

ABSTRACT

Title of Thesis: EXPLORING THE EXPERIENCES OF
WOMEN WITH ANOREXIA NERVOSA IN
COMMITTED ROMANTIC
RELATIONSHIPS: A QUALITATIVE STUDY

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Eating disorders (EDs) significantly affect an individual's quality of life and have the highest mortality rate of all psychological disorders. Therefore, understanding EDs is imperative for researchers and treatment professionals. EDs have a systemic impact; however, previous research largely focused only on impacts with adolescents and their families. The present study fills a gap in research on how Anorexia Nervosa (AN) influences adults within their romantic relationships. Qualitative data analysis was conducted by interviewing 9 adult women who ranged in age from 21 to 32, had been diagnosed with AN, and were in committed relationships for at least 6 months during some point in their recovery. Using grounded theory, their perceptions of how their ED symptoms and recovery interact with the functioning of their relationships were investigated. The results provide insight on the interaction between AN and romantic relationships and can aid in development of more effective couple therapy for individuals with AN.

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IN COMMITTED ROMANTIC RELATIONSHIPS: A QUALITATIVE STUDY

by

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Table of Contents

Acknowledgements.....	ii
Table of Contents.....	iv
List of Abbreviations.....	vi
CHAPTER 1: INTRODUCTION.....	1
Statement of the Problem.....	1
Purpose.....	9
Literature Review.....	10
Development of EDs.....	10
EDs and Attachment.....	12
EDs in Adulthood.....	14
Eating Disorder Effects on Overall Life Quality.....	15
ED and Aspects of Relationship Dysfunction.....	16
The Partner’s Experience as a Caregiver.....	24
Reciprocal Influence between EDs and Relationship Functioning.....	26
Treatment of EDs in the Couple Context.....	28
Theoretical Foundation.....	32
Family Systems Theory.....	32
Research Questions.....	35
CHAPTER 2: METHOD.....	37
Sample.....	37
Data Collection.....	39
Qualitative Data Analysis.....	40
Data Quality.....	42
Reflexivity.....	43
CHAPTER 3: RESULTS.....	45
Part 1: Disclosure.....	45
How Isolation Interferes.....	46
Disclosure: Opening the Door for Support.....	48
Finding Out Together.....	49
Open from the Beginning.....	50
Faster Disclosure.....	51
Gradual Disclosure.....	52
Summary.....	54
Part 2: The Role of Understanding.....	54
The Impact “Not Getting It” Can Have.....	55
Understanding Parts, but Not the Whole.....	58
AN as a Coping Mechanism.....	59
Related to Control.....	59
Body Image.....	60
The Psychology of It.....	62
Attunement.....	62
Connection Between Level of Understanding and Support.....	64
Partners Supporting More in Areas They Understand.....	64
Communicating Needs.....	66

Promotes Intimacy	67
Missteps Happen, But Repair is Possible	69
Importance of Trying to Understand.....	69
Importance of Empathy.....	71
Summary.....	71
Part 3: Variance in Support from Romantic Partners	72
Caregiver Support Compared to Partner Support	73
Caregiver Support	73
Partner Support	74
Differences Between Parental Support and Partner Support	77
Different Desires in Accountability	78
Ways Partners Support.....	81
Meal Support.....	82
Supporting the Treatment Process	83
Distraction.....	84
Listening	85
Supporting with Acceptance and Unconditional Love	85
Feeling Unworthy of Love.....	86
Reassurance that Love is Not tied to Weight.....	86
Acceptance as a Form of Support	88
When Acceptance Feels Like Enabling	89
Difficulties for The Romantic Partner	89
Impacts of Relationship Problems	91
Summary.....	94
CHAPTER 4: DISCUSSION.....	96
Contributions to Research.....	98
Level of Understanding.....	98
Caregiver Support Versus Partner Support.....	99
Attunement.....	100
Co-dependency and Enabling	101
Theoretical Considerations	102
Methodological Considerations	103
Implications for Research	105
Implications for Clinical Work.....	106
Increasing Connectedness.....	106
Psychoeducation	107
Transitioning from Caregiver Support to Partner Support.....	108
Conclusion	109
APPENDICES	110
Appendix A: Participant Descriptor Data.....	110
Appendix B: Interview Questions.....	111
Appendix C: Summary of Findings Sent to Participants	112
REFERENCES	117

List of Abbreviations

ED	Eating Disorder
AN	Anorexia Nervosa
BN	Bulimia Nervosa
EAT-26	Eating Attitudes Test 26
IOP	Intensive Outpatient

CHAPTER 1: INTRODUCTION

Statement of the Problem

Eating disorders (EDs) pose significant challenges for the mental and physical health fields, due to the high rate of comorbidity associated with them; they commonly co-occur with other disorders such as anxiety, depression and bipolar disorder (Le Grange, Lock, Loeb & Nicholls, 2010). EDs are defined as a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning (American Psychiatric Association, 2013). The two prominent types of EDs are the diagnoses of Anorexia Nervosa (AN) and Bulimia Nervosa (BN), although there are other forms such as binge eating. AN is characterized by distorted body image (typically viewing oneself as over-weight when that is not the case according to standard Body Mass Index criteria) and excessive dieting that leads to severe weight loss with a pathological fear of becoming fat (American Psychiatric Association, 2013). BN is characterized by “uncontrolled overeating or binge eating that is recurrent, excessive weight control behavior involving laxative abuse, vomiting which is self-induced, strict dieting and a preoccupation with weight and shape as expressions of self-worth” (Hillegge, Beale & McMastere, 2006, p. 1017). These disorders commonly present significant danger for affected individuals, including risk of death (Hillegge et al., 2006).

EDs are estimated to affect 30 million people in the United States and are prevalent across all races at relatively equal rates (Krug et al., 2012). There is a gender difference, with more women than men affected, but EDs within the male population are getting more attention despite influences of stigma (American Psychiatric Association,

2013). Some studies suggest that men represent 10–20% of the cases of AN and BN, and up to 40% of cases of binge eating disorder, although EDs among men may be under reported (Jones & Morgan, 2010). Jones and Morgan (2010) note that views of the ideal body differ between men and women, thus affecting some of the ways in which eating disorders in males manifest, such as more attention to visible muscle formation, compared to a sole focus on weight. This leads to more symptoms of overeating and exercising seen in men (Jones & Morgan, 2010). EDs as significant health issues transcend culture and race, posing as an issue that needs to be addressed globally. The implications of EDs are notable, in that 20% of those diagnosed with an ED have poor physical and mental health outcomes, including chronic problems such as osteoporosis, anovulation, social isolation, depressed mood, irritability, low self-esteem and anxiety (American Psychiatric Association, 2013; Hillege et al., 2006). Additionally, the mortality rate of those with EDs is a significant 20%, with causes of death including cardiac arrhythmias, infections, and starvation (Hillege et al., 2006). Human service workers have been cognizant of the occurrence of EDs for quite some time; however, since the 1950s the frequency of identified cases has increased, indicating a possibility that preventative techniques are not being used effectively (“National Eating ...”, n.d.). However, the frequency increase might also be due to greater awareness of EDs among health professionals and more careful screening.

A lack of funding for research on causes and treatments has also made further insight into causes and consequences of EDs difficult. EDs are more prevalent than Alzheimer’s Disease, Schizophrenia, and Autism. However, research dollars spent on Alzheimer’s Disease averaged \$88 per affected individual in 2011, for Schizophrenia the

amount was \$81, and for Autism \$44, but for eating disorders the average amount of research dollars per affected individual was just \$0.93 despite the higher frequency (“National Eating ...”, n.d.). Statistics such as these illustrate how important it is to increase attention to the occurrence and severity of EDs and make funding for research a higher priority, so more effective treatments can be developed to decrease the common severely negative outcomes.

AN and BN have been shown to be similar in severity as mental and behavioral disorders with significant psychiatric and medical morbidity (Le Grange et al, 2010), have similar ways they can affect relationships (Dick, Renes, Morotti, & Strange, 2013) and are often treated alike and even together in group therapy. Furthermore, they often both begin with the initial symptom of dieting (Guinzbourg, 2011). However, these diagnoses have been shown to differ in both symptomology, risk factors, and characteristics. The DSM-5 notes that the key difference between AN and BN is that individuals with AN are underweight or have a history of being underweight typically through means that include caloric restriction, whereas those with BN maintain a body weight at or above minimally normal level (American Psychiatric Association, 2013). Research has also shown the pathways to eating disorders differ between AN and BN, and that there are certain differential risk factors for each (Guinzbourg, 2011; Machado et al., 2016). Women who develop BN are shown to have a history of being overweight while experiencing external social pressure (from family, friends, or society) to get in shape or diet (Machado et al., 2016). Those who develop AN have been shown to be perfectionistic, putting more internal pressure on themselves regarding appearance (Machado et al., 2016). These women with AN are also shown to have some external

risk factors that overlap with BN, such as unresolved family disagreements, teasing, negative attitudes regarding parents' body shape and weight, a family history of ED, and early traumatic events (Machado et al., 2016). Guinzbourg (2011) noted how there are many notable psychophysical characteristics among those with AN that are critical to be aware of in treatment. Patients with AN have been shown to be more introverted and have difficulty expressing emotions that sometimes underlie their food-related symptoms and thinking (Guinzbourg, 2011). Guinzbourg (2011) also makes an important distinction with how individuals with AN "presented ideational slippages and morbid, pessimistic, and distorted thinking, which negatively influenced their self-esteem and social ties" (p. 37). Therefore, the social interactions of those with AN might look different from those with BN. Due to these differences between the two major ED diagnoses, the current study a decision was made to focus the present study on women with AN, to learn more how their social interactions in romantic relationships are affected, rather than mixing the two groups. It will be valuable to conduct future research on a sample of individuals with BN, to examine differences and similarities between the disorders. However, to maintain a homogenous sample and identify clear patterns, the present study used a sample of women whose most recent diagnosis was AN.

AN symptoms often lead to psychological distress, medical issues and serious negative consequences for individuals' daily lives. For example, the Diagnostic and Statistical Manual (DSM-5; American Psychiatric Association, 2013) states that, "while some individuals [with AN] remain active in social and professional functioning, others demonstrate significant social isolation and/or failure to fulfill academic or career potential" (p. 343). Many individuals with AN also are characterized as emotionally

avoidant and struggle to express their feelings, which may negatively affect their ability to articulate their needs, tolerate distress in their relationships, or remain close with others (Schmidt & Treasure, 2006). Social functioning and EDs have been shown to have reciprocal influences on one another, and interpersonal factors play an important role in illness persistence (Arcelus, Haslam, Farrow, & Meyer, 2013). Some of these interpersonal factors include troubled personal relationships; difficulty expressing emotions and feelings; history of being teased or ridiculed based on size or weight; history of physical or sexual abuse (American Psychiatric Association, 2013). Interpersonal mistrust, reduced positive social experiences in the person's relationships, and negative communication are a few factors that ultimately are sources of stress in the individual's life and can lead to slower recovery rates from the eating disorder. Thus, relationship factors should also be addressed in treatment (Kirby, Runfola, Fischer, Baucom & Bulik, 2015; Perkins, Winn, Murray, Murphy & Schmidt, 2004).

The average age at which women are diagnosed with AN is 19 years old (National Institute of Mental Health, 2013). This is a key period of the life course for the formation of intimate relationships. Therefore, those who are struggling with these diagnoses in young adulthood face possible negative effects of their disorder on their ability to form intimate relationships that meet their basic human needs (Kirby et al., 2015). Studies have reported a reciprocal relationship between couple dynamics and the course of ED progression and recovery processes (Linville, Cobb, Shen & Stadelman, 2016). EDs can lead to certain problems for individuals such as isolation, communication and boundary setting, but additionally these factors can have a reciprocal nature and influence the ED itself (Linville et al., 2016). Consequently, relationship distress can influence ED

symptoms, and in turn an individual's ED symptoms can affect their close relationships. Overall, research has shown that couples that include a member with an ED report significant relationship distress, lower levels of positive interaction, and more negative communication than couples without EDs (Whisman, Dementyeva, Baucom, & Bulik, 2012). In turn, relational factors can influence the recovery process for these individuals (Linville et al., 2016). Individuals who have recovered from EDs describe supportive relationships as vital to their recovery. Experiencing problems in one's relationship can interfere with the recovery process (Kirby et al., 2015). For example, if a couple is experiencing relational problems that cause the individual with an ED distress, that person may turn to disordered eating behaviors to cope with their emotional distress, thus impeding their improvement from the ED (Belangee, 2007).

When researchers have conceptualized EDs and treated them in a relational context, the primary focus has been on families who have adolescents with EDs. Several systemic models of intervention, such as the Maudsley model, have been developed to address AN in adolescents within the family context (Lock, 2011). The Maudsley approach is an intensive outpatient treatment in which parents play an active and positive role, beginning with being in control of food to restore their child's weight then handing the control over eating back to the adolescent and instilling a healthy sense of identity for the adolescent (Lock, 2011). Research has shown that for adolescents with AN and BN involvement in family-based therapy yielded better outcomes, such as higher weight gain and remission, in five out of eight studies at end of treatment and at follow-up assessments (Brauhardt, Zwaan & Hilbert, 2014). Family-based treatment has been thought to be effective because it works systemically to create a better recovery-focused

environment and provides scaffolding for the adolescent (Brauhardt et al., 2014; Lock, 2011). Furthermore, family treatment for adolescents with EDs has been shown to be twice as effective as traditional individual psychotherapy in terms of long-term remission (Lock, Le Grange, Agras, Moye, Bryson, & Jo, 2010).

However, although researchers have begun to investigate family systemic factors in EDs and test effects of family interventions, less is known about the reciprocal effects of eating disorders and intimate partnerships in adulthood (Linville, Cobb, Shen & Stadelman, 2016). Despite the overall lack of research on EDs and couple relationships, some ED researchers have examined the couple context and discovered that a high percentage of individuals in treatment for AN are in committed partnerships that are essential to their recovery process (Bulik, Baucom, Kirby, & Pissetsky, 2011). “From a systems theory point of view, it is important to explore these tentative findings more in-depth to understand more about how couple dynamics influence eating disorder illness and recovery processes” (Linville et al., 2016, p. 327). Despite the existence of many studies on family-based treatment for EDs, there currently is only one treatment approach that was created and evaluated for helping couples that include a member with an ED: *Uniting Couples in the treatment of Anorexia Nervosa (UCAN)* (Bulik et al., 2011).

The additional research that has examined EDs in couples has focused on specific aspects of interaction between partners, including communication, sexual functioning, and boundaries (Dick et al., 2013). These studies have used various quantitative measures to identify characteristics of relationships in which one partner has a current ED or a history of an ED. However, little research aside from that of Linville et al. (2016) has cast a broad net to look at a variety of ways that couples with an ED function. Linville et al.

(2016) conducted a qualitative study with 17 couples in which the female had an ED, either AN or BN (two identified as recovered, 13 identified as in recovery and two were actively engaging in ED symptoms). The sample ranged in relationship length from two months to more than 40 years, and in age from 19 to 60 (Linville et al., 2016). The researchers highlighted themes that the couples identified as significant patterns in their relationships (e.g., decreased intimacy, added stress and conflict, difficulty making plans around food, couple and individual lifestyles, expectations about duration of recovery from an eating disorder, a strengthened couple relationship, partners' increased self-reflection about food attitudes). Participants in the study were all living in a relatively small geographic area, which may limit generalizability (Linville et al., 2016). Another limitation identified by the researchers was the inclusion of varying stages of the couples' relationships in terms of time and intimacy, within a relatively small sample size (Linville et al., 2016). Linville et al. (2016) recommended that future researchers examine how relational processes are influenced at varying stages of the individual's recovery from an ED, as well as expansion of their study in general.

Overall, there is a need for additional research to build on Linville et al.'s (2016) important but limited study, to expand knowledge about EDs in the couple context. Therefore, while the present study is similar to Linville et al.'s study, it extends the population examined from a homogeneous sample in the Pacific Northwest to a more diverse sample in the Northeast region of the U.S. The present study also differed from the Linville et al. study by creating a more homogeneous sample. It limited the sample age to 21-32 year old women, limited the diagnosis to AN, and only included interviews with the females rather than the couple. This allowed women to share more of the

thoughts and feelings that they might have held back from in a study in which their partner was also involved. This study also investigating more about how individuals make meaning of the development of their ED and consider how their partner influenced their recovery.

AN has been shown to affect many adults' lives adversely, and there is a need to increase knowledge in this area so that more effective treatment options can be designed. Some research, such as that by Bulik et al. (2011), has shown that including romantic partners in ED treatment helps increase the patient's motivation and the effectiveness of treatment, but as already noted there is still very limited research literature on treating couples affected by EDs. Additionally, the research that has examined these issues has focused on specific areas of relational functioning, with little research holistically examining couples with EDs to learn from them what those who live through this experience deem as most salient.

Purpose

EDs can significantly affect an individual's quality of life and can potentially cause severe and life-threatening medical complications (National Institute of Mental Health, 2013). Furthermore, EDs have the highest mortality rate of all psychological disorders (National Institute of Mental Health, 2013). Despite the research that has been conducted on the identification and treatment of EDs, the recovery rates still remain low, with only 46% of clients with AN and two-thirds of clients with BN achieving full recovery (Steinhausen, 2009). Early detection and effective treatment is imperative in minimizing effects of these debilitating and dangerous disorders. Given the substantial evidence that support from significant others is often very helpful to individuals who are

struggling with mental illness (Bulik et al., 2011), increasing knowledge about couple dynamics in the face of ED and how intimate partners can potentially support individuals with ED needs to be a priority.

Given the limited existing research on couples affected by EDs and an even greater gap in qualitative studies that allow members of couples to convey information about their experiences with the disorders more comprehensively, the present qualitative study was intended to investigate how AN affects romantic relationships by applying grounded theory to extricate important themes that women who have or have had EDs identify as important reciprocal influences between their AN symptoms and the dynamics of their romantic relationships. Further, understanding the personal experiences of these women can help develop targeted couple therapy interventions for women experiencing AN and provide future directions for research. The goal of this study was to gather such information from qualitative interviews with a sample of women who have experienced AN and provide context on how relationships are affected by AN, how AN symptomology is affected by relationship factors, and how romantic partners of those women with AN help or hinder recovery.

