Is the Therapeutic Alliance Overvalued in the Treatment of Eating Disorders?

Amy Brown, DClinPsy[1]*
Victoria A. Mountford, DClinPsy[1,2]
Glenn Waller, DPhil[3]

ABSTRACT

In this article, we make the case for a systematic program of research into the causal relationship between the therapeutic alliance and outcomes of psychological treatments for the eating disorders. To make that case, we need to begin by considering the validity of existing assumptions about that alliance-outcome relationship. We will then suggest what research is needed to allow clinicians to structure their work to best effect (e.g., should therapists focus on establishing a strong alliance even if it means not applying more therapy-specific techniques, or should they stress the application of those techniques even when the working alliance might seem likely to be weakened as a result). Although the authors have a background in cognitive-behavioral therapy (CBT), our aim is to suggest a research base that applies to a variety of psychotherapies, allowing for common or different conclusions about the alliance-outcome relationship, depending on what the proposed research indicates. © 2013 Wiley Periodicals, Inc.

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Chicken or Egg? Some Assumptions, and Some Early Evidence

The therapeutic alliance is one of the oldest concepts associated with psychotherapy. We would not argue whether a good alliance is necessary for effective therapy—it is vital to keep the patient engaged. The question is whether that alliance is sufficient to drive therapeutic change. It is commonly assumed that the alliance is a major nonspecific factor driving therapy outcomes, and there is some suggestion that this causal link might be the case for some therapies.[1] However, substantial exploration of the association between alliance strength and therapy outcomes does not support that assumption. Across psychopathologies and psychotherapies, the alliance-outcome correlation is about 0.22—in other words, the alliance explains about 5% of therapeutic gains.[2] Even then, more than one causal explanation is possible.[3] The alliance might indeed be causing clinical improvement: however, it is equally possible that clinical improvement is driving the alliance, or that some third factor is responsible for both. DeRubeis and colleagues[3] summarize the possible causal routes that we need to consider.

As an example, in the field of cognitive therapy for depression, a set of well-designed studies exploring the temporal relationship between therapeutic alliance and symptom change has identified a pattern at odds with that traditional assumption.[4,5] They indicate that initial symptom change leads to improvements in the therapeutic alliance, and that this change initiates a cyclical process, where the enhanced alliance predicted further symptom change. Furthermore, there was some indication that this pattern of linkage was related to the theory underlying the intervention. The aspect of the alliance that predicted symptom change in CBT was "agreement" (on goals and tasks), as one might expect with the task- and goal-oriented nature of CBT. In contrast, symptom change resulted in subsequent improvements on both the "agreement" and "relationship" elements of the working alliance, suggesting that patients feel closer to their therapist as a result of benefitting from treatment.[5]

However, despite this evidence in other disorders, there seem to be different beliefs among clinicians in the field of eating disorders. A survey of eating disorder clinicians showed that 90% endorse the belief that a strong early therapeutic alliance will result in subsequent weight gain during CBT for anorexia nervosa.[6] Moreover, many clinicians report that they are prepared, to some extent, to prioritize the therapeutic alliance over other aspects of CBT.

We recently tested this widely endorsed belief that the alliance is a causal agent in clinical

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*Correspondence to: Amy Brown, Institute of Psychiatry, King's College London, 16 De Crespigny Park, London SE5 8AF, UK. E-mail: amy.brown@kcl.ac.uk

[1] Department of Psychological Medicine, Institute of Psychiatry, King's College London, United Kingdom

[2] Eating Disorder Service, South London and Maudsley NHS Foundation Trust, United Kingdom

[3] Clinical Psychology Unit, Department of Psychology, University of Sheffield, United Kingdom

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outcomes. In a preliminary study of CBT for adult outpatients with anorexia nervosa,[7] the patients reported a strong alliance overall. However, we found that symptom change (in the form of weight gain) predicted the development of the subsequent therapeutic alliance, but that there was no relationship in the opposite direction. Indeed, there was an unexpected (though nonsignificant—$r = -.29$) trend for a particularly strong early therapeutic alliance to predict less weight gain in the later part of treatment. One possibility is that a strong alliance can inhibit clinicians from focusing on dietary change, as that change might be feared and avoided by the patient.

Again, we are certainly not proposing that a good therapeutic alliance is unnecessary—merely that it seems to be overvalued as a therapeutic tool, given the evidence to date. The results from this very early literature suggest that the alliance might not be sufficient to "do the work," at least in some therapies. Therefore, we argue that research is needed to test the relationship between alliance and outcomes in the eating disorders, either to support the assumptions that predominate, or to rectify them in a way that enhances clinical practice.

What are the Key Questions, and What Research is Needed?

