The relationship between therapeutic alliance and treatment outcome in eating disorders:

Do patients get better because they like the therapist, or like the therapist because they get better?

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A meta-analysis of the relation between therapeutic alliance and treatment outcome in eating disorders

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Therapeutic alliance

• Agreement between patient and therapist on therapeutic goals

• Agreement between patient and therapist on therapeutic tasks

• Affective bond between patient and therapist

Bordin, 1979
As eating-disorder clinicians, our job is very hard!

- Agreement between patient and therapist on therapeutic goals → What if patient doesn’t want to gain weight or stop purging?

- Agreement between patient and therapist on therapeutic tasks → What if patient doesn’t want to keep food records or be weighed?

- Affective bond between patient and therapist → Will the patient feel a bond with me if we can’t agree on either of the above?
Alliance in my own practice

• The good:
  – I’m so lucky to have you as a therapist.
  – Thank you for saving my life!

• The bad:
  – All you want to talk about is my eating. Do you even care about me as a person?
  – These food records/weigh-ins are so triggering. You are making me feel worse than I did before!

• The ugly:
  – You are the most cold, manipulative, heartless person I have ever known.
Clinical dilemma of alliance

• If I focus primarily on early symptom change, am I being mean?
  – Maybe, but at least I’m not as mean as Glenn Waller...

• Should I keep pushing for symptom change, or should I make an exception that could potentially enhance alliance?
  – If I push, what will my patient think?
  – If I make an exception, what will Glenn Waller think?

• In other words...
  – Which one should I prioritize: symptom change, or therapeutic alliance?
  – Are they mutually exclusive?
Relationship may be reciprocal

1. Symptom change → Alliance
2. Alliance → Symptom change

1. Brown, Mountford, & Waller, 2013; Constantino et al., 2005, Richardson et al., 2013
2. Bourion-Bedes et al., 2013; Constantino et al., 2005; Treasure et al., 1999
Do patients get better because they like the therapist, or like the therapist because they get better?
Meta-analysis:
Research questions 1-3

Question 1
Early Symptom Change
  Early/Mid Alliance

Question 2
Mid/EOT Symptom Change
  EOT Alliance

Question 3
EOT Symptom Change
  EOT Alliance
Meta-analysis:

Research questions 4a and 4b

Question 4a

Early/Mid Alliance

EOT Symptom Change

Question 4b

Early/Mid Alliance

Controlling for early symptom change

EOT Symptom Change
Meta-Analysis Methods

• Inclusion criteria
  • A sample of patients with an eating disorder
  • Patient-rated treatment alliance measured during treatment
  • At least one statistical analysis of the relation between the alliance & a primary outcome variable (e.g., BMI, EDE-Q, binge or purge frequency)
  • Data not already reported in another study already included
  • Data published before January 2014

• Potential moderators
  • Therapy type
  • Patient age
  • Patient diagnosis
  • Alliance rater
  • Dropout rate
Electronic database search (n = 959)

Duplicate removed (n = 787)

Screened (n = 787)

Full-text articles assessed (n = 48)

Included in meta-analysis (n = 20)

Excluded (n = 739)

Full-text articles excluded for not meeting criteria (n = 21)

Full-text articles excluded for other reasons (n = 7)
Results – Question 1

Does early change in symptoms predict early/mid treatment alliance? Yes!

$\theta = .19, p < .0001^*$

$Q (17) = 28.41 \ p = .04^*$
Results – Question 2

Does mid-to-end of treatment symptom change predict alliance at end of treatment? No.

$\beta = .10, \ p = .15; \ Q(9) = 2.79, \ p = .97$
Results – Question 3

Does end of treatment symptom change predict ending alliance? Yes!

\[ \beta = 0.17, p = 0.003^* \]

\[ Q(17) = 24.17, p = 0.12 \]
Results – Question 4a

Does early/mid treatment alliance predict subsequent symptom change? Yes!

\[ \theta = 0.13, \ p = 0.02 \]

\[ Q (18) = 26.55, \ p = 0.09 \]
Results – Question 4a

Moderator Analyses

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<tr>
<th>Model</th>
<th>Group by tx_new</th>
<th>Study name</th>
<th>Point estimate and 95% CI</th>
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Q (4) = 10.61, p = .03

CBT, BWLT
FBT, individual therapy, multiple therapies
Results – Question 4b

Does early/mid alliance predict subsequent symptom change *above and beyond early symptom change*? No.

![Diagram showing relationships between early/mid alliance, symptom change, and EOT symptom change]

- **Point estimate and 95% CI**
  - \( \beta = .07, p = .21 \)

- **Study name**
  - Bourion-Bedos et al., 2013, sample A
  - Bourion-Bedos et al., 2013, sample B
  - Brown et al., 2013
  - Constantino et al., 2005, sample A
  - Constantino et al., 2005, sample B
  - Forsberg et al., 2013, sample A
  - Forsberg et al., 2013, sample B
  - Isserline & Couturier, 2012
  - Karlsson et al., 2013
  - Prestano et al., 2008
  - Simpson et al., 2005
  - Sty et al., 2013
  - Tasca & Lampard, 2012
  - Zalesco et al., 2008, sample A
  - Zalesco et al., 2008, sample B

- **\( Q (14) = 23.15, p = .058 \)**

Massgeneral.org/eatingdisorders
Results – Question 4b

Moderator Analyses

Controlling for early symptom change

Early/Mid Alliance → EOT Symptom Change

Regression of Sample mean age on Point estimate

Q (1) = 16.20, p < .01
Summary

- Patients probably get better because they like the therapist and like the therapist because they get better
  - Effects went in both directions across our meta-analysis

- However, since early/mid alliance no longer predicted later symptom change after we controlled for early symptom change, it seems somewhat more likely that patients like the therapist because they get better
If we want strong alliances, we can’t be like this goldfish. We need to emphasize early change!

“You don’t say much, but I’m told it’s the therapeutic relationship that counts.”
There are always caveats...

- Early/mid alliance contributes
  - less to later symptom change in individual behavioral therapies (e.g., CBT, BWLT) and in older patients
  - more to later symptom change in less behavioral therapies, in FBT, and in younger patients
    - Perhaps because less behavioral therapies view the relationship as the agent of change?
- Behavioral and non-behavioral therapists are both right, but for their own therapies
Solving the clinical dilemma

• Luckily, therapeutic alliance and symptom change are not mutually exclusive

• How concerned should we be about developing a positive therapeutic alliance?
  – Less so if
    • Delivering CBT or working with adults
  – More so if
    • Delivering less behavioral therapy or working with children

• How concerned should we be about promoting early symptom change?
  – Very much, regardless of patient age or therapy type
Patient who initially found me “cold” and “heartless” gave me this gift post-CBT.