Literature Review

Development of EDs

The core elements of eating disorders are shown to be very similar between AN and BN (Fairburn et al., 2003). Individuals with both diagnoses over-evaluate their body shape, weight, and the control of eating, with patients with AN using food restriction in the same rigid and extreme way that individuals with BN may vomit, misuse laxatives or diuretics, and over-exercise (Fairburn et al., 2003). Similarities also extend to factors that

influence the onset of EDs. One commonly cited factor is the accumulation of societal pressures on women for achieving an ideal and often unrealistic body type that results in chronic dieting, binge/purge behaviors, and hypervigilance about weight and appearance (Gilbert & Thompson, 1996). However, individuals with AN experience more self-consciousness regarding appearance and perfectionism (Machado et al., 2016). AN also differs from BN with individuals being more vulnerable to suffering emotional turmoil and to involving themselves in harmful behaviors and experiencing more distorted and pessimistic thinking (Guinzbourg, 2011).

Outside influences on the development of EDs can include inputs from family of origin. A family's shared relationships with food and body image may have influenced the onset and maintenance of EDs for individuals (Belangee, 2007). For example, a person may turn to dieting and ED behaviors as a way to sustain congruence with the values of his or her original family, even if other outside influences such as friends and health professionals are promoting a healthy relationship to food (Belangee, 2007). Furthermore, if dieting behaviors were used in the family of origin as mechanisms for coping with life stresses, an individual may learn these, use them, and carry them over into new situations (Belangee, 2007). The coping behaviors involving food then can shape the individual's sense of self and become a part of the person's identity, making the behavioral patterns harder to eliminate (Belangee, 2007). Family members can also influence the development of EDs by engaging in negative patterns such as child abuse, attachment injuries, emotional abuse, and family conflict, all of which have been found to be problems associated with EDs (Fox & Power, 2009).

EDs and Attachment

Several studies, including Amianto, Daga, Bertorell & Fassino (2013), have linked attachment insecurity issues to symptoms of EDs such as AN and BN. One possible explanation that has been offered as to why they are correlated is that an individual with insecure attachment uses the eating disorder symptoms as a strategy with which to protect the self from fear of failing, feelings of inferiority, or fear of experiencing hurt or rejection (Belangee, 2007). Women with eating disorders often report experiencing insecure or anxious attachments to their parental figures while they were growing up (Amianto et al., 2013). Furthermore, Zachrisson and Skarderud (2010) noted that two types of insecure attachment have been associated with ED behaviors: avoidant/dismissive attachment and anxious/preoccupied attachment. Moreover, anxious/preoccupied attachment is most often associated with BN and its characteristic bingeing and purging behaviors, whereas avoidant/dismissive attachment is most often associated with AN and its restricting behaviors (Zachrisson & Skarderud, 2010). These findings conflict with the findings of Perkins et al. (2004), who found no differences in attachment patterns between those diagnosed with AN and BN, although they did note that overall those with EDs often have anxious attachments. Individuals with high attachment anxiety tend to devalue themselves and use others for reassurance or validation, which can often be seen in patients with EDs (Bamford & Halliwell, 2009).

Some studies (e.g., Bamford & Halliwell, 2009; Eggert, Levendosky, & Klump, 2007) have looked at possible mediators between attachment style and ED development and symptomology. Bamford and Halliwell (2009) found a mediation pathway through social comparison. Their study found that individuals with high attachment anxiety tend

to devalue themselves and use others for reassurance or validation, which in turn tended to be associated with ED symptoms (Bamford & Halliwell, 2009). Eggert et al. (2007) found in their study that attachment insecurity influences disordered eating indirectly through personality characteristics such as neuroticism and extraversion. They found that individuals with insecure attachment are likely to exhibit disordered eating if they have more neurotic personality characteristics. In terms of causality, Bamford and Halliwell (2009) proposed that the development of an ED may serve a direct function for individuals with high attachment avoidance by helping them to achieve emotional and social avoidance by directing attention to food and weight and away from social activities.

When investigating how EDs and attachment influence romantic relationships, Ward, Ramsay, Turnbull, Benedettini and Treasure (2000) found that women with EDs experience anxious attachment patterns characterized by care seeking, as well as avoidant attachment patterns characterized by extreme self-sufficiency. These two patterns seen in ED patients resulted in an overall pattern of attempting to draw others close while simultaneously pushing them away (Ward et al., 2000). Evans and Wertheim (2002) also looked at how these factors influence relationships and found that women with EDs are likely to display avoidant behaviors and experience feelings of anxiety and fear of rejection regarding their intimate relationships. The research further found that women who had eating problems indicated anxiety about abandonment, mistrust of others, and were inclined to avoid closeness, which is common in those with insecure attachments (Evans & Wertheim, 2002). Additionally, the women affected with EDs were found to

describe their relationships as less satisfying than did women who did not have EDs (Evans & Wertheim, 2002).

EDs in Adulthood

There have been increases in adult diagnoses of EDs and admission rates in treatment facilities over the last decade (Ackard et al., 2014; Elran-Barak et al., 2015). Forman and Davis (2005) reported that as many as 23% of U.S. women presenting for inpatient ED treatment in Pennsylvania fell into the midlife group of 35 years or older. One possible explanation is that as individuals grow older and notice the inevitable changes in appearance that come with aging, they often feel less satisfied with their bodies and therefore are susceptible to more disordered eating behaviors (Lewis & Cachelin, 2001). Cooper et al. (2016) conducted an exploratory study with 130 patients at an eating disorder clinic who ranged from 18 to 65 years of age. The study revealed that two baseline variables were linked to severity of the ED: longer duration of the eating disorder and higher degrees to which women considered body shape important (Cooper et al., 2016). The longer ED duration is pertinent for those who are adults with EDs, because adult patients often have had symptoms present in their life for a longer time, thus possibly reflecting an ingrained pattern of thoughts, emotions and behaviors associated with eating. Kirby et al. (2015) discovered that a significant number of adults with EDs fail to achieve relief from the disorder over time, with many even dropping out of treatment or relapsing.

The current study used a sample of adult women, age 22 to 32, who had been diagnosed with AN and were involved in a committed romantic relationship during one point in their ED or recovery. As noted previously, prior research findings suggest that

adults with EDs enter committed relationships at a rate comparable to that of peers with no EDs (Maxwell et al., 2010). Thus, there are many adults diagnosed with EDs who are involved in committed relationships. Furthermore, in a population of young adults and adults the connection between romantic relationship problems and eating, weight, and shape concerns may be especially salient, because women's desire to form romantic relationships during this phase of life likely increases their attention to physical qualities that they view as relevant to attracting a partner (Bergstrom, Neighbors, & Lewis, 2004; Worobey, 2002). Nevertheless, even though women with EDs are likely to be concerned about their effects on their couple relationships, a substantial proportion of women seeking treatment for EDs report that they consider their partners an essential part of the recovery process both in terms of providing motivation for change and support throughout treatment (Bulik, 2011).

Eating Disorder Effects on Overall Life Quality

Magallares, Jauregui-Lobera, Gamiz-Jimenez, and Santed (2014) conducted a study with 104 women (79 women diagnosed with EDs with mean age of about 24, and 25 control group women who had no EDs with mean age of about 20) to investigate the relationship between EDs and subjective well-being. They found that the women with EDs reported less satisfaction with life in general and less overall positive affect than the control group. The researchers did note some limitations to their study such as the cross-sectional nature of the design, inclusion of only women in the study, and lack of a standardized measure of psychological well-being (Magallares et al., 2014). Nevertheless, the study provided some support for an association between EDs and individuals' overall psychological functioning.

ED and Aspects of Relationship Dysfunction

Overall, research has found that couples with ED report lower relationship satisfaction and greater marital discord (Kiriike, Nagata, Matsunaga, Tobitan & Nishiura, 1998). However, current research also has focused on ways in which EDs influence intimate relationships beyond reducing couples' overall satisfaction. Because EDs have been shown to be disruptive, pervasive, and long-term, it is likely that many areas of both an individual's life and their partner's life are affected. Van den Broucke and Vandereycken (1997) found that among couples in which one partner is diagnosed with an ED, there are problems in the areas of intimacy, communication, and conflict management strategies. Symptoms associated with EDs have been shown to affect the couple; for example, women's drive for thinness predicted increases in male partners' reports of negative events in the couple relationship over two months (Morrison, Doss, & Perez, 2009). Moreover, bulimic symptoms and women's body image distress during couple sexual interactions both predicted a decrease in partners' positive relational experiences (Morrison et al., 2009). These types of effects can lead to the formation of negative couple dynamics and increase overall couple distress (Van den Broucke & Vandereycken, 1997). This is significant because conflict within a relationship has in turn been shown to increase risk for relapse or illness persistence for various psychiatric disorders, including EDs (Baucom, Belus, Adelman, Fischer, & Paprocki, 2014). Thus, prior findings suggest reciprocal processes in which symptoms of EDs take a toll on the quality of couple interaction, and negative couple patterns of coping with stressors and conflict are risk factors for ED relapse and maintenance.

Effects on couple communication. One area that has been established as affected by EDs and thought to influence relationship satisfaction is communication.

Communication among patients with EDs is imperative; it is critical for gathering support with recovery and the challenges that come with it, and communication is the most consistent predictor of long-term relationship functioning (Bulik et al., 2011). One possible explanation for the poorer communication is that the individual who has an ED may not communicate his or her thoughts and feelings in fear of failure or letting down the partner, which then leaves the partner not understanding the person's ED symptoms and what is wrong (Belangee, 2007).

A study conducted by Van den Broucke, Vandereycken, and Vertommen (1995) looked at how women with EDs engaged in conflictual and nonconflictual conversations with their partners, compared to both maritally distressed and non-distressed couples. They found that the couples with an ED engaged in more negative nonverbal communication than the non-distressed couples, but less than the distressed couples, placing them between the two groups. These couples also employed fewer constructive communication skills than the non-distressed couples (Van den Broucke et al., 1995). Findings also suggested that individuals in the ED group managed to decrease negative messages during conversations compared to distressed couples but failed to include enough positive interactions, thereby making the conversations less fulfilling to the partners. Van den Broucke et al. (1995) also suggest that that relationship between communication problems and ED symptomology is circular, with couple communication both being influenced by the presence of the disorder, and in turn influencing the further course of the disorder. Overall, while there are inconsistent reports from various studies

describing the types of communication problems in couples with EDs, couple struggles to resolve conflict and a sense of secrecy surrounding the ED are two common areas of weakness in communication among these couples (Dick et al., 2013).

Conflict strategies. Conflict occurs in a variety of areas in the relationships of couples experiencing EDs. Van den Broucke et al. (1997) found that these couples often have arguments over emotionally charged topics such as their sexual interactions, the temperament of their partners, or the amount of affection demonstrated by their partners. More specifically, individuals with BN have been shown to contribute to conflict in their relationships through both communication difficulties and a pattern of impulsivity issues (Van den Broucke et al., 1995). Conflict can also arise when a pattern of secrecy is discovered; those affected with EDs tend to feel a component of shame, making it hard for them to self-disclose to their partners (Kiriike et al., 1998). That pattern can lead to the couple feeling confused, emotionally disconnected, frustrated, and overwhelmed or can lead to arguments when the person's partner becomes unwilling to put up with the secrecy any longer (Kiriike et al., 1998). These findings differ from those of Van den Broucke et al. (1995), who found that the degree of self-disclosure among ED couples was higher than among non-distressed couples; however, that pattern may be due to ED couples needing to self-disclose more often because they experience more relational or personal distress. Therefore, the amount of secrecy may differ among couples with ED, but when it is present it can lead to conflict within the relationship.

Emotional expression. A number of studies such as Maier (2015), Harrison, Sullivan, Tchanturia and Treasure (2010), and Van den Broucke et al. (1995) have linked emotional dysregulation to symptoms manifested in EDs such as AN and BN. Research

has shown that EDs may involve the expression of extreme emotions (e.g. anxiety, anger) triggered by weight and food issues (Maier, 2015). ED patients can also struggle to label their emotions and mistake their internal emotional experiences with bodily sensations, causing them to “feel fat” when emotionally aroused (Skårderud, 2007). Specifically regarding AN, individuals have been shown to be emotionally avoidant and resist expressing their feelings. This lessens their ability to express emotions, communicate needs, tolerate relationship distress and maintain a sense of closeness with their partner (Van den Broucke et al., 1995). Individuals also have been shown to engage in ED behaviors in order to inhibit their experience of distressing emotions (Belangee, 2007; Fox & Power, 2009). Belangee (2007) found that when couples are involved in situations that induce feelings of inferiority in individuals who have EDs, those individuals may use ED symptoms and behaviors (e.g., binge eating, purging, avoiding self-disclosure to their partners) to cope with and avoid their negative feelings. This unhealthy coping pattern further degrades communication in the couple because the individual uses the ED as a counterproductive coping style rather than learning to address and express their emotions with their partner (Belangee, 2007).

EDs are commonly associated with emotions of depression, fear of gaining weight, other types of anxiety, and anger (DSM-5; American Psychiatric Association, 2013). Regarding comorbidity, Blinder, Cumella and Sanathara (2006) found that 46% of female inpatients with BN also met criteria for concurrent major depressive disorder. Cycles of bingeing and purging were shown to be correlated with low mood, but findings of studies differ on whether the low mood reaches a level appropriate for a clinical diagnosis (Fox & Power, 2009). Concerning AN, Altemus and Gold (1992) found

starvation and protein malnutrition may lead to elevations in corticotrophin-releasing hormone, playing a role in the manifestation of depression. Fox and Power (2009) note how the association between depression and EDs has been researched in depth, and that studies suggest depression can both lead to and develop from EDs. EDs have also been shown to evoke anger from individuals, and that anger is a particularly difficult emotion for people with both BN and AN to experience and express (Fox & Power, 2009). Anger often results when individuals with an ED are pressured to eat in a different way than they wish or when they feel the stresses of recovery. While a person with an ED may be truly experiencing vulnerable feelings of sadness, guilt, shame, loneliness, etc., they may utilize a “secondary emotion” such as anger because it is feels safer to express (Fox & Power, 2009). Additionally, Geller, Cockell, Hewitt, Goldner, and Flett (2000) found anger and aggressiveness to be key components of EDs both as a precursor to the development of an ED and as emotional triggers for engaging in ED behaviors for those who already have an ED. The prior research also has found that those diagnosed with AN tend to display significantly high levels of anger suppression (Geller et al., 2000). However, individuals with AN may display anger when challenging topics such as sexuality and body image arise between members of the couple and trigger emotional escalation (Bulik et al., 2011).

Effects on intimacy. When an individual with an ED feels alone, she or he may enact ED symptoms and behaviors to cope with difficulties of feeling a lack of connection with a partner, highlighting the importance of intimacy (Belangee, 2007). In general, couples with or without EDs need to develop a sense of togetherness and intimacy while still maintaining some degree of each member’s individuality; otherwise,

their sense of couple-hood is easily disrupted by distress or negative communication (Epstein & Baucom, 2002; Root, 1995). Couples in which an individual has an ED are at a greater risk for problems in balancing couple-hood and individuality, because these couples are likely to have a greater number of topics that create conflict, due in part to their typically lower levels of intimacy based on the ED partner at least partially living a life of secrecy and low self-disclosure (Dick et al., 2013). Development of intimacy may be further stunted in these couples when the individual with the ED fails to turn to the partner for emotional support, also causing the relationship to lack a sense of exclusiveness (Dick et al., 2013).

Effects on sexual experiences. Women with EDs may desire physical sexual intimacy but may avoid it or be uneasy when physically intimate because of their insecurity about the way their bodies look (Morrison et al., 2009). Both members of the couple have been shown to report that they experience sexual problems when an ED is present (Huke & Slade, 2006; Woodside, Lackstrom & Shekter-Wolfson, 2000). Pinheiro et al. (2009) found that 66.9% of women diagnosed with an ED experience low sexual desire and 59.2% have elevated sexual anxiety, in addition to AN patients having lower libido. Sexual drive and hormones are influenced by body weight, and therefore severe weight loss can negatively affect libido. Women with lower body weight commonly experience a loss in libido, and this is exacerbated by the effects of malnutrition (Pinheiro et al., 2009; Wiederman, Pryor, & Morgan, 1996). Wiederman et al. (1996) found that sexual satisfaction in AN is inversely related to degree of caloric restriction, and thus the more individuals are restricting, the more sexual difficulties they may experience. Loss of sexual interest is also affected by the psychological symptoms of EDs as well. For

example, distorted body image, body dissatisfaction, and shame can compromise healthy sexual functioning for those affected with EDs (Pinheiro et al., 2010; Pryor, 2009; Sanchez & Kiefer, 2007). Thus, loss of libido among individuals with lower BMIs may be due in part to psychological symptoms such as profound body discontent, body image distortion, depression, and uneasiness with physical contact (Pinheiro et al., 2010). Beumont, Abraham, and Simson (1981) found that when patients work to restore their weight, increases in sexual drive also occur due to the lessening of both physiological problems and psychological symptoms.

Body image can also affect other facets of the couple relationship (Morrison et al., 2009). As Morrison et al. (2009) suggest, women typically want to be with a partner who finds them attractive, and if a woman perceives that her partner is dissatisfied with her body it can ultimately affect her relationship satisfaction negatively. The researchers conducted a study with 88 heterosexual couples, with measures of their relationship satisfaction and eating, weight, and shape concerns across two points spanning two months (Morrison et al., 2009). The male partner's comments and feedback regarding the female partner's weight or body shape were shown to have negative impacts on the woman's relationship satisfaction and level of body satisfaction (Morrison et al., 2009). An important note that Morrison et al. (2009) made was that when looking at the male partner's satisfaction with their partner's body, the women affected by EDs were liable to perceive disapproval and negative comments about their body whether or not disapproval actually exists on the male's part. This highlights how a partner's comments about the woman's body can negatively affect the recipient's relationship satisfaction and body satisfaction even if the comments are not intended as critical (Morrison et al., 2009). The

sensitivity of the woman with ED to evaluation of her body can play a significant role in how she interprets feedback from a partner or other people.

