partners to share their feelings more openly—a major goal for both patients and partners within the UCAN framework. With the aid of communication skills training, the couple is assisted in sharing their thoughts (including fears, concerns, wishes) and feelings about the eating disorder, and the patient hears firsthand as the partner articulates deep fears about the fact that the patient is very ill and may even die. Listening to these concerns being voiced in such a vulnerable manner can be a significant motivator for the patient to engage more fully in recovery. Thus, UCAN helps enhance the patient's engagement in treatment, encourages the partner to be more open, and helps the couple to be less avoidant of addressing the eating disorder. By balancing both partners' treatment needs (e.g., the partner is learning how to help the patient, and the patient is developing a more fulfilling relationship with her partner), the UCAN therapist can successfully navigate and typically prevent strain to the therapeutic alliance despite the patient's reluctance to change eating disordered behaviors.

Working with both partners toward recovery in UCAN has created a perspective shift within the treatment team in conceptualizing their work with adults with anorexia nervosa. One of the authors (TR) and a senior therapist on our team reflects, “I know that when I began conducting family based therapy for adolescents, it became hard to imagine treating teens without involving their family. I feel the same way now about couple therapy—we can't expect the extent of change that is needed without involving one of the most influential people in the patient's life. And why would we ask a patient to engage in something as challenging as eating disorder treatment without facilitating support from the person who cares most?”

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References

Baucom, DH., Epstein, NB., Kirby, JS., LaTaillade, JJ. Cognitive behavioral couple therapy. In: Gurman, AS.Lebow, JL., Snyder, DK., editors. Clinical handbook of couple therapy. 5th. New York, NY: Guilford; 2015. p. 23-60.

Berkman, ND., Bulik, CM., Brownley, KA., Lohr, KN., Sedway, JA., Rooks, A., Gartlehner, G. Management of Eating Disorders Evidence Report/Technology Assessment No. 135. Rockville, MD: AHRQ Publication No. 06-E010; 2006.

Bulik, CM., Baucom, DH., Kirby, JS. Couples therapy for anorexia nervosa. In: Alexander, J., Treasure, J., editors. A collaborative approach to eating disorders. New York, NY US: Routledge/Taylor & Francis Group; 2012a. p. 189-200.

Bulik CM, Baucom DH, Kirby JS. Treating anorexia nervosa in the couple context. Journal of Cognitive Psychotherapy. 2012b; 26(1):19–33. DOI: 10.1891/0889-8391.26.1.19 [PubMed: 22904599]

Bulik CM, Baucom DH, Kirby JS, Pisetsky E. Uniting Couples (in the treatment of) Anorexia Nervosa (UCAN). International Journal of Eating Disorders. 2011; 44(1):19–28. DOI: 10.1002/eat.20790 [PubMed: 20063308]

Bulik, CM., Baucom, DH., Kirby, JS., Pisetsky, E. Uniting couples in the treatment of eating disorders; Paper presented at the Academy for Eating Disorders, International Conference on Eating Disorders; Miami, FL. 2012.

Darcy AM, Doyle AC, Lock J, Peebles R, Doyle P, Le Grange D. The Eating Disorders Examination in adolescent males with anorexia nervosa: How does it compare to adolescent females? International Journal of Eating Disorders. 2012; 45(1):110–114. DOI: 10.1002/eat.20896 [PubMed: 22170022]

Epstein, NB., Baucom, DH. Enhanced cognitive-behavioral therapy for couples: A contextual approach. Washington, DC: American Psychological Association; 2002.

Fairburn, CG., Cooper, Z., O'Connor, M. Eating Disorder Examination (Edition 16.0D). In: Fairburn, C., editor. Cognitive Behavior Therapy and Eating Disorders. New York, NY: Guilford Press; 2008. p. 265-308.

Fischer, MS., Kirby, JS., Raney, TJ., Baucom, DH., Bulik, CM. Integrating couple-based interventions into the treatment of adult anorexia nervosa: A case example of UCAN. In: Thompson-Brenner, H., editor. Casebook of evidence-based therapy for eating disorders. New York, NY: Guilford; 2015.

Heavey, CL., Gill, D., Christensen, A. Couples Interaction Rating System (CIRS). University of California; Los Angeles: 2002.

Jacobson NS, Truax P. Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. Journal of Consulting and Clinical Psychology. 1991; 59(1):12–19. doi:http://dx.doi.org/10.1037//0022-006X.59.1.12. [PubMed: 2002127]

Lock J. Treating adolescents with eating disorders in the family context. Empirical and theoretical considerations. Child and Adolescent Psychiatric Clinics of North America. 2002; 11(2):331–342. doi:http://dx.doi.org/10.1016/S1056-4993(01)00009-8. [PubMed: 12109324]

Maxwell M, Thornton LM, Root TL, Pinheiro AP, Strober M, Brandt H, Bulik CM. Life beyond the eating disorder: Education, relationships, and reproduction. International Journal of Eating Disorders. 2011; 44(3):225–232. DOI: 10.1002/eat.20804 [PubMed: 20143323]

Mazer NA, Leiblum SR, Rosen RC. The Brief Index of Sexual Functioning for Women (BISF-W): A new scoring algorithm and comparison of normative and surgically menopausal populations. Menopause. 2000; 7(5):350–363. [PubMed: 10993034]

