



Therapeutic alliance and weight gain during cognitive behavioural therapy for anorexia nervosa



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ABSTRACT

This study examined the relationship between therapeutic alliance and primary symptom change (weight gain) during CBT for anorexia nervosa. The aims were threefold: (1) to establish the strength of the therapeutic alliance across the treatment, (2) to determine whether early therapeutic alliance is associated with the completion of CBT for this client group, and (3) to determine the direction of the relationship between therapeutic alliance and weight gain. Adult outpatients ($N = 65$) with a diagnosis of anorexia nervosa (or atypical anorexia nervosa) completed a measure of alliance at session six and at the end of treatment. Weight was recorded at the start of treatment, session six and at the end of treatment. The strength of the alliance was consistently high in the sample. However, early therapeutic alliance was not associated with either the likelihood of completing treatment or subsequent weight gain. In contrast, both early and later weight gain were associated with the strength of subsequent alliance. These findings indicate that it might be advisable to focus on techniques to drive weight gain rather than rely on the therapeutic alliance to bring about therapeutic change.

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It has been suggested that a number of factors hinder the development of an effective therapeutic alliance in the treatment of anorexia nervosa, including the patient's fear of change and development, investment in anorexia nervosa as a primary identity, denial of the problem, and impaired cognitive functioning due to malnutrition (e.g., Bruch, 1973; Couturier & Lock, 2006; Katzman, Christensen, Young, & Zipursky, 2001). Despite those proposed factors, the therapeutic alliance in the psychological treatment of anorexia nervosa is actually relatively strong (e.g., Pereira, Lock, & Oggins, 2006; Waller, Evans, & Stringer, 2012). What is not clear is the causality of the relationship between the therapeutic alliance and symptom change during treatment for anorexia nervosa. The evidence to date is that the two are correlated (Isserlin & Couturier, 2012; Pereira et al., 2006), but the widespread assumption that the therapeutic relationship drives symptom change (e.g., Miller & Mizes, 2000) is unsupported to date in the eating disorders as a whole (e.g., Loeb et al., 2005; Waller et al., 2012; Wilson et al., 1999; Zaitstoff, Doyle, Hoste, & Le Grange, 2008).

In order to understand this relationship, it is important to consider the relevant research in other areas of psychological treatment. Two meta-analyses have found a robust association between therapeutic alliance and symptom change (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). However, the size of the alliance–outcome correlation is modest at best ($r = .22-.26$), explaining approximately 5% of therapeutic gains. Furthermore, the order of change is not clear from most such studies – does the therapeutic relationship drive symptom change, or does symptom change drive the therapeutic alliance (as suggested by Safer & Hugo, 2006)? In the depression literature, there is evidence that changes in symptoms precede improvements in therapeutic alliance (DeRubeis & Feeley, 1990; Feeley, DeRubeis, & Gelfand, 1999; Strunk, Brotman, & DeRubeis, 2010; Tang & DeRubeis, 1999). There is also evidence of a more complex pattern, where symptom change predicts therapeutic alliance, but that alliance then goes on to predict subsequent symptom change (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Webb et al., 2011). However, it is not known whether this pattern would be found in other disorders, including the eating disorders.

This study examined patients' perceptions of the strength of the therapeutic alliance during CBT for anorexia nervosa. It also considered whether early therapeutic alliance is associated with the

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completion of CBT for this client group. However, the primary aim of the study was to determine the direction of the relationship between therapeutic alliance and key symptom change during CBT for anorexia nervosa – does therapeutic alliance drive weight change or vice versa?

Method

Participants and procedure

The study was approved by the relevant NHS Research and Development committee and the ethical committee at Royal Holloway, University of London. The original set of participants were 65 outpatients (64 female, 1 male) who had been referred to an adult outpatient eating disorder service (lower age limit = 16 years), covering an urban and suburban area of London. All participants were diagnosed as suffering from anorexic disorders, using ICD-10 criteria (World Health Organisation, 1992) and a semi-structured interview (Waller et al., 2007). Of the 65 participants, 56 met full diagnostic criteria for anorexia nervosa at the start of treatment (including a BMI of less than 17.5), and nine met criteria for atypical anorexia nervosa (BMI between 17.5 and 18.5, but all other criteria met). There was no lower BMI limit, so long as patients were assessed as physically safe to undergo outpatient treatment. The mean BMI at the start of treatment was 15.9 ($SD = 1.43$; range = 12.9–18.4). Among younger cases (age 21 years or younger), the service practice was to measure height at each of these points, to ensure that any change in height was accounted for in BMI calculation. Patients with comorbid diagnoses were not excluded. The mean age at the start of treatment was 25.7 years ($SD = 9.21$; range = 16–42 years), and 81% of the sample were Caucasian. Of the 65 cases who were identified as eligible, 21 dropped out of treatment and there were missing data at all three time points. Consequently, the sample size varies considerably across the reported analyses.