Prior Qualitative Research on EDs and Relationship Quality

Linville et al. (2016) conducted the first qualitative study of couples with ED, which has a few similarities to the present thesis project. The researchers conducted 51 interviews with 17 couples in which one member identified as currently suffering from or having recovered from an eating disorder (two recovered, 13 were in recovery and two actively engaging in ED symptoms). The sample ranged in age from 19 to 60 and relationship length from two months to more than 40 years (Linville et al., 2016). Using grounded theory analytical methods, the researchers found a systemic interplay between an ED and the couple relationship experiences, learning about each partner's perspective of the ED and its role in their relationship, the impacts the ED has on each of the individuals' lives, and strategies that couples use to cope with EDs. Lineville et al. (2016) found a central pattern in which "ED symptoms and relationship dynamics reciprocally influence one another" and that the partners who do not experience an ED themselves still experienced significant distress from dealing with their partners' ED symptoms. More specific themes that emerged from the data included decreased intimacy, added stress, tension, and conflict, difficulty making plans around food, couple and individual lifestyle conflicts, expectations about duration of recovery from an ED, strengthened couples' relationship from coping with the ED together, and increases in both partners' self-reflection about food attitudes (Linville et al., 2016). Subthemes regarding coping strategies involved social support from friends and family, within-couple support, communication patterns, and emotion regulation (Linville et al., 2016).

The study showed how couples often experience an ED as a “third party” in their relationship (Linville et al., 2016). Some partners of those with EDs identified feeling pressure to monitor their partner’s behaviors or fearing playing a role of responsibility for a relapse, as well as confusion and isolation. Despite these concerns, most participants expressed that going through the ED illness and recovery processes as a couple made them more united despite the significant challenges they endured (Linville et al., 2016). Relationship security was shown to be related to an increased sense of recovery from the illness. Therefore, recovery itself may strengthen a couple even though the ED can pose significant challenges (Linville et al., 2016). Linville et al. (2016) identified a need for additional research on the influence of timing of disclosure about the eating disorder to their partner (which they did not ask about), along with the role of community support for the couple relationship. The researchers also highlighted the need to work on enhancing open couple communication, healthy coping responses, and psychoeducation for both members of a couple to prevent negative relational influences.

The Partner’s Experience as a Caregiver

EDs have a broad scope of effect. These disorders not only influence the individual but also have ripple effects that have impacts on the individual’s partner, family and friends. For some, romantic partners may be placed in a caregiver role, which can both cause unique challenges as well as create an imbalance in the relationship. Fisher, Baucom, Kirby and Bulik (2015) conducted a study that revealed how an eating disorder can affect caregivers and partners of the individual. This was a cross-sectional design to assess associations between self-reports of patients' perceived negative consequences of AN (such as caregiver distress, negative affect, relationship satisfaction)

and observational coding measures of the individuals' partners' behavioral strategies for promoting change and conveying acceptance/validation of the patient (Fisher et al., 2015). The results from the 16-pair sample revealed that there was a significant interaction effect of patients' perceived negative consequences of the ED and caregivers' change promotion (Fisher et al., 2015). A high level of a patient viewing the ED as something that ruins their caregiver's life was associated with a high rate of the caregiver trying to change the patient, and this was shown to predict caregiver distress (Fisher et al., 2015). Furthermore, the study found that the critical ingredient for relational success was whether the relationships are "in sync," with the two members viewing the ED in the same way (Fisher et al., 2015). In addition, caregivers who both gave and felt higher acceptance/validation experienced less negative affect, possibly because it helps the two members of the couple have an opportunity to assist each other in coping with the strains that the ED has had on their lives (Fisher et al., 2015).

Adult ED patients will turn more toward their partner rather than family members as their primary support, and being the primary support for a person with an ED has been shown to be very difficult, often resulting in feelings of emotional distress, self-blame, helplessness, frustration, and inadequacy (Huke & Slade, 2006). Furthermore, these partners may feel a sense of responsibility for the well-being of their partner's recovery, adding additional stress to the couple interactions (Huke & Slade, 2006). Partners often then feel a need to attempt to help their partner with the ED, but the attempts may be met with resistance, causing a sense of powerlessness as their well-intentioned attempts at supporting their loved one backfire (Kirby et al., 2015). These negative interactions can lead to partners becoming fearful of saying or doing the wrong thing or hurting the

patient, leading the partners to withdraw and become avoidant in order to avoid saying the wrong thing, while some caretaker partners may become critical and blame the individual with the ED (Kirby et al., 2015). This interactional pattern can unintentionally confirm or aggravate the patient's shame, secrecy, and self-critical nature, thereby affecting the couple relationship negatively (Kirby et al., 2015).

Partners will often find the secrecy surrounding eating disorder behaviors challenging to live with, causing them more anguish with the relationship (Huke & Slade, 2006). Partners can easily find themselves questioning their relationship due to the impacts of the ED (Treasure et al., 2001). This is often seen with partners reporting feelings of bereavement and grief associated with the loss of the premorbid relationship. Overall, individuals involved in a relationship with someone who has an ED have been shown to experience a wide variety of negative effects, including shame, guilt, caregiver burnout, and helplessness (Bulik et al., 2011; Huke & Slade, 2006; Treasure et al., 2001).

Reciprocal Influence between EDs and Relationship Functioning

Researchers have conceptualized the link between ED severity and relationship functioning in a variety of ways. Some investigators such as Woodside et al. (2000) theorize that EDs in adult women may be precipitated by marital distress, and that psychological problems of male partners may lead to the development of the ED in the female partner. Kiriike et al. (1998) found results that supported this view, as in their sample comparing single and married women with eating disorders, 69% of the married patients reported that their eating disorder was triggered by marital problems, separation, or divorce. It is important to note that this study only looked at EDs that began in

adulthood and did not look at the large percentage of adults who have had EDs in adolescence as well.

Those findings conflict with the research conducted by Wiederman and Pryor (1996), which did not find significant differences in eating disorder symptom history and severity in their comparison of ever-married and never-married women. Friedman, Dixon, Brownell, Whisman, and Wilfley (1999) also found that marital status was not associated with increased body dissatisfaction, but body dissatisfaction originates from other sources such as culture, media and family of origin.

Other researchers have proposed that a man may be attracted to and seek out a woman with an ED in part to a desire to fulfill fantasies of being a rescuer, or as a reflection of his immaturity (Van den Broucke & Vandereycken, 1988). This perspective considers that the male partner does not cause the development of an ED but could be uncomfortable if the female partner actively tries to recover, thereby disrupting the couple relationship system. The diversity of the conceptualizations of relationship factors in the development of EDs have pointed to a variety of possible ED patient and non-ED partner factors that need to be investigated further in future research (Kirby et al., 2015). Therefore the current study was designed to address this question. Overall, couples who are affected by EDs can have a variety of differing experiences, as suggested by the prior research findings. Some couples have had a relationship before the ED developed, whereas in other cases the ED existed before the couple relationship formed, and perhaps the person kept it a secret for a while but eventually it was revealed. These two scenarios can have different effects on the partner and couple relationship.

Treatment of EDs in the Couple Context

In the past, clinicians often had negative perceptions about male partners of women with EDs, and the partners were often viewed as part of problem and blamed for either the development or maintenance of the ED (Dick et al., 2013). This was similar to how during the 1970s and 1980s clinicians commonly viewed families as playing a dysfunctional causal role in various types of psychopathology, rather than having empathy for the severe stresses that families experienced from living with an individual's psychopathology symptoms and intervening to help the family members cope with their stress. This historical blaming occurred toward partners of individuals with EDs (Linville & Oleksak, 2013). These previous systemic conceptualizations made it difficult for families and couples to engage in treatment, due to the worsening of guilt they felt when exposed to therapists' negative mindset (Linville & Oleksak, 2013).

Recently, research has found that the presence of supportive relationships with partners is significantly related to higher recovery rates in women with EDs when compared to women who had these disorders but who reported a lack of relational support (White, 1995). Moreover, Bulik et al. (2011) found that among adults with EDs the most commonly cited factor associated with recovery was having a supportive partner, and women with AN reported that a supportive relationship was the "driving force" in their recovery. Although some research findings suggest the possibility of romantic partners being a factor that may enable and maintain an ED, romantic partners also have the ability to assist their partners in recovery from their ED (Bulik et al., 2011).

Based on previous treatment methods that tended to approach partners as causes of EDs, partners commonly had concerns that participating in ED treatments as a couple

may cause complications and disharmony to their relationship (Root, 1995). This could occur if the romantic partner was resistant to changes occurring in the individual with the ED or is fearful of being blamed for the other's ED. However, Woodside et al. (2000) found that individual treatment of the ED with the affected member did not diminish marital satisfaction for the couple. In fact, patients were shown to have improved marital satisfaction ratings over the course of treatment, and spousal ratings of intimacy and satisfaction did not change or worsen over treatment (Woodside et al., 2000).

Treatment of EDs in the couple context may include both treating the ED symptoms in a similar way to individual therapy (e.g., working on behavior change, replacing ED symptomology with better coping skills, engaging in introspection) and engaging the partner more in that process in addition to possibly treating relational difficulties with more traditional couple therapy techniques such as improvement of communication skills (Linville & Oleksak, 2013). Addressing relational issues is imperative because of the reciprocal relations between the ED symptoms and relational distress (Linville et al., 2016). This balance between treating ED symptoms and treating negative relational patterns can be challenging, because occasionally couples may resist true progress in treatment or refuse to examine other aspects of their relationship besides the ED (they were not prepared to face relationship issues). In addition, a clinician may bring up relational issues and problems regarding how invested the partners may be in their relationship when one partner resists discussing this topic and the other is willing to talk about it (Root, 1995). Furthermore, problems can arise when the needs of the non-symptomatic partner or the relationship demand so much attention that the needs of the individual with the ED are not addressed adequately (Root, 1995). Despite these

difficulties, it is important to address relational conflict, because if not addressed the conflict may affect the course of treatment and recovery negatively, in addition to causing relational problems that may remain after ED recovery (Dick et al., 2013). As described previously, couples who experience EDs have been shown to have troubles with communication, sexual functioning, relational boundaries, and emotional health, which contribute to lower rates of relational satisfaction and also interfere with an individual's chances for recovery (Dick et al., 2013).

Researchers and clinicians have begun to stress the importance of working with rather than against a woman's partner, with methods such as inviting the partner to play a supportive role in the process of treatment (Van den Broucke & Vandereycken, 1997). This allows for a double message that the support and cooperation of the partner is needed but that he also has a responsibility to help his partner (Van den Broucke & Vandereycken, 1997). Studies show that family members want to be of assistance, but often they do not know how to help the patient (Bulik et al., 2011). Therefore, it becomes the clinician's job to help the partner feel more competent to assist the individual with the ED and to decrease the partner's sense of helplessness (Bulik et al., 2011).

Uniting Couples in the Treatment of Anorexia Nervosa (UCAN). As noted previously, currently there has been one treatment program developed that focuses specifically on couples affected by EDs and that uses the romantic partner to assist in an individual's recovery specifically from AN. UCAN is a model that is based on the perspective that although one member of the couple has AN, the disorder occurs in an interpersonal and social context (Bulik et al., 2011). Most of treatment in UCAN is integrated with the patient's efforts in individual therapy by simultaneously helping the

couple develop a good support system for the work that is being done by the individual and moves into addressing more specific couple relationship domains (Baucom et al., 2014). These domains include how all of the core AN symptoms (body image, affection and sexuality, relapse and recovery) play out in the couple context (Bulik et al., 2011). Including the partner in treatment facilitates tapping some additional strengths unique to systemic models; it provides a significant source of support to the patient, allows for an additional reinforcer for appropriate eating and other health-related behaviors while avoiding punishment, improves couple functioning, and increases comfort and acceptance of one's body for the individual with the ED without providing inappropriate reassurance (Bulik et al., 2011).

The UCAN model uses three phases to organize treatment. The first phase of treatment centers on creating a foundation for later work (Bulik et al., 2011). The three goals addressed in this phase include understanding the couple's experience of AN, providing psychoeducation about AN and the recovery process, and teaching the couple effective communication skills (Bulik et al., 2011). The second phase focuses on addressing AN within a couple context (Bulik et al., 2011). During this stage, couples develop ways in which the patient and partner can discuss eating in a manner that promotes recovery, and in which they can increase positive interactions during meal times. This can contribute to the patient's development of healthier eating and increase the partner's confidence in his (or her) ability to help (Bulik et al., 2011). Couples also work on their joint decision-making process (practicing problem-solving skills) to develop ways to promote recovery in their lives inside their home (Bulik et al., 2011). This phase closes with examining how the couple's physical relationship can influence

and be influenced by the patient's experience of a negative body image and the ED more broadly (Bulik et al., 2011). The final phase of UCAN is relapse prevention and treatment termination, aimed at having the couple plan for possible setbacks and transition out of the high level of care (Bulik et al., 2011). The UCAN model of treatment does an excellent job of incorporating romantic partners to assist in recovery, as well as addressing both the ED symptoms and their effects on the couple's relationship (Baucom et al., 2014; Bulik et al., 2011).

Given this recent trend toward conceptualizing and treating EDs in the couple relational context, there is a great need for more research evidence on the links between EDs and couple relationship dynamics. The initial qualitative study by Linville et al. (2016) provided important information in this regard, but clearly more than one study is needed to develop a body of evidence regarding effects that EDs have on couple relationships, and in turn how couple interactions affect the course and recovery from EDs. The current study's scope was limited to just the female with the ED, using more restrictive inclusion criteria to create a more homogenous sample and a clearer picture for how women with AN are affected. The present qualitative study addresses contextual issues involving on how the individual's intimate relationship is affected by their AN, how their AN symptomology is affected by their relationship, and how their partner has helped or hindered their recovery.

Theoretical Foundation

Family Systems Theory

Because the current study utilized Grounded Theory, the constructs derived were driven by the themes expressed by the participants. However, family systems theory also

aided in the development of the research questions. Family systems theory further provided a framework for the current study to explore the circular causality between EDs and relationship factors. Systems theory views families and couples as social systems that are boundary maintained units comprised of interdependent and interrelated parts, where one part affects all other parts of the system (Smith & Hamon, 2012). The systems perspective is characterized by four basic assumptions: (1) all parts of a system are interconnected, (2) understanding the system and any of its parts is only possible by viewing the whole, (3) all systems are governed via through environmental feedback, and (4) systems are heuristics and not reality (White & Klein, 2008). Systems theory stresses that the locus of pathology is not within one person, but rather the symptoms that a member exhibits are reflections of dysfunction in the system itself (Smith & Hamon, 2012). Thus, a pure interpretation of this framework assumes that an ED is not only due to factors within the individual who exhibits the disorder, but rather that systemic dysfunction elicits and maintains the ED symptomology. Furthermore, systems theory posits that change in one member of the system results in changes for other members (White & Klein, 2008). This is evident with couples in which one member has an ED but the other member also experiences challenges and effects.

Systems theory also includes a core concept that in social interactions among members of a family system circular causality governs the individuals' behaviors, such that members of the system simultaneously influence each other's responses, and such reciprocal patterns of interactions develop within the system without the members' conscious intentions (Smith & Hamon, 2012). As described earlier in this literature

review, EDs have been studied in terms of circular causality, and relational processes have been shown to influence ED symptomology, and vice versa (Linville et al., 2016).

Feedback processes is a core concept in systems theory, involving a circular loop that brings a system's output back into the system as input information (White & Klein, 2008). This can either be "positive feedback" that promotes change by rewarding deviation or "negative feedback" that discourages change and occurs when individuals use corrective measures to get other family members who express deviance back in line (Smith & Hamon, 2012). Feedback is often seen among couples affected by EDs and is beneficial when positive feedback occurs to promote change in the diagnosed member in the direction of recovery (e.g., a partner expresses empathy for the individual's emotional distress but also encourages engagement in treatments to reduce ED behaviors) rather than maintaining symptoms. In contrast, a counterproductive negative feedback process might involve a partner "cooperating" with the individual's maintenance of secrecy regarding the ED.

Some writers have presented critiques of systems theory as being too global and abstract and more of a model than theory, as well as for blaming individuals for their own problems and symptoms. However, the core concepts of systems theory regarding mutual influences among members of a family and the power of feedback processes are helpful for conceptualizing areas of family and couple functioning related to EDs and designing treatments that take into account the complex influences among family members (Smith & Hamon, 2012; White & Klein, 2008). Systems theory concepts also were helpful in generating qualitative interview questions for the present study and using grounded theory to explore the relationship experiences of individuals with AN. In

addition, although a strict interpretation of the theory would seem to blame individuals for causing their own problems such as psychopathology symptoms, partner violence victimization, etc., those who apply the theory do not routinely make such an assumption (Epstein, Werlinich & LaTaillade, 2015). The present study was designed to obtain a picture of ways in which ED symptoms and relational patterns influence each other.

Research Questions

Expanding on the assumptions of previous research that EDs and relationship factors have a reciprocal influence, the current study investigated how these factors influence one another among women who have had a diagnosis of AN and are in ongoing committed relationships. Additionally, the present study examined how the women's romantic partners helped or hindered the recovery process. Specifically, this qualitative study was intended to answer the following questions:

- How does a romantic relationship affect an ED, as perceived by the partner who has (or had) an ED?
- How does having an ED impact one's relationship?
- How does a romantic partner influence ED recovery?

This study differed from previous studies that looked at the reciprocal influence of romantic relationships and ED symptomology because it focused on the perceptions of women who have been diagnosed with AN rather than both members of couples with any ED. Additionally, the research questions extended beyond Linville et al.'s (2016) purpose of just looking at the reciprocal influence of couple dynamics and eating disorder illness and recovery processes. This study extended prior work by looking at how the romantic partner influences the recovery process. Thus this study was designed to increase

understanding of ways in which the reciprocal influence between relationship factors and ED symptomology exists in a systemic way, as identified by the diagnosed women. The study also had a goal of providing knowledge about how recovery is affected within a relationship that may help in the design of more effective therapeutic interventions.

CHAPTER 2: METHOD

The present study utilized a qualitative methodological approach, permitting a comprehensive exploration of how AN influences couple relationships. A qualitative approach allows participants to explain how they have been affected by their AN, the recovery process, and how they make meaning of their situation. Understanding these individual experiences is necessary to develop theory that explains how AN affects a couple and how a relationship affects an individual's AN. A qualitative method was chosen to help address the complexity of the breath of ways that EDs affect couples. Furthermore, this study was intended to be exploratory, to develop a conceptual model rather than test a specific hypothesis. Although prior research findings regarding EDs, and AN in particular, and couple relationships guided the selection of questions that were posed to the participants, the emphasis was on allowing the participants to express their personal ideas and emotions regarding their AN and their couple relationship, with the investigator extracting themes from the narratives.

Sample

This study involved primary data collection. Partnerships were developed with ED support groups and clinicians in the state of Maryland and the greater metropolitan area to recruit participants and distribute contact information for participation. The sample for this study included nine female patients who were diagnosed with AN and who identified themselves as being in a committed romantic relationship during their recovery. The participants ages ranged from 21 years old to 32 years old. This age window was chosen because parental involvement is less frequent and romantic relationships are more serious within this age range. It was also required that the

participants had been in the committed relationship for 6 months or more during one point in their recovery, to have enough time for gauging the impacts of the AN on the relationship. The participants' relationship length ranged from .75 to 6.5 years.

