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The impact of early symptom change and therapeutic alliance on treatment outcome in cognitive-behavioural therapy for eating disorders

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ABSTRACT

The present study explored the impact of early symptom change (cognitive and behavioural) and the early therapeutic alliance on treatment outcome in cognitive-behavioural therapy (CBT) for the eating disorders. Participants were 94 adults with diagnosed eating disorders who completed a course of CBT in an out-patient community eating disorders service in the UK. Patients completed a measure of eating disorder psychopathology at the start of treatment, following the 6th session and at the end of treatment. They also completed a measure of therapeutic alliance following the 6th session. Greater early reduction in dietary restraint and eating concerns, and smaller levels of change in shape concern, significantly predicted later reduction in global eating pathology. The early therapeutic alliance was strong across the three domains of tasks, goals and bond. Early symptom reduction was a stronger predictor of later reduction in eating pathology than early therapeutic alliance. The early therapeutic alliance did not mediate the relationship between early symptom reduction and later reduction in global eating pathology. Instead, greater early symptom reduction predicted a strong early therapeutic alliance. Early clinical change was the strongest predictor of treatment outcome and this also facilitated the development of a strong early alliance. Clinicians should be encouraged to deliver all aspects of evidence-based CBT, including behavioural change. The findings suggest that this will have a positive impact on both the early therapeutic alliance and later change in eating pathology.

A considerable amount of research has been directed towards understanding the factors that impact treatment outcome in the delivery of CBT, with early symptom reduction and the therapeutic alliance being among those variables investigated in more depth. Early symptom change has been identified as a strong indicator of treatment outcome across a range of psychiatric disorders (e.g., Lutz et al., 2014; Lutz, Stulz, & Köck, 2009; Tang & DeRubeis, 1999). Similar findings have been reported in the eating disorders field. For example, studies exploring early predictors of outcome in CBT for bulimia nervosa (BN) have identified early reduction in binge eating and/or purging as significant predictors of outcome (e.g., Agras et al., 2000; Wilson et al., 1999). Using a transdiagnostic sample of eating disorder patients, Raykos, Watson, Fursland, Byrne, and Nathan (2013) explored the prognostic value of early change in cognitive-behavioural therapy – enhanced (CBT-E). They found that those who responded rapidly to treatment (i.e., showed a reduction in scores on the Eating Disorders Examination-Questionnaire (EDE-Q) global score of at least 1.53 in the first 4–6 weeks of treatment) had better treatment outcomes, achieving lower scores on the global EDE-Q post treatment and being twice as likely to achieve full remission compared to slower responders (53% vs. 23%) post-treatment (Raykos et al., 2013).

The therapeutic alliance has also been investigated in relation to its potential to impact treatment outcome (e.g., Crits-Christoph, Gibbons, & Hearon, 2006). The therapeutic alliance can be defined as the collaborative relationship that develops between patients and their therapists, where there are shared goals and an agreement and willingness from both parties to engage in the tasks that need to be done in order for therapy to progress. As such, the therapeutic alliance is commonly seen as having three shared components – goals, tasks and bond (Bordin, 1979). The relationship between alliance and clinical outcome has been researched

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across a range of disorders. Whilst it is commonly assumed that the alliance has a significant impact on clinical outcome, meta-analyses have shown that the therapeutic alliance predicts only 5–6% of the variance of treatment outcome (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Consequently, a number of authors have suggested that the alliance, although necessary, may not be sufficient to ensure change, with that change potentially being driven more by the consistent delivery of the core components of treatment protocols (e.g., Shafran et al., 2009).

The relationship between therapeutic alliance and outcome has also been studied in the eating disorders across a number of therapeutic modalities, with mixed findings. In the treatment of anorexia nervosa (AN), the therapeutic alliance has been associated with improved treatment outcome in family based treatments for adolescents (e.g., Isserlin & Couturier, 2012; Pereira, Lock, & Oggins, 2006). In a large RCT comparing CBT and interpersonal psychotherapy (IPT) for BN, Constantino, Arnow, Blasey and Agras (2005) found that strong early (session 4) and mid-treatment (session 12) alliance was associated with fewer purging episodes at the end of CBT for BN, after accounting for baseline purging frequency. In contrast, Loeb et al. (2005) found that alliance at sessions 6, 10 or 18 failed to predict post treatment purge frequency in either CBT or IPT for BN, again after accounting for baseline purging frequency. More recently, Raykos et al. (2014) explored the relationship between therapeutic alliance and outcome in CBT-E for BN. Their results indicated that the therapeutic alliance was strong at all stages of CBT-E (beginning, middle and end), but they did not find any evidence that the alliance was significantly related to treatment outcome.