Replication and Extension of the Existing Research

Clearly, the first issue here is the generalizability of the findings to date. Will they apply to different therapies, different eating disorders, different age groups, and so on? Is there clearer evidence that an excessively strong alliance can weaken outcomes? Our research proposals have to address generalizability. For example, is the therapeutic alliance more or less important in therapies that emphasize behavioral change or in those that emphasize the relationship as the mechanism of change? Similarly, while there is evidence that clinician age is positively associated with the client's perception of the alliance,[8] there needs to be more investigation of the role of other therapist variables that might moderate the alliance-outcome relationship (expertize, tolerance of uncertainty, etc.). In addition, the interaction of patient and therapist factors on the alliance-outcome association might be important. Among patients, such factors might include illness duration and previous experiences of treatment (exposure to different therapeutic modalities, "failed" treatments, etc.), but the interaction of those features with therapist characteristics (e.g., training, gender) will also merit consideration. The result might be different clinical "rules" for different contexts and different therapists, or it might be a broad "rule" about how the alliance is viewed (cause or consequence of symptom change), but it would be better to know that any "rule" is justified rather than being assumption-based. It is to be hoped that the development of such "rules" will enhance the association of the alliance and outcomes in future clinical practice (whatever the causality of that relationship). However, we suggest that any replication of meta-analyses[2] to determine that improvement should distinguish the outcomes of studies based on completer vs. intent-to-treat analyses, as it is quite possible that those who drop out have different alliance patterns. It will also be important to consider whether studies employ selection and retention criteria (e.g., only entering a patient into a trial if that patient returns for the second session) that result in a sample of patients whose tendency to ally with the therapist is not reflective of routine clinical settings (e.g., higher level, less variability).

To ensure comparability of studies, we propose that a common set of measures should be employed (behavioral change, body mass index, Eating disorders examination-questionnaire, working alliance inventory-short form). While it might seem strange for a group of CBT clinicians to be recommending the use of a measure of the alliance that is based on attachment principles, we have found it to be useful across therapeutic approaches. However, it is important that the patient should be the one who completes the alliance measure, as evidence to date is that the patient's (less optimistic) perspective has greater clinical validity than that of the therapist. It is also important to consider the degree to which patients see their needs as unmet, as addressing those needs can be a key factor in enhancing patients' (but not therapists') perceptions of the working alliance.[9]

Appropriate Designs for Studies of the Alliance–Outcome Relationship

Whatever the therapy or the eating disorder under consideration, the core design for such studies is, inevitably, longitudinal. Cross-sectional designs have shown a weak link between alliance and outcome, but have no contribution to causal understanding. We advocate a path analysis approach that is based on multiple measurement points.[10] In other words, it should be possible to

use early symptom change and alliance at time point 1 to predict both symptom change and alliance at time 2, and so on. However, it must be remembered that there are systematic biases in such studies, particularly associated with the way in which severity and prognostic factors influence the therapy chosen for the disorder (e.g., the choice of a less behaviorally based therapy for a chronic eating disorder, which might enhance the level of alliance while reducing clinical outcomes). Such studies might merit the use of propensity adjustments control for such biases, clarifying the association of the alliance and therapeutic outcomes.[11] Moreover, whenever feasible, clinical factors (e.g., length and severity of illness, axis I and II comorbidity) should be controlled for when modeling the alliance-outcome relationship.

Why Might Clinicians Overvalue the Alliance?

When the preliminary research to establish generalizability of the nature and causality of the alliance-symptom change relationship (above) is complete, then we will be in a position to determine why clinicians hold the alliance in such high regard as an agent of change. One possibility is that they will turn out to be correct, at least for some therapies. Alternatively, clinicians might focus on the alliance because it is related to therapy outcomes that are less tangible or that are not directly addressed in many research trials (e.g., social functioning, patient satisfaction). Therefore, therapists' views should be sought in order better to understand their focus on the working alliance. However, if those hypotheses prove to be groundless, there will be a need for systematic research into the beliefs of clinicians, and what drives their overvalued ideas. It has been suggested that our own biased thinking impedes learning from clinical experience.[12] Perhaps clinicians who endorse the importance of the therapeutic alliance seek and attend to information that evidences alliance as a change process—preferentially remembering patients with whom we had a good therapeutic alliance and who did well in treatment. However, there might also be other such biases—perhaps there is something rewarding for clinicians in believing that we are personally important to bringing about change in our patients, rather than attributing improvement to application of techniques?

In this case, the obvious first step would be to use a survey design to ask clinicians with different therapeutic orientations whether they value the therapeutic alliance with different eating disorders, whether they prioritize it over therapeutic techniques, and why. However, we also recommend the measurement of clinicians' own characteristics as potential predictors of the holding of such attitudes. For example, is a greater reliance on the alliance related to the clinician's age, gender, personality or emotional traits? Would the pattern in the eating disorders be similar to that for other disorders?

Modification of Clinicians' Beliefs?

If the proposed research does provide support for the hypothesis that therapeutic alliance is overvalued in the treatment of eating disorders, this raises the complex issue of how therapists' beliefs and practice can be modified in line with that conclusion? We frequently ask our patients to challenge their own highly-valued beliefs, using a range of therapy-specific methods (e.g., in CBT, psychoeducation, cognitive restructuring, behavioral experiments, etc.). Research into such modification of overvalued beliefs on the part of clinicians might use an intervention-based design. For example, does teaching and training in the most effective methods of change result in changes in practice on the part of the clinician and outcome for the patient? On the other hand, if the alliance proves to be key to symptom change, then the target for such intervention will be more about focusing clinicians on the development of the relationship.

Conclusion

In this brief—and possibly controversial—article, we have endeavored to stimulate curiosity regarding the widely-held assumption that a good therapeutic alliance is central to treatment success. Rather than reaching conclusions at this early stage, we feel that it is important that clinicians and researchers should treat this as a prime topic for further research, using the methods and designs outlined above, among others. Such research could improve clinical practice, whatever it reveals.

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