The sample also was restricted to heterosexual couples in which the female was diagnosed with AN because that is the most commonly seen pattern (American Psychiatric Association, 2013), although future research should include different types of relationships. Participant were also screened for ED severity to ensure that those who participated would be safe to do so and would be at low risk of experiencing emotional distress and ED symptoms due to the content discussed in the interviews. The screening occurred by having possible participants take the Eating Attitudes Test 26 (EAT-26) (Garner, Olmsted, Bohr & Garfinkel, 1982). The EAT-26 is the most widely used standardized self-report measure of symptoms and concerns characteristic of EDs and was derived from the original EAT-40 that was first published in 1979 (Garner et al., 1982). The assessment yields three different scores based on different criteria: 1) the total score based on the answers to the EAT-26 questions; 2) answers to the behavioral questions related to eating symptoms and weight loss, and 3) the individual's body mass index (BMI) calculated from their height and weight (Garner et al., 1982). For the purpose of this study, if the scores met the threshold to be considered "high risk" (an individual scores higher than 20 on the test questions, selected a certain answer to the behavioral questions, and/or met BMI criteria for very underweight), the individual was given referral information for ED treatment facilities and did not participate any further in the study.

The sample had variability in relationship duration, ED severity, and recovery duration. Five participants had the restrictive subtype and three participants had a binge/purge subtype of AN; the sample's EAT-26 scores ranged from 0 to 19. This variability increased the generalizability of the concepts that were developed from the qualitative coding process about the relationship between AN and couple relationship processes. However, as noted earlier, the age range for participants and the AN diagnosis were restricted compared to previous studies in order to create a more homogeneous sample. This study had a 11-year age range and only looked at women whose most recent ED diagnosis is AN (rather than a diagnosis of BN), so the generalizability of the findings necessarily is somewhat limited. A table showing the descriptor data of the sample is included in Appendix A.

Data Collection

Data were collected as individuals meeting the sample criteria were found and provided their written informed consent to participate. The study used a semi-structured interview format (see appendix B). Interviews occurred in person to create a warm environment and help elicit sharing of information. Interviews were audio recorded and then transcribed, using pseudonyms to ensure confidentiality. The interview procedure included questions pertaining to the development of the ED, impacts on the individual and couple from the perspective of the women with a history of AN, impacts on recovery, and more. Once interviews were transcribed and coded using grounded theory methods, participants were contacted via phone, and the codes and themes extracted from their interviews were shared with them. This check-in process allowed for participants to agree

that the themes depict their experience or correct the coding if it does not match their conceptualization.

Qualitative Data Analysis

Using a grounded theory approach, the current study was designed to describe more about how AN and romantic relationships interact in a systemic way and how recovery is influenced by relationship dynamics. Grounded theory is both inductive and deductive: it uses an inductive approach to generate codes from the data then deduces theoretical concepts, which generates more focused questions the interviewer can ask (Daly, 2007). Grounded theory uses a triadic coding scheme, which includes three phases: open, axial, and selective coding (LaRossa, 2005).

Open coding is described by Strauss and Corbin (1990) as a process in which “the data are broken down into discrete parts, closely examined, compared for similarities and differences, and questions are asked about the phenomena reflected in the data” (p. 62). These parts are referred to as codes, which can both be both informed prior to data collection and emerge through the collection process (LaRossa, 2005). Deductive codes are developed from prior knowledge based on previous research and the researcher’s experience (Daly, 2007). For example, the present study is based on previous research indicating that EDs, and AN specifically, affect communication, intimacy, and sexuality, so these were among some of the deductive codes. Other deductive codes in the study included, but were not limited to: Acceptance, secrecy, disclosure, control, self-esteem, partner support, and treatment. Emergent codes are developed during the process of data collection directly from participants’ descriptions of their experiences (Daly, 2007). Emergent codes allow for recognition of the participants’ descriptions, and this inclusion

of the human experience contributes to the depth of the data. Some of the emergent codes that were found in the study included attunement, enabling, and “not getting it”. These were codes that were not anticipated, but the participants’ numerous accounts that were described by these codes contributed to the depth of the study and current findings.

The next phase of grounded theory analysis is axial coding. Axial coding is centered on the development of hypotheses involving statements about the relationships among variables (LaRossa, 2005). This process is conducted through looking at similar codes and developing categories, and contrasting these categories with one another (Daly, 2007). Similarities in concepts allows researchers to tie codes together into abstract concepts that are the beginning foundations of theory development in grounded theory (Daly, 2007). Through this phase, I looked across interviews to locate patterns among the women regarding their experiences with AN in their relationship. During this phase of coding some patterns that surfaced were communication, body image, acceptance, codependency, disclosure, caregiver support and partner support.

The final phase of the grounded theory process is selective coding. This is a process in which researchers look at the interrelations among categories and use these to select a central category (Daly, 2007). The central category represents a theory or concept for how categories are connected, and it creates a framework to explain the relationships among variables extracted from the interview data (Daly, 2007). This was done through tying codes together. For example, codes such as “not getting it”, “acceptance”, “attunement”, and communication” were all categorized into a broader theme of “level of understanding”. Similarly, codes of “caregiver support”, “partner support”, “meal time support”, “distracting”, and “listening” were all coded as forms of “support”. Concluding

these phases, the researcher achieves a sound perception or theory of the phenomenon being studied. The current study was able to draw a connection between “level of understanding” and how that influenced the “support” given by partners.

Data Quality

A selection of measures helps to ensure integrity and dependability of the data. First, because the interviews gathered personal and sensitive information about the participants, the transcripts were not shared with individuals outside the study, and pseudonyms were utilized to protect participants’ identities. To help gather this personal information and encourage the participants to discuss intimate topics, interviews were conducted in person. To increase convergent validity of data, “triangulation” of the data was used (Daly, 2007). Daly (2007) defines data triangulation as the process of gathering accounts from participants who are at different stages in their experiences, from a variety of different settings, or who bring different backgrounds and viewpoints to the research. In the present study, this involved collecting data from a variety of individuals who have been diagnosed with AN and who came from different backgrounds, ages, and relationship duration. Additionally, individuals with AN differed in subtype (AN restrictive subtype, AN binge/purge subtype), length of diagnosis, and stage in recovery (although currently severe cases were ruled out). Although the sampling criteria contributed to variability, it helped with triangulation and generalization from the data. To maximize trustworthiness of the data, the researcher checked in with the participants following the interviews. The researcher shared her understanding of the participants’ viewpoints to allow the participants to reflect on the degree to which the findings were accurate representations of their experiences.

Reflexivity

Qualitative data allow for interpretation, as different researchers will approach studies from different perspectives. This can lead to a fear of generating biased data, but as Malterud (2001) stated, "preconceptions are not the same as bias, unless the researcher fails to mention them" (p. 484). Thus, throughout the course of the study, this investigator engaged in reflexivity activities to inspect how her personal experiences might influence her interpretation of the data and affect the findings.

There are numerous ways in which this investigator's personal experience affects her approach to this study. The largest influence is that I currently am in recovery from AN myself. I also have family members who have had disordered eating. I have attended support groups for EDs and have seen the effects and narratives of those affected. My personal experience has contributed to my passion for researching this topic and adding to the literature on EDs. Furthermore, I developed my ED in late adolescence/ early adulthood, when I was entering the dating world. This shaped my interest in how EDs affect romantic relationships. Being in recovery myself can add a level of difficulty to make sure that I did not interpret data based on my experiences but am interpreting only the data provided by the participants. However, my experience can also offer strengths in that I have a level of insight that can help in coding salient themes for the participants. In addition, currently I am a therapist intern in a couple and family therapy clinical training program. This has shaped my systemic perspective and ideas about ways in which the impacts of an individual's disorder are widespread and will likely affect her or his romantic partners. Furthermore, this practice with systemic thinking will aid in my coding of the data.

To foster reflexivity, I developed a reflexive journal. During the course of the study, I wrote entries about methodological decisions, study logistics, and reflections on what is happening with my values and interests. This diary enabled introspection that aided in separating my personal experience from my interpretation of data from the study. Additionally, I kept an open dialogue with my thesis chair and own therapist to assure that differentiation continued.

CHAPTER 3: RESULTS

The interviews elicited a wide array of data and possibilities for findings. This chapter highlights the findings this investigator chose to focus on. The identified themes include disclosure, level of understanding and variance in support from romantic partners. These themes were revealed to be interconnected in many ways. Disclosure was often the first step for women to allow their partners to understand their experiences in relation to AN and to allow the partner to support them. However, some women in the study disclosed the ED more gradually, only after their partner showed understanding of some experiences that related to the ED such as body image struggles or perfectionism. Levels of understanding and support were often entwined. For some, understanding led to more support, and for others supporting their partner elicited more understanding about the ED. Moreover, women identified that their partners were unable to understand all components of the ED, but they were able to understand aspects related to AN. Furthermore, partners frequently provided more support in areas that they understood. A quote from Gina captures how level of understanding affects the relationship:

I think that's probably the hardest part about it, that it is this sort of gulf between us, and sometimes it is smaller. It's much like a stream, and other times it can feel as huge as an ocean, but all you can do is I guess just keep on trying to make sure there is a bridge.

Gina's words capture how difficult coping with AN can be for a couple. However, support is one way to bridge a gap in understanding and contribute to a strong level of connectedness some of these couples experienced.

Part 1: Disclosure

In the first section of the findings, I discuss how support with the ED can be difficult to acquire because EDs themselves often involve isolation. Interviews presented how the individual's moments of disclosure about her AN let their partner in and allowed for the partner to support her. Four different timelines of disclosure emerged from the interviews: finding out together, open about it from the beginning, disclosed within 2 months, and gradual disclosure. Despite the differences in disclosure, the women all reflected on how this moment allowed their partner to understand more about them and allowed their partner to support them. Furthermore, disclosure was found to foster connectedness and intimacy within the couples.

How Isolation Interferes

One common experience, both discussed in literature and in the present interviews, is how EDs such as AN involve isolation. Gina expressed how her AN truly led her to isolate herself, “as the ED took hold and when I was at my lowest weight, really in the thickest part of it, I definitely isolated myself from everyone and certainly to an extent from him”. She elaborated more when she discussed how she feared the isolation affected her partner:

Like I said, I got super antisocial for a while, and it's hard to have a relationship with someone who is too tired to get up off the couch and too tired to even engage in conversation. And when we do have conversations, that person is too, delusional is too strong of a word, but just not connected to reality. I was so pulled into a spiral of self-loathing that it was it was really hard to connect with me [...] I always, I still encouraged him to go out, like I did try and make him hermit with me, but I think that was also incredibly awkward for him.

Gina was afraid that her isolating would not only affect her partner but also hurt her relationship. For Gina, getting to a place where she feels like she can socialize more was a true source of motivation for recovery. Gina felt that her ED led her to isolate herself because of the exhaustion and difficulty with connecting to reality that result from EDs.

Faith also saw how when she was heavily in her AN and exhibited a heavy use of symptoms, she isolated. Faith felt that her isolation truly created an uphill battle for her relationship and was a main contributor to her initially not wanting a relationship:

I get in my own world when I start acting on symptoms again, like I start isolating from people aside from family and stuff and people I am comfortable with and I know if I do act on symptoms around they really won't say anything um so I think that it kind of left him in the dark and he actually asked me out one time before he went, so he is in the navy, and when he was going on deployment one time he asked me out, and I said no due to the fact that I was sick, and then we dated when I was sick again and I think that that just wasn't, I don't think that I could have been in a relationship when I wasn't healthy myself.

Faith felt that her AN prevented her from being able to even be in a relationship. Faith's AN was associated with a lot of secrecy, and that caused her to keep people at a distance. This isolation prevented the formation of intimate relationships and prevented her from gaining a source of support. Faith emphasized the difficult conflict that individuals with an ED such as AN have between seeking isolation and wanting intimacy:

I think that with relationships you crave them more in a sense, even though you like to isolate, because of that you crave attention. But it is something that helps make you feel good about yourself [...] but I do also like to be alone when I'm in

an episode, I guess you could say, because I don't like to talk about it all the time. But at the same time, I do crave appreciation so it's like the push pull type of thing.

Faith's experience highlights that despite the isolation that occurs with AN, women still experience a desire of intimacy. Intimacy is something that is not only desired because of the attention and confidence boost it provides, but women also pointed out how intimacy allows for a level of support that was beneficial to their recovery. The benefits to having that support did not discount the difficulty that some of the women had with connecting with others and that was displayed in the significant variation in level of disclosure.

Disclosure: Opening the Door for Support

To gain support from their partners, women had to initially clue their partner into their experience and disclose their AN. As shown in the previous chapter, partners often experienced difficulty understanding the intricacies of EDs. However, by opening a door for communication and support, partners were able to better understand what was going on for the individual with AN, thus fostering connectedness. Claire felt this when she fully disclosed her AN to her partner:

It became a way for me to start, I guess, knocking down walls I had built around myself. So, in some ways I think it probably... the ED slowed down the rate of our coming closer, but once I started talking to him about it more and explaining it you know it brought us closer together. I mean maybe more than we would be if I hadn't gone through any of that just because it forced me to reflect on a lot of things.

Claire was initially very secretive and hesitant to share about her AN. In time, Claire felt that her ED was not something to keep secret, and by disclosing her struggles to her partner she was able to connect more with him. Additionally, by disclosing she was able to use him more as a support rather than feel like she was alone on her recovery journey.

Finding Out Together

Disclosure was shown to vary in timelines and ways. Some women developed AN while they were with their partner and were transparent about their struggles from the start. This then meant that the couple found out about the ED together. This was the experience of Hannah and Gina. In Gina's experience, it was her partner who knew something was wrong prior to her realizing it:

He knew about it before I did. He, the poor guy, just went through this period where he felt like he was nuts. I kept on seeing doctors for all the different side effect that come from an ED. The brain fog, the fatigue, constantly being cold, the circulation issues, really, really slow heartbeat, all of that. And the doctors kept on saying everything was totally fine, and no one said anything about my weight. And they all weighed me at their offices, and no one said this seems like it is not quite lining up properly. And he felt like he was going nuts. He kept trying to find something online, some resources or something.

Gina was unaware of her ED, and doctors also seemed to perpetuate the denial. Gina's husband was enough of an outsider to see objectively that there was a problem, and he was also close enough to Gina to see the symptoms and know they were related to her eating. Gina's husband was able to provide support by helping her become aware of the problem. This was not easy for him, and his experience highlights the need for more

information for adults regarding identifying an ED. Hannah also struggled with denial. She went through various stages of questioning if she had an ED, and throughout that journey she was open and honest with her partner. Therefore, Hannah's partner was able to support her in this stage of discovery and acceptance, although, it seems his level of understanding hindered his ability for that. Nevertheless, for those couples who find out together, it provides an opportunity for partners to lend support in discovering the initial diagnosis and helping to find appropriate treatment for the problem from the start.

Open from the Beginning

Another disclosure pattern that emerged was when participants knew of their AN prior to beginning their relationship but told their partner about it before they even began dating. This was seen with Dianne and Emily. Diane described her disclosure when she stated, "Um, that's kind of interesting because we were friends before we started dating so he knew about it before then, before he really saw me as a romantic interest". She was friends with her partner prior to developing an intimate relationship and was transparent about her struggles with AN. In turn, he was supportive of her as a friend, and eventually things progressed into a relationship. For Diane, this communicated that he was not only supportive but that her AN did not detract from her desirability. Diane felt that being open about her AN allowed for her partner to be informed about what was going on for her. This same though process led Emily to disclose her AN before meeting her husband in person:

I talked about it before we even met because I met him online and I was finishing up treatment, I met him when I was 20. And was finishing up treatment from the first time I was hospitalized, I met him when I was in I.O.P. (Intensive

Outpatient). And I was like just, so you know, before we even meet, full disclosure... so, so he's known the entire time.

Emily believed that it was important to be forthcoming about the disorder to make sure that her partner was aware of her experience. By disclosing prior to dating, partners are informed of the situation, and it opens the door for more communication. Furthermore, partners are able to show their support initially and suggest to the individual with the ED that this disorder is not by any means a deal breaker for a relationship, conveying a level of acceptance.

Faster Disclosure

The findings from this study also revealed disclosure happening at a relatively fast rate of within two months of the couple meeting one another. This occurred with Amelia, Brenda, and Isabella. Amelia was compelled to disclose her AN to her partner because she wanted to gain some support and admit to someone that she was struggling. When she disclosed to her partner, she discovered that he was aware even before she had to say anything:

We pretended not to date for like a few months so umm and like during that time I was like actively eating disordered and then we started actually dating and I was like 'ohh I have an eating disorder' and he was like 'duhh, like obvious'.

Amelia's partner was well aware of the ED but chose to not discuss it with her. Thus, when she finally disclosed her ED there was an ability to communicate about it.

Unfortunately, he was not as supportive as she had hoped when she disclosed, but this would not be known if disclosure did not occur. Isabella was compelled to disclose her

AN because she felt that withholding it was detrimental to her recovery. She described how the secrecy interfered with her eating:

Our second date, we went to D.C., and we hadn't had lunch, and I was so worried I was like, "Oh my God. I haven't had lunch. I have to eat". I would get really grumpy and cranky if I didn't have what I needed, and so I think the date after that I just kind of told him, "This is a part of who I am right now", because I felt I really wanted to pursue this with him, and I didn't want him to think I was a terrible human being, I just needed food, and he was really understanding ... it was a slow disclosure. I think at first, I just told him I get really hungry, I just need to eat at certain times, and then I think as time went on, I sort of disclosed more and more about what I was going through.

Isabella felt that her dating was interfering with her meals, and thus in order to pursue her recovery she had to get the support of her partner and disclose to him. She went about this by sharing her need to eat meals regularly and at certain times to prevent mood swings prior to disclosing fully that she had an ED. Eventually when she did fully disclose, Isabella felt that she was able to use her partner more as a support and felt that it enhanced their intimacy. Isabella felt her disclosure was gradual because she slowly revealed piece by piece during the first few weeks of her relationship. This same type of gradual disclosure also occurred for other participants over the course of a longer timeline.