The direction of the relationship between clinical change and alliance has also been explored. Whilst it may be assumed that the alliance drives change, a growing body of evidence suggests the opposite; that early clinical change drives the development of the therapeutic alliance (Crits-Christoph et al., 2006; Tang & DeRubeis, 1999). Some studies have looked at the relationship between therapeutic alliance and early change in individual treatment for eating disorders. For example Waller, Evans, and Stringer (2012) failed to find a relationship between early therapeutic alliance and early change in eating disorder symptoms in a mixed sample of eating disorder patients. In their study of CBT for AN, Brown, Mountford, and Waller (2013a) found that early therapeutic alliance was not associated with subsequent weight gain. However these authors did find that both early and later weight gain were associated with the strength of the subsequent alliance, and from this they recommended that therapists should consider focusing on techniques to drive weight gain rather than relying on the therapeutic alliance to bring about clinical change (Brown et al., 2013a). Furthermore, Raykos et al. (2014) found that neither broader patient factors (e.g., emotional difficulties, interpersonal style) nor symptom severity at the start of treatment interacted with alliance to impact outcome. Instead they found that early symptom change was the strongest predictor of eventual clinical change, and that this was independent of the strength of the therapeutic alliance.

It has recently been suggested that further research might usefully explore whether there is a causal relationship between the therapeutic alliance and outcomes and, if so, its direction in the treatment of eating disorders (Brown, Mountford, & Waller, 2013b). The interaction between early change and alliance and its impact on outcome also warrants further study, particularly given the potential for these variables to impact treatment delivery and prognosis. Within the eating disorders field, studies exploring these relationships have to date been largely conducted on samples of patients with either AN or BN. Research has yet to explore relationships between these variables in transdiagnostic or community samples that include atypical presentations, despite the fact that atypical cases are relatively common (Turner & Bryant-Waugh, 2004) and recent developments in treatment have taken a transdiagnostic perspective (e.g., Fairburn, Cooper, & Shafran, 2003). Furthermore, with the exception of the work of Raykos and colleagues (Raykos et al., 2013, 2014), much of the research to date has been conducted in the context of controlled treatment trials. In addition, studies have tended to focus on one element of early change, such as reduction in behaviours (Wilson et al., 1999), weight change (Brown et al., 2013a) or global EDE-Q score (Raykos et al., 2013).

Aims

The current study aimed to address some of these issues, adding to our knowledge about interactions between these key variables discussed above. In a community-based transdiagnostic sample of eating disorder patients who had received a course of outpatient CBT, relationships were examined between different elements of early change (cognitive and behavioural), the early therapeutic alliance, and later clinical change. Hypotheses were based on previous findings as follows. Based on the existing literature, the first hypothesis was that early change would be a significant predictor of later change in global eating disorder psychopathology. The second was that the early therapeutic alliance would be strong for the sample. The third hypothesis was that the early therapeutic alliance would not predict later change in global eating disorder pathology. Finally, we hypothesised that the early therapeutic alliance would not mediate the relationship between early and later change in eating pathology.

1. Method

1.1. Participants

Participants were recruited from an adult outpatient Eating Disorders Service serving a defined geographical area in the UK. The service receives referrals from family physicians as well as mental health practitioners. It treats patients presenting with AN, BN and related atypical eating disorder presentations, although not binge eating disorder. All potential participants were assessed using the Eating Disorders Examination, version 16 (Fairburn, Cooper, & O'Connor, 2008), administered by trained interviewers, and were diagnosed based on DSM-IV-TR criteria (American Psychiatric Association, 2000). Those presenting with AN, BN or EDNOS were subsequently offered treatment. All potential participants were sent an information sheet along with their initial therapy appointment letter. At their subsequent attendance at the service all potential participants were provided with a verbal overview of the study, its aims and what participation would involve. Those who wished to take part completed a consent form. Ethical approval was granted from the Oxford NHS Research Ethics Committee.

1.2. Procedure

Participants completed study measures at the start of treatment, following session six, and at the end of therapy. These included measures of eating disorder psychopathology and therapeutic alliance. Eating disorder psychopathology was measured at all three time points, while therapeutic alliance was assessed after the 6th treatment session. These measures are administered as part of routine clinical practice in order to monitor the overall effectiveness of treatment. Given that data were collected as part of routine clinical practice, it was not possible to obtain a complete dataset for all participants, and therefore the numbers vary in some analyses.