NICE. 2004. http://www.nice.org.uk/page.aspx?o=101239 Retrieved October 5, 2012

Pinheiro AP, Raney TJ, Thornton LM, Fichter MM, Berrettini WH, Goldman D, Bulik CM. Sexual functioning in women with eating disorders. International Journal of Eating Disorders. 2010; 43(2):123–129. DOI: 10.1002/eat.20671 [PubMed: 19260036]

Rizvi SL, Peterson CB, Crow SJ, Agras WS. Test-retest reliability of the Eating Disorder Examination. International Journal of Eating Disorders. 2000; 28(3):311–316. DOI: 10.1002/1098-108x(200011)28:3<311::aid-eat8>3.0.co;2-k [PubMed: 10942917]

Sabourin S, Valois P, Lussier Y. Development and validation of a brief version of the dyadic adjustment scale with a nonparametric item analysis model. Psychological Assessment. 2005; 17(1):15–27. DOI: 10.1037/1040-3590.17.1.15 [PubMed: 15769225]

Schmidt U, Treasure J. Anorexia nervosa: Valued and visible. A cognitive-interpersonal maintenance model and its implications for research and practice. British Journal of Clinical Psychology. 2006; 45(3):343–366. DOI: 10.1348/014466505x53902 [PubMed: 17147101]

Snyder, DK. Marital Satisfaction Inventory Revised. Los Angeles, CA: Western Psychological Services; 1997.

Taylor JF, Rosen RC, Leiblum SR. Self-report assessment of female sexual function: Psychometric evaluation of the Brief Index of Sexual Functioning for Women. Archives of Sexual Behavior. 1994; 23(6):627–643. DOI: 10.1007/bf01541816 [PubMed: 7872859]

Thompson-Brenner, H., editor. Casebook of Evidence-Based Therapy for Eating Disorders. New York, NY: Guilford Press; 2015.

Tozzi F, Sullivan PF, Fear JL, McKenzie J, Bulik CM. Causes and recovery in anorexia nervosa: The patient's perspective. International Journal of Eating Disorders. 2003; 33(2):143–154. DOI: 10.1002/eat.10120 [PubMed: 12616580]

Table 1

Scores and clinically significant change indices for eating disorder and relationship outcomes

Scale (possible range)	Pre	Post	Follow-up	Reliable Change from pre?	Passed cutoff[1]?
EDE: Global Score	3.92	4.05	2.96	No	No
Restraint	3.93	3.80	1.40*	Yes (follow up)	Yes (follow up)
Eating Concern	3.60	3.40	2.40	No	No
Shape Concern	4.75	5.00	4.63	No	No
Weight Concern	3.40	4.00	3.40	No	No
DAS-4 (0-21):					
Laura	11	16*	--[2]	Yes (post)	Yes (post)
Steve	11	17*	19*	Yes (post and follow up)	Yes (post and follow up)
MSI[3]: Laura	72	69	58	Yes (follow up)	No
Steve	66	63	45*	Yes (follow up)	Yes (follow up)
CIRS Demand (1-9)					
Laura	3.67	--[2]	2.00*	--[4]	Yes (follow up)
Steve	5.83	--[2]	4.25	--[4]	No
CIRS Withdraw (1-9)					
Laura	3.56	--[2]	0.83*	--[4]	Yes (follow up)
Steve	2.33	--[2]	1.17*	--[4]	Yes (follow up)

Note. EDE = Eating Disorders Examination, DAS-4 = Dyadic Adjustment Scale; MSI = Problem Solving scale of the Marital Satisfaction Inventory; CIRS = Couples Interaction Rating System.

*score in normal functioning range.

[1]cutoff *c* (Jacobson & Truax, 1991).

[2]Missing data.

[3]Problem solving communication subscale (T-scores).

[4]RC could not be calculated because test-retest reliability was not available for this measure

Table 2
Sexual Functioning total and subscale scores (R-BISF)

Dimension (possible range)	Time point	Laura	Steve
Composite (-16 to +75)	Pre	7.08	46.20
	Post	16.42	45.83
	Follow-up	--	53.98
Thoughts/Desire (0-12)	Pre	3.25	9.00
	Post	2.75	9.00
	Follow-up	3.75	10.25
Arousal (0-12)	Pre	1.00	4.00
	Post	1.00	4.00
	Follow-up	2.00	4.00
Frequency of Sexual Activity (0-12)	Pre	6.00	3.00
	Post	4.00	3.00
	Follow-up	7.50	8.50
Receptivity/Initiation (0-15)	Pre	3.00	15.00
	Post	4.00	15.00
	Follow-up	5.00	11.00
Pleasure/Orgasm (0-12)	Pre	3.00	12.00
	Post	9.00	12.00
	Follow-up	9.00	12.00
Relationship Satisfaction (0-12)	Pre	1.00	10.00
	Post	4.00	10.00
	Follow-up	4.00	11.00
Problems Affecting Sexual Function (0-16) [1]	Pre	10.17	6.80
	Post	8.33	7.17
	Follow-up	--	2.77

[1] Higher scores on this scale indicate greater impact of problems, the reverse pattern of other scales.

-- Scale scores could not be calculated due to missing data.