Gradual Disclosure

The last type of disclosure revealed in the present study was a gradual disclosure. This often resulted from the shame and fear women had about disclosing their ED, fear

about judgment and rejection. Faith felt those fears, which led her to disclose only when it was about more positive aspects of recovery and not about the struggles that she was having:

So, I definitely wasn't open about it once so ever. But when I was open it was only about the positive things never like the negative or if I was acting on symptoms or anything. It would just only be if I was doing well.

This type of disclosure felt more comfortable for her and allowed her partner to not know the extent of the problem she was having. Faith was also not ready to change when she met her partner, and thus that contributed to her fear of disclosing. Faith later reflected on how this prevented her from connecting to her partner and also did not help her recovery because it was easier to be symptomatic and more difficult for her partner to know that he needed to support her.

Claire was also afraid to open up about her ED. She felt a sense of shame with her AN and discussed it in terms of how she feared it was a weakness. This combined with her fears regarding intimacy led to a slower disclosure rate, and she described her rate of disclosure as:

Little by little for a long time. I would make comments like you know I'm not where I should be with my health or I'm not um you know I mean he knew about my therapy and anxiety and all of that, but I wasn't very explicit about how it affected my body image, or you know weight over time. I think it took several months maybe more for me to tell him that I had ever been in treatment for an ED. Um, especially because you know every time he would make you know compliment me or my body or something I was like well, if this changes, and if he

likes who I am now when I know I'm in a place where I shouldn't be, I just didn't know, it took me a long time to be secure that he would rather me to be healthy then for me to stay where I was.

Claire's experience highlights fears regarding disclosure, including worries about changing and pursuing recovery when the partner seems to like the "ED self". Once Claire did disclose the AN, her partner was able to support her recovery rather than indirectly supporting her AN with the compliments he was giving. This highlights how critical disclosure can be, because it allows partners to support the women's recovery and foster intimacy. Regardless of the rate at which disclosure happened, the women all felt that disclosure was critical in their connectedness with their partner and strengthened their relationship. Furthermore, it created the opportunity for partners to support their recovery.

Summary

This section discussed how for these women the moment of disclosure was significant in the development of their relationship. The variances in types of disclosure highlight the differences in difficulty it was for these women to reveal this part of themselves and share their diagnosis and struggles with their partner. Nevertheless, for partners to understand what the women were experiencing and be able to openly support the women with AN, self-disclosure needed to occur on the part of the women. For the participants, disclosure helped to create an open line of communication and contributed to understanding from the partner and created a line of support.

Part 2: The Role of Understanding

In this section I outline how level of understanding plays a role in the ways couples face AN and recovery. Throughout all nine interviews, the women discussed how difficult it is for anyone to truly understand the complexity of an ED and how this difficulty has affected their relationships. Interviews revealed that when a partner does not understand one's ED experience it can lead to detrimental relationship interactions. However, this is not always the case, as some women discuss how their partners have learned to make sense of the AN in particular ways that allow them to relate or empathize with their partner. A commonly expressed way to combat the negative patterns that can arise from not understanding the AN was communication. Furthermore, findings highlight how difficulty understanding one's partner's AN can lead to relationship problems, but effort and empathy can lead to repair and relationship betterment.

The Impact “Not Getting It” Can Have

Several participants in the present study discussed the devastating nature of having a past or current partner who did not understand the ED. Emily, age 25, reflected on how her husband of 6 years had difficulty understanding how AN would manifest as a problem:

Yeah, he doesn't really understand it. He's joked about it being first world problems, even when I try and educate him on the fact that it's not just a first world problem. And he understands it a little bit better when I try and tell him it's a control thing. But it's, it's still, nothing that he really quite gets.

Emily expressed feeling deeply hurt at his conceptualization of her AN and his making light of something that causes such significant distress. Despite being hurt, Emily chose to work on helping her husband to understand the ED through pointing out reasons for its

manifestation, such as control, rather than feeling defeated and settling with his current level of understanding. For Hannah, a response from her partner elicited true fear that the relationship could not work:

He and I actually broke up because I cancelled a weekend with him [...] I was supposed to go up and take care of his cat while he helped his brother move, and I cancelled it because I was feeling depressed and anxious and didn't feel like I could leave the house. And he was like 'this is ridiculous, it's not that severe of a problem, it's not like you have cancer, that kind of thing.' So, he really didn't get it. We broke up for a couple of weeks and then we got back together.

Hannah was so hurt and offended by her partner's downplaying of her distress that she questioned the relationship. At the time Hannah was considering entering residential treatment for the first time due to feeling overwhelmed by her AN. She was in search of support for her mental illness but rather felt like her partner minimized her struggles. Feeling unsupported and emotionally wounded, Hannah's relationship ended for a while until she felt that her partner was more willing to try to understand. Hannah's experience depicts how a low level of understanding can end relationships, but how a willingness for the partner to try and understand can mend a relationship.

Some women also revealed how past partners' views of their AN differed from their current partner's understanding. Having a comparison point created the ability to see what felt better and what was more supportive. Brenda, age 21, pointed out how in her previous relationship her partner would make insensitive and hurtful comments and how detrimental that was for her relationship, and how it negatively affected her self-esteem. Brenda also felt that her low self-esteem is what kept her in that relationship at the time,

because she did not see a problem in the way her partner treated her or the comments that he made about her ED. When Brenda then entered a different relationship, that partner treated her very differently, and Brenda saw that he had a better understanding of the AN and how to support her in recovery. Isabella had a similar story with a previous partner having less understanding with how to treat her after learning of the AN, compared to her fiancé now. Isabella reflects on how her current fiancé might not understand it completely, but his response was vastly different from her previous partner's:

He's more accepting of it than I could have ever asked. It's something that he's not familiar with, he's never had an experience with, but my ex would say very demeaning things. He would say, 'I can't touch you because you'll break.' He didn't make me feel supported at all in what I was going through, he just made me feel like I was sick, I needed to just stop. (My partner)'s take on it is much more, 'This is something you've been through, and you've gotten over it, but we're still working through it.'

Isabella's previous partner conceptualized her AN as something that made her sick and quite possibly broken, which left her feeling unsupported and judged. Conversely, her fiancé's understanding is that it does not make her broken and that the AN is just a part of her story. Her fiancé's conceptualization of the ED left Isabella feeling more supported and stronger, quite possibly aiding in motivation and the recovery process. Both Isabella and Brenda felt that previous partners displayed a poor level of understanding and a biased viewpoint regarding the ED, but in their current relationships there was a shift in that and a shift in the support they received. This finding shows how partners can differ in understanding. Moreover, as previously mentioned with Emily and Hannah's stories,

romantic partners can even fluctuate in their level of understanding, highlighting the possibility of increasing understanding.

Understanding Parts, but Not the Whole

He just doesn't really understand it because eating is such an essential part of life and being that it is basically like the same things as saying 'I think I breath too much, so I think I am going to stop breathing.' So, he doesn't really fathom how somebody could do that. And I've tried to explain that to him that its obviously tied to a bunch of other stuff and it's never just about the food. -Gina

Women with AN often articulated how their romantic partners struggled to understand the ED in its entirety, especially symptoms related to food and extreme weight loss. Gina's partner's comments highlight his inability to fathom certain symptoms. Claire also shared that her partner had difficulty understanding the thought process involved in AN:

Yeah, I mean now, I'm still not sure he understands sort of the level of the obsessive thoughts I would have about food. When I talk about that it feels kind of silly, it's just hard to explain how that would come about or... that type of thing sort of feels like a more shallow concept or shallow symptom of the ED, it's hard to explain.

Claire also worried that her partner's inability to understand this aspect of the ED might lead to judgment about it, calling it shallow. Overall, women did feel that their partners were unable to understand facets of the AN; however, they adapted to this by learning to help their partner understand through discussions of specific traits and characteristics that might be more relatable, such as coping, control, body image, and neuropsychology.

AN as a Coping Mechanism

Some of the participants mentioned how they helped their partner understand the AN as a way to cope with difficult life situations and how it developed as a coping mechanism. For example, Diane reflected on how her partner could not understand many aspects of AN and her current symptomology; however, he has had more understanding with the reasoning behind the ED and how for her it developed as a coping mechanism. Diane grew up feeling like she did not have control of things in her life, was neglected by her parents, and was feeling depressed. These factors led for a need to cope, which her partner could understand, and he was able to empathize with her on that level. Claire had a similar situation with getting her partner to comprehend the AN in those terms, as she stated, “I think he understands it’s a coping mechanism I developed at a time where I didn’t know how else to cope with my situation. Um, I think he understands that”. Both Claire and Diane felt their partners were able to understand the need for coping and how AN might develop from that, even if they do not quite understand the more complex symptoms of the disorder.

Related to Control

Other participants found that another way to help their partners understand AN was by discussing the ED in terms of control dynamics. As the professional literature suggests, for many individuals who have EDs, the disorder is used to help them feel in control of their lives by controlling things such as food intake and weight. For example, Hannah identified how her AN developed:

Started out as just wanting to lose a little bit of weight and eat healthier, and then it just became more obsessive and yeah like I’ve always been a bit of a

perfectionist and get straight A's in school, so yeah, just another thing to control and keep perfect in my life.

Hannah's ED was largely tied to control concerns and efforts. Emily also commented on how she felt that her AN developed because she was a "control freak," and it was something that took a hold of her as well. Hannah and Emily shared the experience of using their AN as a means of giving them a sense of control in their life. Furthermore, they both used this to help their partner understand the natures of their EDs more. Emily stated how she felt, "he understands it a little bit better when I try and tell him it's a control thing. But it's, it's still, nothing that he really quite gets." This illustration highlights how romantic partners might have difficulty understanding the ED in its entirety but were able to grasp how it is connected to control.

Body Image

One large component of AN is the distorted views that women have about their bodies and struggles with body image. Participants mentioned not only their troubles with their weight and appearance in their interviews but also discussed how this is a facet of the disorder that more people, including their partners, can relate to. For instance, Claire discussed in her interview how she found her boyfriend was able to understand and empathize with having issues with body image because he was once overweight and had self-esteem issues related to that. While body image is tied to EDs, many of the women in the study emphasized how their AN was not solely tied to body image and appearance, and how it was important to them that their partners understood that. This was a source of frustration for Faith, whose partner had difficulty grasping that:

I think supportive but not understanding, because like the first thing he always said is that ‘why?’ because I look good and my body is fine, and stuff like that. So, I think that’s in the background, that it was just based off of appearance, and not the control aspect and that was how I would cope with things, and it was just simply looks so I think that to him he is still confused as to why this is even an issue in my life and so reoccurring.

Faith felt that her partner could not understand her ED because he believed it was just tied to body image and that if someone looks good they should not have AN.

Furthermore, Faith’s partner was unable to recognize the aspects of control and coping that go along with an ED, unlike some of the other romantic partners described previously.

Not A Vanity Thing. While Faith’s partner did not understand how the AN was more than just experiencing issues with appearance, other women’s partners were able to understand there was more to the ED. Additionally, there was more understanding that issues with body image did not mean the AN was ever about vanity. Emily’s comment that “a lot of people think it is like a vanity thing and he (partner) knows it is not so much like a vanity thing”. However, Emily still did not feel like her partner is able to understand the AN but does understand this portion. Emily was comforted by this fact, and it helped her feel like he was not at a total loss with comprehending her disorder. Gina also experienced this and commented on how she knew it was more than body image related:

And I think he’s realized that and he certainly understands it’s not a vanity thing either, it may have started out as oh I want to look my best for my wedding, but

you know one you get below 100 pounds, you're not looking good, you're not looking good at all.

Gina believed, like most, that while her AN might have started out as a diet and way to change her appearance, it developed because of other factors and was never about vanity. For Gina and Emily, their partners' acknowledgement of that was important to feeling like the partners were able to understand some aspects of the disorder and provide support.

The Psychology of It

Another component of the AN that some romantic partners could understand was the psychological aspect of the ED and how brain chemistry might play a role. Claire found that her partner was able to understand the anxiety-related symptoms and how the medication was needed to help in this area. Hannah felt that her partner was able to relate because of her partner's own experiences with mental illness:

He had a bout of depression in high school transitioning into college, and he actually went to a psychiatrist for some time, probably a few months or years ago. And he learned a lot about psychology through that and has an open mind with psychology and is willing to learn.

In addition to her partner's ability to empathize through his own experiences with depression, Hannah also felt that his knowing basics of psychology helped increase his understanding and broadmindedness. This component of understanding might also aid in the treatment process with the partner's understanding the need for therapy and intervention.

Attunement

One phenomenon that emerged from the data was the notion of partners being attuned to the struggles or difficulties that the women might experience in recovery. When this occurred, women were amazed by how their partner could recognize the obstacles they were having in that moment and proceed to support them. Women felt that while their partner might not understand the ED in its complexity, this attunement communicated that they were able to know when they were struggling. Brenda shared, “he could just tell if I was having trouble at a meal and know what to do and he would communicate to his family if I was having trouble with thing”. Brenda felt her partner was attuned to her in that moment and was comforted by knowing she did not necessarily have to voice her concerns with him but that he was able to read her and respond accordingly. During Diane’s interview, she emphasized how surprised and amazed she was by her partner’s ability to attune to her:

Oh, one thing he is really good about that is really important, if we go out to eat, he can sense when I am starting to get uncomfortable with food somehow and is like ‘do you want me to finish it?’ I don’t know how to explain it but [...] like once we did the restaurant week thing where you get an appetizer, a meal, and dessert and we were sharing everything. And I’m really okay with food but then with the dessert I get... I mean not triggered but I start to get uncomfortable and it’s like he knows, he can see, maybe I slow down eating or tense up or something and he’s like ‘okay ill finish it’, I mean he doesn’t mind because he like to eat. I just feel like the fact that he can tell like okay you’re ready to go instead of making me sit there and stress about it.

Diane's partner has learned to pick up on cues that she is uncomfortable with a meal. This attunement is not only a reassuring thing for Diane; it also allows her partner to be able to support her when she fails to communicate her difficulties verbally. However, not all participants mentioned the notion of attunement, and when this does not exist direct communication is even more critical.

Connection Between Level of Understanding and Support

Partners Supporting More in Areas They Understand

Findings from the coding of interviews revealed that communication and support were viewed by the women as related to a partner's level of understanding, meaning that couples' conversations about an ED tend to correspond to areas about which the partner has a greater level of understanding. One area that some women felt like their partner could understand more was regarding body image, as discussed previously. Since partners understood this facet, women would go to their partner more for support regarding that issue. For example, Hannah was often quiet about her ED and would not ask her partner for much support. Yet when it came to body image she did utilize his support more often:

Sometimes I am open about it with him, particularly with body image like if I am having a bad day because I put on something and I'm like oh my this is so bad what happened to me. I am very open about that with him. I have called him crying hysterically with him before because we are supposed to go to a wedding and I am like this dress doesn't fit me, I'm freaking the hell out, like what am I going to do. He is very good with things like that.

While having difficulty asking her partner for support, Hannah did not feel like she was alone in her recovery because she found a domain that her partner could provide her support in helpful ways. Hannah's partner was able to understand how to help her with body image; however, Emily found that this domain was something her partner did not quite understand. Emily share this when she stated, "I talk to my husband but not necessarily about the weight stuff. Like he still doesn't quite understand it, so like I'll talk to him about my general emotions". Emily found that her husband did not understand issues with weight and body image enough for him to be able to support her in that area. Emily did find a way she could gain support from him and that was with general emotions such as having a hard day at work. Interviews showed how for women it was important to find an area their partner understood more and then utilize his support more in that area. Furthermore, when they were not able to understand they found it helpful to turn to their treatment team. Gina expressed more about this:

For stuff like I had a larger lunch than I planned, and I feel really guilty about it, that one, the sense of guilt is going to be something more that a therapist will be able to understand and help out. So bigger and easier to reach sort of stuff I go to him but the stuff I know that it's not going to be anything logical, it's just a lot of weird hang-ups is when I go to the professionals.

Gina's point of view echoed others in the study. When their romantic partner did not understand certain aspects of the ED, often food related, the women found it more beneficial to go to people who were trained to understand.

Communicating Needs

The interviews with the participants in this study showed how women adapted to their partners not understanding their AN and how to assist the partners by telling them explicitly how best to provide support. Gina saw how this benefited her relationship:

He lets me sort of let him know what I need. Like I said honesty is really important to us and I don't think it's fair for me to expect him to behave without telling him what it is so sometimes I will say to him I am feeling crappy and I just need you to sit here while I vent and don't try and fix it like it's totally fine. And other times will be like I feel really crappy and I need you to tell me I'm okay, and what I am eating I fine and I don't look like a stuffed sausage in these pants that like it's okay and that's really what he does is just sort of continually add support and lend support and let me dictate what form I need that support to be in.

Gina was very open with her husband about what she needed in the moment, and she felt that this was something that really benefited her recovery and her relationship. By voicing what support the individual recovering wants, it lessens the pressure on their partner to somehow know how they should support the individual, and thus, this communication can be a real benefit for the romantic partner. Support was shown to be more difficult when a partner does not understand the ED in that moment, and thus conversing about what type of support is best reduces the risk of miscommunication and increases the likelihood of truly beneficial support.

Gina felt serious benefit in expressing her needs to her partner; however, not all individuals know how to do this initially, but through recovery and treatment they might learn to see how critical it is to not assume their partner will know how to help and that

communicating is imperative to bridge the gap and prevent misunderstandings. Faith was one participant who made this discovery:

He is very nice and very sweet to me, but I don't think he understands mental health and he doesn't really have that um, what's the word I'm trying to think of, like he cannot really like talk to me on a certain level like besides goofiness. So, [...] he didn't really actually know how to really respond. And that's partially, not blaming it on myself, but I learned in treatment that I need to not leave people in the dark because I can't expect people to know what I'm going through, and I need to tell them what to say.

Faith did not always know the importance of communicating her experience and needs to her partner. This prevented him from becoming informed and understand more about Faith's AN and the support she wanted. Ultimately Faith was left feeling more isolated in her ED because of the lack of couple communication and the misunderstandings that resulted from that. Faith eventually learned how to communicate more in treatment, which opened the door for more emotional intimacy and connection in her relationships.