Design

The study used a longitudinal case series design. The time points (and measures) included in the current study were session one (diagnosis, BMI, eating attitudes), session six (therapeutic alliance, BMI) and end of treatment (BMI, therapeutic alliance). The temporal relationships between weight gain and therapeutic alliance were explored correlationally.

Treatment

Patients were treated using a manualised CBT approach (Waller et al., 2007). This method stresses change in dietary structure and content from early on, with the aim of weight gain (and overcoming the anxiety associated with such weight gain, through exposure). Sessions lasted approximately 1 h, and were normally conducted weekly. A guideline for routine clinical practice in the service is 40 sessions of CBT per treatment episode, although that varies according to clinical need. In total, there were nine clinicians who treated the participants included in this study. The clinicians consisted of six who had a doctoral level training in clinical psychology, one who had a professional training in another discipline (occupational therapy) with a postgraduate CBT training (two years), and two who were in the final year of a doctoral training in clinical psychology. All clinicians were supervised individually and through peer supervision, in order to ensure therapeutic consistency across cases. Each recorded sessions for presentation to their supervisors, to ensure quality of treatment.

Measures

The primary outcome variable of weight gain (as shown in BMI change) was used (Bulik, Berkman, Brownley, Sedway, & Lohr, 2007). For the current purposes, treatment completion was defined whenever the assigned therapist indicated that the treatment episode was completed successfully or where it was maintained for at least 30 sessions. Non-completers were any participants who dropped out of treatment without having recovered after less than 30 sessions. Treatment success was defined by whether the patient achieved: a functional weight for height (periods present for three consecutive months or ovarian maturity achieved on pelvic ultrasound, as identified by an experienced radiographer); absence of starvation symptoms (cognitive flexibility and emotional stability identified by both clinician and patient); a normal, diverse dietary intake (balancing carbohydrates, protein, fat and fruit/vegetables, with no feared foods); normal levels of eating attitudes (within 1 SD of population norms, as used by Fairburn et al. (2013)); and not being driven by a disturbed body image (as identified by the patient, and by an EDE-Q shape concern score that was within one SD of non-clinical norms for this age group [$<. 40$], as identified by Mond, Hay, Rodgers, & Owen, 2006).

Working Alliance Inventory – revised – short form (WAI-SR)

The WAI-SR (Hatcher & Gillaspay, 2006) is a short form of the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). It was completed by patients rather than clinicians, as this is a more valid approach (e.g., Barber et al., 1999). The WAI-SR is based on the three-element model of the therapeutic relationship (Bordin, 1979), and measures the patient's opinions of the shared goals of therapy, the shared tasks of therapy, and the attachment bond. In the current sample, the WAI-SR overall score and all subscales were internally reliable at both session 6 and the end of treatment (Cronbach's $\alpha > .80$ in all cases). The range of possible scores is 1–7, where higher scores indicate a stronger perceived working alliance.

Eating disorders examination – questionnaire, version 6.0 (EDE-Q)

The EDE-Q (Fairburn, 2008) is a self-report scale of eating disorder psychopathology, with good reliability and validity (e.g., Carter, Aime, & Mills, 2001). It includes 22 items that provide an overall level of eating disorder attitudes, made up of four subscales – restraint, eating concerns, shape concerns, and weight concerns. The range of possible scores is 0–6, where higher scores indicate more pathological eating attitudes.

Data analysis

Due to the exploratory nature of the questions posed in this study, all analyses were two-tailed. Logistic regression was used to determine whether any clinical variables (EDE-Q scores, WAI-SR scores, BMI, early change in BMI) predicted early attrition. The remaining analyses were run on treatment completers only, as the main objective of the study was not to measure the effectiveness of the treatment but to examine the relationship between factors at different points in treatment. The sequential relationship between weight gain and therapeutic alliance (Fig. 1) was examined using Pearson's correlations and multiple linear regressions. Different analytic strategies have been used to test such sequencing in the existing literature, dependent on the specific question being addressed (e.g., session-by-session records – Strunk et al., 2010). The present strategy was similar to that used by Feeley et al. (1999), as it was consistent with the nature of the data and the potential relationships being explored (where behavioural change could drive a positive alliance and vice versa).

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