Promotes Intimacy

The women in the study all felt that their AN added complexity to their relationship, and some even saw relationships hurt by their ED and the isolation it brought. One finding of the present study was that couples' communication about the disorder fostered intimacy. This juxtaposed the experiences of secrecy, which often led to loneliness and a low level of intimacy. Brenda discussed how she had a prior relationship in which communication and understanding were low, and she felt judged by her partner. The low level of communication then created a real separateness from her partner. This

was vastly different from the experience she had with her most recent partner, where open communication was much more frequent:

I think it brought us closer together, because it did let me stop hiding things from him and kind of made it easier for me to just talk to him when I was struggling or ask for help when I needed it because I didn't talk really to other people. I have trouble talking to friends about this kind of issue so, um, I kind of relied on him a lot and so I think for a while it made things, it just made us, it felt like we got closure and I learned more about him, and I feel like we were both able to be more open with each other, and it kind of opened up just like a no secrets, it is okay to tell me stuff I am not going to leave, you know what I mean. Because that was something I was always afraid of after the first one, just that like if I say this kind of stuff that makes me not as desirable of a person or whatever, so it was just nice to know that he was accepting of it.

Brenda found that opening a line of communication allowed her to connect more with her partner, thus promoting intimacy. This communication also happened to lead to her partner disclosing more about his emotions, adding to their attachment. By opening herself up to honest communication with her partner, rather than engaging in secrecy, Brenda became vulnerable. This vulnerability was difficult, as echoed by other participants in the study, but in the end, it led to increased intimacy. Moreover, Brenda felt like her partner was unconditionally supportive rather than judgmental because she opened the line of communication. The current study demonstrates how communication is not only a powerful tool in preventing misunderstandings; it also helps partners connect.

Missteps Happen, But Repair is Possible

He's made missteps in what's he's said to me, like how I look or his expectations with like what is attractive to him, things like that. So that has caused disputes, but it is never anything that is like catastrophic or something to the relationship. - Hannah

Hannah's experience highlights how partners often make mistakes and have misunderstandings with the individual with the ED. This is not specific to couples facing EDs, but is instead a normative difficulty that most couples face. However, when there is a mental illness as severe as AN, the stakes feel higher, and partners might have greater fear of doing the wrong thing. Hannah acknowledged that while her partner made mistakes and did not always understand what to say or do, their relationship was still strong. Findings of the present study revealed how partners will not be able to quite fully understand the experience of AN, which may result in making missteps regarding the ED. However, this does not mean that partners should fear making these mistakes or avoid communicating about the ED, because AN participants' experiences point out how partners' attempts to understand and empathize strengthen the relationship and help repair any missteps that do occur.

Importance of Trying to Understand

Women in the current study discussed how when their partner made efforts to understand or learn about their ED they felt a level of responsiveness from their partners that increased connectedness and led to a feeling of more support from their partners. Emily first noticed her partner's attempts to understand the disorder when they first met:

I know that when we met up for coffee and he had his phone out and was showing me something on his phone and was on his internet browser and was on the Wikipedia page for Anorexia Nervosa. Which cracked me up. Um, so I thought it was nice he was trying to get to know it a little bit before we even met.

This willingness to learn was something that led Emily to feel good about her partner from the start. She knew that while he might never fully understand what she has gone through because of her ED, his self-initiated learning showed a level of empathy that would help in a relationship. Diane also noted the importance of having a willingness to learn when she reflected on her partner's enthusiasm to learn about what she did each day in treatment:

And he actually wanted to know. So, it was a shoulder to not really cry, but to lean on, to have somebody who, it just made a difference to be able to talk about it afterwards with someone you're close to when previously I would do treatment or therapy and it would be my thing but didn't really have anyone else to talk to about it. Like my family never really talked about it, and I wasn't really telling my friends about it, so he's been a really good support.

Diane felt a genuine interest and desire from her partner in trying to understand her experiences both with the AN and with her treatment. This led her to feel truly supported by him and enhanced their intimacy as a couple. The attempts that partners made to understand the experiences faced by the women with AN did not mean that they would not make mistakes; however, their willingness to learn communicated empathy to the women.

Importance of Empathy

Empathy was something that participants connected to the success of their relationship. For example, Hannah felt that her previous relationship truly lacked a level of empathy, which was a main contribution to their break-up. Conversely, Hannah saw that empathy was present in her current relationship:

We do have our disagreements but were good about talking it out. And we both have a really good depth of empathy with each other, so we can explain what's going on. So, I would say overall, we have a really strong relationship. Like I said the healthiest I've probably been in.

Hannah saw that empathy was the main contributor to a successful relationship. She felt that empathy helped facilitate communication and intimacy in her relationship.

Furthermore, having empathy in her relationship helped counteract the misunderstandings and missteps that did occur. Hannah felt that her previous relationship was not able to withstand the mistakes that were made in part because there was no empathy to buffer and repair the damage. This study's results show how empathy helps repair a relationship and leads to stronger relationships, even when misunderstandings occur.

Summary

Level of understanding was one theme that emerged from all nine interviews in the present study. Women felt that their partners had an inability to understand AN in its entirety. This difficulty in understanding and relating was an added challenge for these couples to develop intimacy. However, women did feel that their partners were able to understand certain aspects of the AN, including non-food related aspects such as control, body image, and psychological factors. The partner's understanding of these domains

helped to facilitate the women's comfort in communicating about them. Communication was shown to be critical in preventing secrecy and fostering intimacy. Intimacy was also found to be enhanced through the partner's attunement, willingness to learn about the ED, and empathy. Additionally, these behaviors helped to repair any missteps that did occur due to a lack of complete understanding. The ED can create a disconnect, because partners struggle to understand; however, the current study has shown that couples are often able to find ways to connect despite this. By communicating and trying to understand, couples become more connected and experience increased relationship satisfaction. Furthermore, partners are then able to better support the recovery process.

Part 3: Variance in Support from Romantic Partners

In the previous section, I examined how level of understanding affects couples who are affected by AN. Understanding was revealed to affect partners' support of the recovery process. This section expands on the theme of support in greater depth. The section attends to two different styles of support, which I call caregiver support and partner support. Caregiver support more closely mirrors the support style of a parent. It is more directive, and the partner takes on more responsibility with holding the woman accountable. Partner support differs from caregiver support because the partner provides fewer commands and more suggestions, allowing more individualization for the woman. Furthermore, as this chapter will demonstrate, partners provide support in a wide variety of ways. Support methods included mealtime support, support with treatment, distracting, listening, and providing acceptance and unconditional love. Support can be challenging for partners in several ways, but it is often critical for both relationship satisfaction and recovery success. The present study aligned with previous studies by finding the

reciprocal relationship between relationship satisfaction and AN severity. This chapter highlights this with how relationship difficulties and a lack of support from the partner leads women to experience a worsening of the AN symptomology. For this reason, support is critical, and it is important to address the difficulties, to help partners better support the individual's recovery and improve relationship satisfaction for both parties. The last section of the chapter ties the theme of support to the previous chapter's theme of understanding and how they influence one another.

Caregiver Support Compared to Partner Support

As noted earlier, two types of support emerged from the present study. These were termed caregiver support and partner support. Romantic partners displayed various combinations of the two types of support, and the receptiveness to and helpfulness of the types varied among the participants.

Caregiver Support

In the current study, this investigator defined caregiver support as the style of supporting and helping with recovery that is often suggested to parents of adolescents with EDs. This is a more directive support style in which the caregiver, the romantic partner in this study, provides more monitoring of the person with the ED and checking in. Amelia's husband provided this type of monitoring:

He'll check I on me occasionally about my weight and make sure it's been stable. But if, um, we've been busy on a weekend and he knows I've been studying all day he goes 'well what have you had to eat today?' and check-in with me on that and then he'll go "okay lets go out to eat" or something and we will go out to a place he knows I like to go to. So supportive in that way.

Amelia found this to be one way her partner shows his support. In addition to the monitoring, a caregiver might give commands, dictate food choices, and control situations for the person with the ED when providing caregiver support. This type of support is beneficial in creating a recovery-oriented environment. Caregiver support limits the control and freedom for the person with the ED. This may be less of a problem with parents, where there is an established hierarchy in the relationship, but with couples, when this type of support is given to the extreme, it can create a difficult power dynamic. Amelia felt the frustration with this and discussed how she wished her husband would provide less of this type of support.

Partner Support

Partner support differs from caregiver support by not creating a power hierarchy. Instead of monitoring and checking in on the person with the ED, partner support occurs through non-directive but supportive actions. These actions include listening, distracting, going to support groups and treatment appointments, expressing love and encouragement, setting a healthy example, and eating with the person. Partner support means that the support person does not provide commands but rather offers suggestions to the person. This then gives more control to the person with the ED and prevents a power struggle that can be taxing on the support person and foster resentment from the person with the ED.

Giving Suggestions. One component of partner support that emerged from the data was partners offering suggestions to the women. Claire noticed how her partner and she had a conversation about how important it was to them that he offers suggestions rather than giving commands. Claire and her older boyfriend have a larger age gap, and

she noticed how this in of itself created a difficult power dynamic that they had to work to prevent. Thus, partner support and providing suggestions was important to them:

Talking about all of these things has made us both aware or made him be very careful about making suggestions because his, um, first instinct like if I'm struggling with something or worried, like his first instinct is try and fix it for me. And he is very conscious that he doesn't know what I am going through and thinking of ways he can make suggestions without making me feel like it is something I have to do. But it is also on me, so it is something we both work on. But I think it's made us both, like the more I share with him the more careful we are about our language and you know saying instead of 'we should do this', 'we could do this.'

Providing suggestions is one aspect of partner support than prevents a power imbalance. Furthermore, it allows the person with the ED to see things in a new way but still have control over their behavior and choices, which can be empowering. Providing suggestions can often be difficult because partners often want to fix the problem and tell their partner what to do rather than just providing a suggestion that might be turned down. This was not only exemplified by Claire's partner, but Diane also felt this way when she stated, "you know guys are fixers, and he sometimes is like 'well maybe will this help', but not in a judgmental way". Diane also felt that making suggestions came across as nonjudgmental, which further promotes communication and intimacy between members of the couple.

Allowing for Individualization. The findings revealed how partner support was shown to allow women to feel independent. This did not negate the support they felt but

rather left them feeling like they were teammates with their partner and on equal ground.

Isabella spoke to this experience:

I think it's amazing, and I think that we are teammates. I don't ever feel like he is controlling anything that I'm doing, we're doing it together, and I feel much better and secure in who I am as a person.

Isabella felt that her partner's support promoted her to make her own decisions. This did not mean that she was alone and unsupported, but rather that someone was there to assist in it while simultaneously promoting individualization. Furthermore, this helped foster a sense of empowerment that left Isabella feeling more secure with herself.

Compared to Codependency. When individualization did not occur, women felt like they were dependent on their partner, and often in an unhealthy way. Isabella and Hannah experienced this in their earlier relationships, and they saw it as something that truly made recovery challenging. Hannah felt like she needed to rely on someone, which led to a sense of dependency on her old partner:

So, all through high school I had a boyfriend and then starting the first semester of college I had a new boyfriend who I was with for 9 years. And basically, when my ED started I was with that person, um, we were, it was basically, looking back it was a very codependent relationship and I don't think I was ever able to form my own identity. I always saw myself as needing a person in my life, sort of as a surrogate parent in a partner.

Hannah often felt like she needed a caregiver in her life, and once she left her parents she sought that out in her intimate relationships. Hannah's experience highlights how without individualization a person can feel a sense of disempowerment. This disempowerment

might influence recovery by causing individuals to feel that they might not be strong enough to tackle their ED. Thus, promoting empowerment and fostering individualization may indirectly help the recovery process, which is something that should be looked at further. Partner support was shown to counteract codependency and promote individualization.

Differences Between Parental Support and Partner Support

Caregiver support and Partner support can both be beneficial to individuals struggling with AN. Caregiver support mirrors many recommendations made by the Maudsley approach where the parents play an active and positive role, beginning with being in control of food to restore their child's weight (Lock, 2011). However, this approach might not always be best for romantic partners because in healthy relationships there is not a hierarchy but rather a more egalitarian partnership. Claire noticed how there is a difference in the way one interacts with a caregiver or parent and the way one should interact with one's partner. However, Claire did not initially desire this difference and instead wanted more of a caregiver than partner:

He loves protecting me, and loves taking care of me, but he wants me to be happy without him too. He wants me to be independent but with him, rather than dependent on him. And that was something I wasn't really about for the first 6 months or year with him. I wasn't sure how much I was leaning on him or um how much I wanted to be dependent on him because I like being taken care of. First it was my parents, and you know some of that has shifted on to him, but I think he's making me want to be independent too.

Claire's partner wanted to help foster her independence and did not want to be a caregiver to her. This was initially hard for Claire to face, but as a couple they both grew to value the partnership that partner support created. Claire also was then able to develop more self-directed agency with her recovery, while her partner supports her choices rather than making decisions for her. Claire's experience also depicts how women in the study varied on the type of support they want at any given moment.

Different Desires in Accountability

One thing that differs between caregiver support and partner support is the level of accountability the support person holds the other to. Caregiver support usually comes with a higher level of accountability, and accountability looks like more checking in on the person with the ED. Accountability looks different with partner support. With partner support the person with the ED must hold themselves accountable more, while the supporter helps them when prompted. The findings of the present study revealed that the women differed in the level of accountability they want from their partners. These differences might be tied to their AN severity, as individuals seem to want more accountability and caregiver support when they are acting out more ED symptoms, while those more involved in their recovery appear to want more autonomy and prefer partner support.

Wanting More Accountability. Amelia and Faith shared how when they were heavily involved in their AN symptoms their partners were not there to hold them accountable. This was something they wish they had more of. Amelia's experience was unique to the study because she was going through difficulties with AN at the same time when her partner was struggling with drug addiction. This made it difficult for him to hold her accountable, especially when he had his own views regarding recovery. The

support Amelia did receive from him she felt only occurred when she was extremely sick. Rather than supporting her in recovery, she described her partner's approach by stating, "he basically was like a buffer to the absolute abyss, like circling the black hole but not quite crossing the event horizon". Amelia felt like her partner was not there to help her in her recovery process and that he was not ready to support her in that process because he might have feared her progressing when he himself was struggling. This left Amelia craving that her partner would be more recovery oriented and would hold her more responsible:

I wish he would have called me out on my bullshit more and held me more accountable, um and that it had been a real thing where we are both try to do better instead of like "well I might be fucking up, but so are you" and you know what I mean and um I ... wish that he had kinda been more involved in my recovery [...] Like I wish he had been recovery oriented more like a source of motivation and strength in that area.

Amelia's experience highlights how important it is for a partner to be recovery oriented. Additionally, Amelia was struggling with her symptom use and believed that she needed someone to monitor that more and provide more caregiver support.

Faith also craved more accountability, but she acknowledged that at times she really appreciated how her partner did not monitor her AN or hyper focus on helping her in her recovery. Instead he showed his support through making her laugh and distracting her. Faith enjoyed having this when others in her life were all serious about the ED and concerned, although she was aware that it might not have always been helpful that he did not check in on her recovery more often. Faith also felt like her partner did not really

want to talk about the AN, so he was not providing partner support either. Overall, Faith felt that her partner's lack of holding her accountable hindered her recovery as well as contributed to a disconnect in their relationship. Both Faith and Amelia were struggling with their recovery and secrecy with use of symptoms. They were engaging in behaviors they wished they could stop and desired that they had someone to help monitor them and point out when they were making poor choices. This aligns more with caregiver support. Their experiences reflected how women may want more caregiver support when an ED is more severe and when the person is struggling with their recovery.

Wanting More Freedom and Less Caregiver Support. While some women desired more accountability and caregiver support from their partners, other women wanted less. For example, Emily wished her partner would transition away from caregiver support. Emily's husband provides support with monitoring:

He's just supportive with making sure I, I'm continually eating, and he'll check on me occasionally about my weight and make sure it's been stable. But if, um, we've been busy on a weekend and he knows I've been studying all day, he goes 'well what have you had to eat today?' and check in with me on that, and then he'll go 'okay lets go out to eat' or something, and we will go out to a place he knows I like to go to.

Emily's husband takes on the role of checking in on her weight and if she ate. Emily's husband also would be directive and tell her they are going out to eat if he feels like it is necessary while being supportive by choosing a place she would enjoy. Emily inferred that he did this often out of fear of relapse and understood the rationale behind him

providing caregiver support. However, Emily did wish the way he supported her would shift:

If anything, I want him to focus on it less now. Just because I have been stable, and I've been doing so well. But he's just afraid that I might relapse again, so he still likes to check in so, focusing less on it would be helpful for me because it's not necessarily something I like to think about all the time if you know what I mean. It's not something I like to define myself, like as the girl who had an ED or the recovering anorexic or whatever you want to call it. There's a lot more to me than that.

Emily felt that she was in a far different place from engaging in symptoms and wanted her husband to recognize that by providing less monitoring and more freedom. Emily might feel like there is a power differential at play and would like more equality, so she feels like an equal with her partner. Emily also perceives that the monitoring shifts the focus of the relationship to the ED rather than acknowledging that her identity consists of more than that. Caregiver support interactions may become largely focused on the ED, which takes away from and may prevent other important relational interactions and connectedness. As individuals progress further along in recovery, it seems that caregiver support can become problematic for romantic partners, and a shift to partner support is critical in preventing troubling power dynamics and creating space for more positive relationship interactions outside of the ED.

Ways Partners Support

In the current study, partner support was displayed in various ways. All of these methods of supporting the individual with AN were non-directive but allow the women to

feel like their partner cares about them and about their recovery. These methods of support helped women in a variety of ways.

Meal Support

One important area of support discussed was support with meals. This manifested in the study's interview narratives in various ways. One way partners supported the individual with the AN at meal times was by modeling healthy habits. Brenda found this truly helpful from her partner because she grew up with her parents constantly dieting. This created a distorted perspective on food, and having a new person in her life who could show her a healthier perspective was beneficial for her recovery process. In her interview Brenda described her partner's support when saying, "He had normal eating habits which was helpful. And um I don't know, when I got out (of treatment) he was really good about if I needed someone to eat with me". Brenda found his modeling a valuable tool in her recovery as well as having him there during meals. Meal time is often the most stressful time for people in recovery, because individuals are going against their urges to restrict intake and challenging their urges resulting from their AN, and this causes an immense amount of anxiety and guilt that lead meals to become true sources of stress. Having support with that time is treasured, and sometimes even just the presence of a loved one makes a difference. Having a partner there also allows for the modeling of pace in eating. Some women with AN eat more slowly as a symptom of the ED, but this also is something that is good to challenge in the recovery process. Claire shared this experience when she stated, "it's also helpful eating with someone else to practice pacing and things like that so it's become more natural". Claire's experience highlights how modeling is not only about food choices but can include pacing as well. Having this

support allowed for meals to become more natural for Claire and was one way her partner was able to support her.

Another way partners were shown to support the women during meal times was by helping prepare the meals. Preparing meals and cooking can be quite stressful for people recovering from an ED because it almost prolongs the meal time. Additionally, it can create stress with making choices about what to eat or how to prepare the food, as well as having to see the food being made. Thus, having someone do this can be helpful. However, for some this may be difficult because it involves giving up some control. Nevertheless, having someone there to help cook can be a true source of support. Amelia often expressed how she wanted more support from her husband at the time but did share, “like sometimes when he was feeling in a particular nice mood he would like make food for me and help me in that way”. Amelia did find this supportive for her recovery and helped her create progress. Other women’s experiences echoed Amelia’s, showing that another way partners can provide support during meal time is to create the meal.

Supporting the Treatment Process

Another way women felt supported by their partners was through their presence in the treatment process. This included going to appointments, attending support groups, and encouraging their partner to continue the treatment process and follow treatment recommendations. Emily touched on this type of support when sharing, “He visited me every day when I was inpatient, so he was supportive that way... he went to all the therapy appointments I asked him to, so he was supportive that way”. Emily felt that her husband’s involvement in the recovery process both enhanced her treatment and communicated her husband’s support for her. Emily’s account mirrored that of other

women in the study who also mentioned that supporting the treatment process ultimately conveyed showing support for them.

Distraction

Another type of support that emerged from the data was distraction. Women in the study commented on how when they are caught up in the anxiety of the ED distraction can be helpful in bringing them out of that and focusing more on other things. This allows them to not overthink about their food-related actions, which can help in preventing too much thought about food choices before meals or help in lessening the guilt that might result after meals. Brenda was one person who described the usefulness of distraction:

He was a good distraction, like he tried to do fun things with me too and it wasn't always about treatment. And he visited me like every day when I was inpatient and played games with me and made it feel like less like I was on my own. I think that was part of it, it made it feel like a wasn't on my own the whole time even though it was lonely I always kind of knew he was on the outside, that he would be there when I got out.

Brenda pointed out how distraction was not only useful during meal time; it was also supportive for her during the inpatient treatment process. Inpatient centers, like Brenda's, often restrict patient access to phones and internet in order to create a more recovery-oriented environment; however, that can also lead to boredom and more time for anxious thoughts. This was where having a supportive partner truly helped, and Brenda felt grateful to have received that from her boyfriend, including his role in providing distractions.

Listening

Findings from this study indicated that another important component to partner support was listening. Women often reflected on how important it was to have someone there to hear their struggles and hear their victories. This was not only beneficial for the women; it also allowed their partners to learn more about their experiences and help with understanding. Listening also helped to increase connectedness and intimacy between partners. Diane discussed how her partner's listening showed his true support because he was able to convey a level of caring and interest when he listened:

He would listen to me and that I think, more than just how he reacted to me telling him, but the part that he would actually listen and care what I did in treatment kind of made a big impact because it kind of just reassured me he wasn't going to, like not there to just hang out, that he was there for the long term and if he could get through this with me I think it would be good.

Diane's partner showed his support through his genuine interest and listening. Diane was moved by this and truly felt supported and cared about. Her partner's listening sent Diane the message that she had someone there who wanted to hear about her experience and accepted her despite the AN, truly fostering intimacy for the couple.

Supporting with Acceptance and Unconditional Love

The current study showed that one of the most profound components of support for the women was feeling a sense of acceptance from their partner and unconditional love. The women who perceived that their relationship was strong and felt truly satisfied expressed a sense of feeling fully supported by their partner despite the difficulties that their ED caused them. However, there is an important distinction between partners

accepting the individual and their recovery and partners accepting the AN symptoms. When an individual was motivated for their recovery, the acceptance from their partner enhanced that. Conversely, if the individual was engaging in symptoms and was not recovery-oriented, too much acceptance from the partner often felt like unhelpful enabling. Nevertheless, a level of acceptance from the partner regarding the development of the individual's AN and the partner's conveying that it does not make the individual less lovable were shown to be a component of a strong relationship and shown to help recovery, according to this study's participants.

Feeling Unworthy of Love

Women discussed how the notion of being accepted by their partner was difficult to comprehend. This was often tied to issues with self-esteem. Prior research has indicated that it is a common phenomenon for individuals with AN to struggle with their sense of self, and this was supported by the interviews in the current study. Diane stated, "but I think that's just part of the ED because you're afraid it makes you less worthy of someone loving you". This notion of being loved and accepted regardless of their flaws was astonishing to the women. When they did receive that acceptance, they were initially surprised, but it led them to feel safer with their recovery and weight restoration, and to feel supported. They identified that acceptance as enhanced their relationships.

Reassurance that Love is Not tied to Weight

Findings from this study indicated that one difficulty that can occur when women are still in the weight restoration phase of recovery and begin dating is that they may feel concerned about gaining the weight that is recommended for them in their recovery. This is what transpired for Claire:

I mean as far as body image like, I mean in some ways earlier on the relationship kept me in the ED because I was saying before like whenever I got a compliment about something it felt like okay that's something I can't change now. Or you know if he says something once, it has to be that way every time, sort of the black and white thinking I guess about um, you know, like he's only seen my apartment looking pristine, so I can never not clean everything before he comes over um, you know being obsessed with what I eat during the day before I see him so I am not boated and then also not wanting to you know, thinking that there were maybe excuses I could give like if I did have that feeling of bloating before I date or something I'd say "of I worked out really hard at the gym and I'm still full of water" but then do I have to say that every time. Sort of not wanting to set precedents for the way I thought we would move forward but at the same time kind of feeling kind of locked into that anyway because um, I thought that his first image of me was something that I had to um keep up.

Claire feared that she had created a standard for the way her partner viewed her and thought that if she did not maintain that version of herself her partner would not accept her and leave. Claire shared how this created difficulties for her weight gain, because she was afraid that her partner would no longer find her attractive. Eventually with time and with Claire disclosing more to her partner, he was able to convey more to her that he loved her unconditionally and not because of her weight or pristine apartment. This was difficult for her to believe, but Claire found that the idea helped her feel more assured with herself and allowed her to progress more in recovery. For Claire and other women,

learning about their partners' unconditional acceptance was supportive for both their recovery and relationship.

Acceptance as a Form of Support

Acceptance from the romantic partner was shown to be connected to support, as women who felt like their partner accepted them unconditionally felt supported by their partner. Diane felt this to be true:

He is like the most supportive partner I have ever had. Like I was a single mom and 30 and going back to school and not really looking to meet someone new.

And I say he puts up with me, but he doesn't really see it as putting up with me, he just accepts I'm not perfect but doesn't expect me to be.

Diane felt that her partner accepted her and did not see her flaws. This acceptance helped foster a belief in herself, and that was something that may have helped propel her recovery. Believing that she is loved for who she is and not based on characteristics such as her eating or weight allowed her to tackle the AN and to have faith in herself. Isabella also saw the benefit of more self-assurance on herself:

I feel much better and secure in who I am as a person because I am confident that he loves me as the person that I am now, not something that he wants me to be. I don't feel like I need to do anything to change or be a certain way to make him wanna stay, which I think in the past is what I've felt like.

Isabella felt that it took her husband's unconditional love and individual work in therapy to learn to accept who she is and be proud of it. This progression was imperative in her recovery because she no longer believed that she needed to shape herself into a certain mold, which had been a major contributor to her AN. By gaining a sense of security in

herself and learning to accept her own flaws, Isabella felt less of a pull to act on AN symptoms. Furthermore, her partner's support by providing unconditional acceptance of who she was helped her develop that for herself.

When Acceptance Feels Like Enabling

Unconditional acceptance of the individual does not mean accepting the ED. The study revealed that when partners seemed to accept the individual's symptom use it felt like unhelpful enabling to the woman. For example, Amelia felt that her partner and she initially bonded over the fact that they were both aware of each other's struggles related to mental health and accepted each other despite it. However, if this acceptance developed into comfort with the status quo of AN symptoms rather than accepting each other as individuals who were facing challenges, it was viewed as developing into an unhealthy form of codependent relationship:

[We] got into this codependent spiral, like the more time went on the worse it got and like the, I don't know, the other person's mental health bullshit was okay because I had my mental health bullshit, and my mental health bullshit was okay because they had their's.

Amelia described the codependency dynamic as making it difficult for her to recover. She felt that her partner was so accepting of her AN symptoms that it allowed her to not see it as an issue, thus enabling continued symptom use. Although Amelia felt supported and understood by her partner, his level of acceptance became too much about accepting symptom use and thus was detrimental to recovery.

Difficulties for The Romantic Partner

I asked my fiancé before I came here, I said, ‘You know, this is about relationships, and how my eating disorder affects us,’ and I said, ‘I know that it's not currently going on in front of you,’ but I said, ‘How do you think it affects you?’ And he said, ‘I wish you wanted pizza more often.’ -Isabella

So he gets frustrated with it because it's something that can't be fixed, it's not like I broke my leg and I wear a cast for 6 weeks and then I'm fine this is something that is always probably going to be there in the back of my head that something will set it off and other times it won't be quite so bad but it's always going to be there and sometimes it takes away joy from things that should just be fun and easy and not a problem and sometimes it sneaks in and makes me really sad or really angry and he hates watching that as anybody would. -Gina

When I got sick again, it really upset him. You know he didn't know why I couldn't just eat like a normal person. And he still doesn't quite get it. He accepts the fact that I'm a little cocoo, but... -Emily

As noted throughout this thesis, EDs not only take a toll on those who struggle with them; they can also cause stress in the romantic partners. The level of stress and difficulties for romantic partners vary from minor hindrances caused by the ED to severe distress. Partners might change their lives in some ways because of the ED and recovery. This can include not going on as many dates at restaurants, not having as much choice in food, having to make more time for meals and cooking, and making time for appointments related to treatment. Although it may involve aspects of daily life that a partner might wish were different, the women in this study described how their partners

often seemed to be willing to make these adjustments to support their partner and limit their distress.

Another challenge that the partners of these women with AN experienced was watching someone they care about struggle and not being able to fix it. There is a sense of helplessness that can take a toll on partners, and thus their finding ways to support the individual with AN rather than fixing the basic problem is a key aspect of their experience as a successful source of support. Partners can also experience caregiver burn-out, which is another reason why transitioning from giving caregiver support to more balanced partner support is beneficial for couples. This means not providing caregiver support indefinitely, but instead learning to transition the power to the person with the ED and allowing her or him to have more independence in decision-making and coping. More research into how this transition should occur is recommended.

Impacts of Relationship Problems

The interviews from this study indicated that the women's AN symptoms were at risk of flaring up when there were relationship difficulties and break-ups. Hannah and Brenda both experienced break-ups that drove them into a spiral with their AN. Brenda described how negative her former relationship was and how it was a true catalyst with her ED:

I didn't have the confidence, and after that I think he just kind of decided that gave him the card to treat me really horrible because I wasn't going to do anything about it. And so he made like my body image really worse like he would call me fat or tell me I need to change this or that about what I looked like and compare me to this other girl and um it got to kind of this abusive point and I

didn't have the self-confidence to do anything about it and my eating got worse at that point so even though I had been to treatment I think it just didn't work because I put myself back into a negative situation. Um which ended up with him breaking up with me and I ended up devastated for like months and made everything even worse with my eating, so it was just emotionally linked to that situation that it started getting worse and my depression started getting worse and linked to my symptoms and so that went downhill for a while.

Brenda's break-up led to increased severity of her AN symptoms, but the negative relational patterns that were occurring while she was dating were also a source of stress, contributed to her lack of self-worth, and were a barrier to her pursuit of recovery.

Brenda reflected on how once she was no longer experiencing that relationship distress she was able to pursue her recovery and make better choices regarding food and her emotional well-being.

Hannah also noticed how difficulties in relationships and fears about not having the type of love she desired in her life caused a worsening of symptoms. This highlights how relationships are often tied to a sense of worth, and how challenges in relationships might lead the individual to doubt her or his worthiness. When this sense of doubt exists, the woman might try to alter her behavior or seek control through her AN patterns. This is what Hannah experienced:

I think having a boyfriend was always a source of validation, and I always like needed that to make me feel whole, to make me feel like I'm good enough, that kind of thing. And I think where my ED has sort of flared up the most is when there might be any challenge to that paradigm that I have developed in my life, or

where I felt like I couldn't control things in the relationship, or, you know, not just in relationships but also elsewhere in life and sort of clung to the ED then as my way of controlling since I kind of knew deep down I could not always rely on this one person in my life to always be there, we can't control that.

The AN also gave Hannah control, and she felt that when her relationships were something she had no control over she could turn to controlling her food intake. Hannah also felt a need for validation through having a partner, which meant a greater risk of symptoms when things in her relationships were not going well. Hannah was able to work through this by learning to value herself and become more independent. Nevertheless, her experience depicts how relationships can influence ED severity.

The present findings provide evidence that another way that relationship difficulties might influence an ED such as AN is when there is fighting between the partners. Emily experienced this influence when she and her husband moved across country. This shift led to many stressors that contributed to her relapse, but one of those stressors that she especially identified was the couple's marital conflict. Emily's husband was a member of the military and shifted from being gone often to living with her. This greatly increased level of interaction led to arguments:

So, my husband was gone quite a bit before we moved out here, and I had to get used to him being around all the time, and our relationship was suffering because of the fighting from that. And I took it out on myself when I relapsed so... yeah.

Emily felt frustration from her relationship problems and turned to her AN to cope. This accentuates how couple relationship quality can influence AN, and in this instance in terms of the difficulties in one system domain leading to difficulties in another. Emily

shared how one of the reasons she went into an inpatient treatment program was because they required couple counseling. Through this intervention, Emily felt that her relationship improved, and that that also helped her AN. Whereas couple relationships can adversely affect ED severity in a variety of ways via fighting and break-ups, positive relationship qualities such as connectedness can help reduce AN severity and aid in recovery. Clinical interventions have potential to reduce negative effects of relationship conflict on EDs such as AN.

Summary

The interviews in the present study show the wide variety of forms of support that can be provided by a romantic partner. Emerging from the data were the notions of caregiver support and partner support. Caregiver support with monitoring and more accountability for the women was found to possibly be desired more when the woman was actively engaged in expressing AN symptoms and struggling with recovery. However, women who were further along in their recovery process expressed more of a desire for and happiness with partner support. This might be because partner support allows for individualization and prevents power dynamics in the relationship. Partner support transpired through various form of meal time support, attending treatment appointments, distracting and listening. Providing unconditional acceptance and love was also shown to be meaningful for the women and their recovery as it helped reassure them that there are not too flawed because of their disorder and that they do not have to try and conform themselves, a factor contributing to AN. However, when support was not for the woman's recovery but rather accepting the status quo of existing AN symptoms, women felt that their partner was engaged in counterproductive enabling. That acceptance might

arise when the partner is confused about the best way to show support. This shows the connection between level of understanding of AN and the patient by the partner and the ability to provide useful support. Partners were shown to help more in domains of the ED that they understood and therefore women in the study found it helpful to inform their partners how to support them when their partner did not understand.

CHAPTER 4: DISCUSSION

The primary purpose of this study was to investigate through qualitative methods how relationships are affected by AN, how AN symptomology is affected by relationship factors, and how romantic partners of those women with AN help or hinder recovery. Much of the systemic research into EDs has focused on the family unit. Previous literature emphasized this problem. For example, Kirby et al. (2015) stressed that adults struggle more than adolescents to receive relief from their ED, and the standard treatment for adults is individual therapy despite partners being negatively affected and typically wanting to help in an effective and loving way that might promote recovery. This finding was echoed by participants during the phone screening, when a few shared how their primary reason to participate was because they wanted to contribute to research on the influence that EDs have on couples because they and their partners found that information scarce when looking for resources. This affirmed the need for more research into how couples are affected by EDs and how romantic partners can help in recovery.

The present study's results aligned with those of previous studies, such as Linville et al. (2016), in revealing a reciprocal relationship between relationship satisfaction and AN symptoms. The findings showed how romantic relationships can influence AN in particular and recovery in both positive and negative ways, as well as how AN symptoms can influence individuals' couple relationships. The study found how romantic relationships can negatively affect AN recovery through couple conflict or when a break-up occurs. However, the major set of themes revealed by the women's responses to the qualitative interviews showed that positive aspects of the couple relationship such as unconditional acceptance from one's partner, open communication, actively listening by

the partner, and couple intimacy all aided in lessening AN symptom severity and promoted recovery. The individuals' AN symptoms were also shown to affect the couple relationship in terms of causing isolation by the individual with AN, and stress and helplessness from the recovery process that can be experienced by the partner. The present study highlighted how for a few of the women isolation might occur prior to the manifestation of ED symptoms and could possibly be related to attachment. This confirms Bamford and Halliwell's (2009) research findings suggesting that the development of an ED may serve a direct function to individuals with high attachment avoidance by helping the individual to achieve emotional and social avoidance. The study showed how isolation can also take a toll on the romantic partner. Research also shows that being the primary support for a person with an ED can result in feelings of emotional distress, self-blame, helplessness, frustration, and inadequacy (Highet, Thompson, & King, 2005; Huke & Slade, 2006; Whitney et al., 2005). The current study confirmed this, as women suspected and expressed that their partners were feeling aspects of powerlessness and frustration. These bidirectional influences found in the study are consistent with those from previous studies, in that EDs and relationship dynamics have reciprocal influences.

The study also was intended to expand upon previous research and explore more of what the support from a romantic partner has looked like for the participants with AN, and the women's perspectives on its usefulness. Furthermore, new themes and contributions emerged from this study that can add to the limited literature on couples dealing with AN. This study found that support occurs through various methods and patterns. Two philosophies of support emerged: caregiver support and partner support.

When analyzing the data, another theme arose, involving how the partner's level of understanding about the AN affects the couple relationship and the individual's recovery. Level of understanding was also shown to be interconnected with and influence the quality of the support that was provided. Women felt that their partner could never understand all the intricacies of the ED, but they did find that their partners could relate to certain aspects or domains of the ED. Overall, the present study was able to both confirm previous literature and add to research through the stories of nine women who experienced relational impacts of their AN.

Contributions to Research

Level of Understanding

One of the main contributions from this study was the discovery of how understanding can influence couples experiencing AN and the recovery process. All nine women mentioned how understanding has played a role in their relationship. There was a shared belief that their partners could never fully understand their AN. This difficulty with understanding was especially relevant for food related symptoms such as restriction and guilt regarding meals. Women found domains of their AN that their partners could relate to more to counteract this difficulty in understanding the whole picture. For many, they found that their partners could understand body image issues and relate to that component of the AN. Others felt that their partner did not understand the body dysmorphia they experienced but were able to understand aspects of their AN such as their basic moods and stresses. Women found it vital that their partner understood how their AN developed and how it was related to coping and control. It was also important that their partner understood that while they have issues with body image it did not mean

that AN was about vanity. When partners showed this understanding about the etiology of the ED, women felt like supported and a bit more understood by their partner. Support also was revealed to be linked to the partner's level of understanding. Understandably, partners seemed to help more in the areas that they understood. For example, those that comprehended the role that body image played could support their partners more through validating and communicating about that issue. Even though partners might not understand the ED as a whole, they were shown to understand components that might help facilitate the support they give. While this concept was mentioned in some of the preexisting literature, it lacked the attention that it deserved. Previous research focused on communication and connectedness between the partners, and as the current study highlights, understanding often precedes communication and contributed to a sense of connectedness. Therefore, a new finding discovered was that partners who make attempts to understand more about the ED communicate more with their partner, and women with partners who did so identified more connectedness and intimacy in their relationship. Furthermore, level of understanding helps develop partner support and is supportive in of itself for the women.

Caregiver Support Versus Partner Support

Findings about support depicted two major themes of support. These were termed caregiver support and partner support. These themes are new to the conceptualization of couples facing AN, and they are significant for both recovery and relationship functioning. Caregiver support consisted of more checking in and monitoring, taking control from the individual with the AN, and telling her what to do. This is often what is recommended to parents of adolescents with EDs. However, a parent-child relationship is

hierarchical, whereas a romantic relationship is ideally more egalitarian. Thus, provision of caregiver support can conflict with equality by creating a power differential. Caregiver support might have an appropriate place, such as when the individual with AN is heavily using symptoms to avoid emotional distress and is struggling in her recovery. This was shown to be relevant when the women expressed wanting more accountability from their partner. However, as suggested by the findings of this study, when women progressed further in their recovery they might desire and value more partner support.

Partner support is support that does not create a hierarchical relationship. It includes less monitoring and checking in, and it consists more of offering possibilities, listening, distracting, cooking, attending treatment appointments, and more. This type of support was meaningful to women without feeling overbearing. Partner support was also shown to contribute to feelings of individualization for women and prevented against feeling dependent on their partner. This was helpful for some in instilling the confidence that they needed to continually challenge their ED.

Attunement

This study adds another contribution to the literature by identifying the new concept of attunement and its impacts. Attunement refers to when the romantic partner was able to “read” the woman’s feelings and specifically cues of her anxiety even before she might communicate them explicitly. Women discussed moments when they would be at dinner with their partner and begin to feel anxious, and their partner would recognize that and then help them through distraction, offering encouragement, listening, etc. Women were surprised by how well their partners were able to be that attuned to them in those moments, which contributed to their feeling even more supported. This attunement

also highlights the level of connectedness and intimacy that some of these couples experienced. While AN was reported to lead to isolation and disconnectedness between partners, this was more so true when the AN was severe, and women were not yet in recovery. As the women pursued recovery and disclosed their AN to their partners, they all felt that they grew closer to their partner. This moment of disclosure opened the door for support and fostered connectedness. This connectedness might have been a factor in fostering attunement. This was one area that was not discussed in previous literature, and due to the small sample size of this study there is a need for more investigation into how attunement develops and aids in recovery.

Co-dependency and Enabling

Another theme that emerged from the data was co-dependency and enabling. There is little research into these topics relating to couples and EDs and much more research needs to be conducted. The present study showed how partners might be showing acceptance to their AN partner in hopes of conveying that they love and support the individual. However, when the acceptance focuses too much on accepting the existence of the AN symptoms, it can be perceived as enabling to the individual with the ED, and it in fact may have that consequence. Therefore, it is important for the partner to know how to communicate their acceptance of their partner regardless of the ED, without communicating that they accept the individual's use of symptoms. Furthermore, when women felt that they lacked individualization and were too reliant on their partners, they reported experiencing a sense of codependency. Previous literature suggested that women with EDs often fear rejection and devalue themselves, which results in feeling a need for reassurance and validation from others (Bamford & Halliwell, 2009; Evans &

Wertheim, 2002). It is possible that this contributes to some women seeking out relationships and having difficulty individuating, thus leading to codependency. Codependency and enabling were new contributions to the literature on AN and romantic relationships, and these patterns were shown to be harmful for recovery and the couple's relationship.

Theoretical Considerations

Informing the underpinnings of this study were the assumptions and concepts of family systems theory. Family systems theory assumes that an issue with one person affects the whole system. This was displayed with how AN not only affects the women, but it also affects their romantic partners and the couple relationship. These effects ranged from wishing they ate more junk food as a couple to feeling helpless and angry about the situation. Family systems theory also includes the concept of hierarchies in systems. Hierarchies emerged in the results of this study with caregiver support compared to partner support. Caregiver support was shown to create a hierarchy that is not normally considered desirable in a couple system, indicating how it might not be an ideal support pattern for couples.

Another component of family systems theory is feedback and feedback loops. "Positive feedback" promotes change by rewarding deviation, whereas "negative feedback" discourages change (Smith & Hamon, 2012). Both of these types of feedback were exhibited in the study regarding partner's communication of acceptance. When there was too much acceptance of the AN symptoms by the romantic partner, it provided negative feedback meaning change or recovery was less likely to occur. This was problematic for the wellbeing of the individual and thus the wellbeing of the couple.

Conversely, some couples showed more positive feedback through recovery-supporting behaviors that promoted change. Partners' support for healthy behaviors often aligned with a positive feedback loop and helped increase or maintain an individual's motivation to recover.

Methodological Considerations

The current study had several assets that contributed to the strength of the data. By using qualitative means, data were able to emerge from participants' narratives, and a theory of how experiences are shaped by the interaction between AN symptoms/dynamics and romantic relationships was able to emerge. The nine interviews were conducted in person, creating an environment that might elicit more information compared to other interview methods, and providing anonymity promoted disclosure further. Triangulation was used with the data, Daly (2007) defines data triangulation as the process of gathering accounts from participants who are at different stages in their experiences. Moreover, because findings gathered accounts from different stages of recovery and at different stages in their relationships, triangulation occurred. Some women had been in recovery for a few years and scored a 0 on the EAT-26, indicating little to no current ED symptoms, while others felt like they were still in the beginning of their recovery and scored as high as a 19 on the EAT-26, indicating some symptom use. Additionally, women's relationships ranged from .75 years to 7 years, some were no longer together with their partner, others were dating, others engaged, and a few were married. These different stages of recovery and relationships help in the triangulation of data. The codes and themes that were extracted from the interview transcripts in this study also were validated through checking in with the participants after the coding

process. The researcher sent a summary of the findings and themes found (Appendix C) to all nine participants to ask for their feedback regarding for accuracy. Eight participants followed up in confirming the findings and articulated that the findings affirmed their experiences and those of their partners. These responses were all short and similar to Hannah's, "I was able to read through your email, and I think it definitely captures what we discussed. Please let me know if you need anything else from me". The ninth participant never returned the phone call and email.

While this study had numerous strengths, there were also limitations. Because a goal of the study was to provide a homogeneous sample regarding ages of participants and ED type, the sample consequently lacked diversity. All participants were Caucasian females in heterosexual relationships, and thus the lack of diversity is a limitation. Another limitation was that demographic information was not obtained that could have influenced the experiences of the women. The sample was also small, with a size of nine, and more information and stories could be gathered to expand upon the current findings until "saturation" is reached, meaning the participants are no longer sharing new experiences but rather reiterating other participants' stories. This investigator had the impression that additional interviews were likely to reveal some new themes; i.e., that saturation may not have been reached. Another limitation to the study is that interviews are a form of self-report data. It is important to note that EDs such as AN are often associated with secrecy, and thus participants might not have shared all aspects of their experience with a stranger. Additionally, the retrospective nature of the interviews might also elicit a less accurate picture of the experiences, as interviewees were asked to recall many details from the past. The study was also limited to only having the perspective of

the female partner who experienced the ED, and thus there were inferences made about the male partner's experiences that might not be completely accurate. The last limitation worth noting about the study was that the interview transcripts were only coded by one coder. Therefore, the data lack evidence of inter-coder reliability. Despite the lack of reliability, the study did include procedures to minimize bias. For example, I, the investigator and coder, kept a journal of how I felt hearing when other women's experiences and the similarities and differences I saw with how my own ED influenced my couple relationship. Keeping this written log aided in differentiating my experience from the women's in the study and limited potential bias. Discussing the process with my own therapist of interviewing women with AN and hearing about their experiences was also critical in limiting my own process and experiences from influencing my coding and findings.

Implications for Research

Limitations to the study have helped shape some recommendations for future research. It is recommended to have more studies continue to expand upon the current study's new findings by using larger samples and providing a more diverse sample. There is a need to expand upon the new theme of caregiver support. It is recommended that investigators look more at the caregiver burnout that can result from providing caregiver support and looking more at the effects that this type of support can have on couple dynamics. It would also be interesting to get the males' perspectives on how providing support has affected them, and more about their couple experiences with the AN females in general. Original themes that emerged from this data set that have very limited prior research evidence include attunement, codependency, and enabling. It is recommended

that researchers also look more into how these affect couples and ED recovery, to expand on understanding more about variations in these experiences among couples who are dealing or dealt with AN. An additional recommendation for future research is to investigate the timelines of disclosure, understanding and support. This study showed how these themes may develop and progress differently for various couples; however, this was not the primary focus of the study. Nevertheless, uncovering more knowledge about timelines in couples' progression through the process of disclosure, understanding and support would be valuable.

Implications for Clinical Work

One of the main goals of this study was to inform clinical work for adults with EDs and help create more targeted interventions for couples. Given the high mortality rate and that only 46% of adult patients with AN recover, it is critical to expand on existing clinical interventions (Steinhausen, 2009). Both preexisting literature such as Arcelus et al. (2013) and the current study highlight how interpersonal factors and relationship distress play roles in illness persistence, and therefore treating couples and the issues they face is beneficial and critical to helping promote recovery. AN was also shown to cause distress for both members of the couple, and this study contributes to informed best practices for helping address the distress that couples with a member diagnosed with AN face. The current study helped highlight a few areas of consideration for clinicians.

Increasing Connectedness

The study showed how connectedness was important for couples as a way to facilitate communication and open the door for support. Women who felt distant from

their partner were more likely to keep secrets and not disclose all aspects of their disorder to their partner. This was detrimental for recovery and also increased relational problems. By increasing couple connectedness through methods such as therapy, therapists can bring a couple together, allowing them to support one another and work on the recovery together. Women in the study shared that when they did divulge more to their partner it also fostered intimacy. Therefore, work with the individual who has an ED to increase self-disclosure to their partner will not only help them open the door for support but also increase the connectedness in their relationship and enhance the relationship's quality. Furthermore, when partners showed interest in trying to understand the ED and empathized with their partners, the couple appeared to be more connected. Therefore, clinicians can also work to help partners communicate and understand one another to aid in the level of connectedness. As mentioned previously, there are very few treatment models designed for couples where a member is struggling with an ED. UCAN was designed to address this gap and focuses on teaching couples communication (Bulik et al., 2011). However, UCAN does not focus much on increasing connectedness for the couple. Thus, clinicians who use this model of treatment or other models would benefit from helping address a couple's connectedness and intimacy in order to promote support and recovery.

Psychoeducation

Another important consideration for clinicians is the importance of psychoeducation for romantic partners. All the women in the study felt that their partners could truly never understand all aspects of their AN. Nevertheless, when their partners made attempts to understand, the women felt supported. Additionally, men in the study

were perceived to feel more confident in supporting in domains that they understood. Consequently, increasing understanding through methods such as psychoeducation can help the partner support the individual with the ED. Higher levels of understanding from a partner were also shown to contribute to more comfort in communication between members of the couple and increase intimacy. Therefore, increasing a partner's understanding might affect the couple dynamics in a positive way. Overall, psychoeducation should be considered to be an important component of treating a couple affected by AN, as a way to benefit both the individual's recovery and both partners' relationship satisfaction.

Transitioning from Caregiver Support to Partner Support

Clinicians might also benefit from becoming aware of caregiver support compared to partner support. Caregiver support might provide benefits and be desired when an individual is struggling with symptoms or in early stages of recovery. However, when caregiver support is provided by a partner, a hierarchy and problematic power imbalance could occur in the relationship. This might lead to resentment on both ends as the individual with the ED might want more freedom and the other partner might experience caregiver burnout. It then might be critical that couples make sure to transition to partner support, and this is one area in which a clinician can help. Couple therapy could provide a context for couples to make sure they are supporting each other in a healthy way. A therapist can also encourage individualization from the person with the ED and promote more self-directed recovery choices on their end rather than having a partner dictate the direction. Ultimately this could prevent unbalanced power dynamics

that could lead to difficulties in the relationship and promote a sense of teamwork for the couple.

Conclusion

While this study has shown that there can be many problems that arise for a couple when one person has AN, it is important to acknowledge the resilience that both members have. Women in the study all shared how despite some fears and shame about their ED they might have had, they saw a true benefit to opening up to their partners. Disclosure was shown to bring couples together and create a strong bond. Some women even expressed feeling that the ED might have led to more connectedness compared to a couple that did not have to go through something similar. While partners might not be able to ever fully understand their partners experience with AN, the support they were able to show contributed to a real strength in most of these couples. Recovery is a difficult journey, but it seems that those who have an informed and supportive partner along the way might benefit both in their recovery and in their relationship.

APPENDICES

Appendix A: Participant Descriptor Data

Name	Age	Race	Eating Disorder subtype	Relationship Length (years)	Still in Relationship?	EAT-26 Score	Age of ED onset
Amelia	24	White	AN binge/purge type	6.5	No	0	15
Brenda	21	White	AN binge/purge type	1.5	No	0	≈16
Claire	26	White	AN restrictive type	1.5	Yes	7	≈17
Diane	31	White	AN restrictive type	0.75	Yes	0	14
Emily	25	White	AN restrictive type	6	Yes	0	18
Faith	21	White	AN binge/purge type	3.5	No	19	14
Gina	30	White	AN restrictive type	7	Yes	2	27
Hannah	32	White	AN restrictive type	5	Yes	11	≈22
Isabella	31	White	AN restrictive Type	3	Yes	5	≈22

Appendix B: Interview Questions

Semi-Structured Interview Questions:

- How did your ED develop?
 - What did your relationships look like at that time?
- Tell me more about what treatment for your anorexia has looked like.
- How did you disclose your eating disorder to your partner?
 - How did that impact you both as a couple?
- When you have struggled with symptoms, how did you cope?
 - Who did you turn to for support?
- How is your relationship with your partner?
 - Has it always been that way?
- How does your partner feel about your eating disorder?
 - Have the feelings ever differed?
- What role does your partner take in your recovery?
 - What role do you wish they would take?

Appendix C: Summary of Findings Sent to Participants

Hello! I wanted to thank you again for participating in my thesis project. I have been working hard on coding the 9 interviews I was able to collect and synthesize the information I found to formulate what I feel describes the multitude of things couples with eating disorders can face. I wanted to report to you my finding to make sure you feel I was able to capture the picture correctly and that you feel like it aligns with your perspective in ways. While the interviews did differ slightly there was also some common themes, so my findings are as follows:

The couple is largely impacted by the level of understanding a partner has about the Eating Disorder (ED)

- The partner can never fully understand the intricacies of the ED without have gone through it
 - When level of understanding is extremely low it can lead to significant hurt and relationship difficulties.
 - There is often a fear of judgment because of the fear that he would not understand
 - Which makes intimacy difficult
- For some partners understanding certain aspects related to the ED, but not others
 - Understanding it's about control
 - Understanding it is not only about the looks
 - Understanding body image is a part of it but not a vanity thing
 - However, other partners thinking it was about the looks

- Understanding the need for treatment, brain chemistry factors, psychological influences
- How impactful attunement is- when a partner can read their partner is struggling
- Importance of communication
 - Don't need to understand everything to communicate
 - Some topics are easier to communicate compared to others
 - Areas he does understand
 - Not assuming he will know- communicating needs to the partner is beneficial
 - Communication bringing people couples closer together- compared to secrecy which is detrimental
- Missteps can happen, but it can be repaired
 - Empathizing and trying to understand matters and can aid in repair

Variances in Support from Romantic Partners:

- Disclosure- opens the door for support
- Caregiver support vs partner support - Caregiver support mirrors more the support style of a parent. It is more directive, and the partner takes on more responsibility with holding the woman accountable. Partner support differs because the partner provides less commands and more of suggestions, allowing for more individualization for the woman.
 - Giving suggestions but not telling has been helpful
 - Difference from parental support

- Differences with participants in how much accountability they want from partner
 - May differ with severity/ stage of recovery- people who are more symptomatic might need and want more caregiver support but want that to transition to partner support
- Partner support allows for individualization
 - Compared to co-dependency and losing your identity that some participants mentioned
- Different types of support seen from partners:
 - Meal support
 - Help with choices
 - Help with pacing
 - Help with cooking
 - Visiting in treatment/ going to appointments
 - Distracting
 - Listening
- Acceptance/ unconditional love have been shown to be helpful
 - Can conflict with the isolation EDs often have
 - ED is tied to feeling less worth of love so someone saying you are worthy helps
 - Reassurance (love is not tied to weight)
 - Helps with the fears of body changing

- Too much acceptance can feel like enabling- when the partner is accepting the ED moves beyond just accepting the recovery struggles
- What isn't helpful
 - Relationship difficulties can be detrimental to recovery and worsen symptoms
- Ties between understanding and support
 - Partners can help more in areas where a partner understands more
 - It is helpful to not assuming he will know- communicating needs to the partner

Main Take-Aways:

- relationship difficulties can impact ED symptomology
 - reiterating previous findings of reciprocal influence
- Partners may understand more non-food related or non-weight related aspects of eating disorder
 - partners can help more in these areas
- attunement is something that enhances the relationship and helps with recovery
- co-dependence and enabling
 - tied to too much acceptance
 - tied to not having individualization
- caregiver support vs partner support
 - might need more caregiver when truly severe and more accountability
 - however, partners must shift to more partner support to prevent weird power dynamics and allow for individualization

Those were the main themes and things I saw and gathered from all 9 interviews. I hope to hear your thoughts and let me know if you feel like something conflicts with your experience. Once again, I truly appreciate your help in this and it was an honor to hear your story!

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