The Role of the Therapeutic Alliance in Eating Disorder Treatment – A Review
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INTRODUCTION

RATIONALE
• Individuals with eating disorders (EDs) are often resistant to treatment.
• Across treatment modalities and diverse non-ED patient populations, the therapeutic alliance (TA) is consistently associated with treatment outcome.1,11
• Very little research has been conducted on the therapeutic alliance in the context of ED treatment.

PURPOSE
The aim of this literature review was to assess the status of research pertaining to the TA in ED treatment within the context of the broader TA literature.

METHOD
• Using PsycINFO, a systematic review of research on the TA in ED treatment was conducted.
• Key search terms included: therapeutic alliance, working alliance, therapeutic relationship, eating disorders, and treatment.
• Titles and abstracts were screened and full texts were examined for relevance of content.
• Peer-reviewed studies were included if they:
  1. Formally measured the therapeutic alliance (either via questionnaire or a coding system), and
  2. Measured at least one other treatment variable (e.g., baseline eating disorder symptoms, dropout).

RESULTS
• 14 studies – 8 randomized controlled trials (RCTs)
• Categorization of studies:
  1. Adult Eating Disorders - 11 studies
     • Bulimia Nervosa (5)
     • Binge Eating Disorder (2)
     • Anorexia Nervosa (2)
     • Mixed Eating Disorder Sample (4)
  2. Adolescent Eating Disorders - 3 studies
     • Anorexia Nervosa (2)
     • Bulimia Nervosa (1)
• 8 different measures of alliance used across studies (irrespective of varying versions)
• Types of alliance measured:
  1. Client-report (7 studies)
  2. Observer-report (4 studies)
  3. Combination: client- and treatment-provider report (3 studies)

Table 1. Summary of Articles Included in the Review

<table>
<thead>
<tr>
<th>Citation</th>
<th>Adult Bulimia Nervosa</th>
<th>Adult Binge Eating Disorder</th>
<th>Adult Anorexia Nervosa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treasure et al., 1999</td>
<td>125 BN 28.8 WAI C, T Y</td>
<td>Stage of change at the outset of therapy (action)</td>
<td></td>
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<tr>
<td>Wilson et al., 1999</td>
<td>120 BN 18.45 HRQ C Y</td>
<td>Remission</td>
<td></td>
</tr>
<tr>
<td>Constantino et al., 2000</td>
<td>220 BN 28.1 IAG C, T, Y</td>
<td>Patient expectations of improvement</td>
<td></td>
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<tr>
<td>Loeb et al., 2000</td>
<td>81 BN 28.9 YIAS O Y</td>
<td>Therapist adherence to treatment protocol</td>
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<tr>
<td>Hartmann et al., 2010</td>
<td>43 BN 25.1 IAG C, T, Y</td>
<td>Intersession experiences more predictive of outcome than TA</td>
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<tr>
<td>Tasca et al., 2007</td>
<td>65 BED 43.9 CALPAS-G C Y</td>
<td>Insecure attachment</td>
<td></td>
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<tr>
<td>Fischinger et al., 2007</td>
<td>78 BED 46.9 vs. 44.1* BPSR-P C Y</td>
<td>Premature termination</td>
<td></td>
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<tr>
<td>Gallop et al., 1994</td>
<td>33 AN, BN, EDNOS - -* WAI C, T N</td>
<td>Premature discharge</td>
<td></td>
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<tr>
<td>Tuman, 2000</td>
<td>18 AN, BN 27.6 Self-created O N</td>
<td>BMI</td>
<td></td>
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<tr>
<td>Tasca et al., 2010</td>
<td>229 AN, EDNOS 26.3 CALPAS-G C N</td>
<td>Group culture</td>
<td></td>
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<tr>
<td>Waller et al., 2012</td>
<td>42 AN, BN 27.2 WAI-SR C N</td>
<td>Baseline Axis I and II pathology</td>
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</tr>
<tr>
<td>Perris et al., 2006</td>
<td>41 AN 15.1 WAI O N</td>
<td>Early weight gain</td>
<td></td>
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<tr>
<td>Zaitsoff et al., 2008</td>
<td>80 BN 16.1 HRQ C Y</td>
<td>Baseline symptom severity</td>
<td></td>
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<tr>
<td>Issler et al., 2011</td>
<td>14 AN 14.0 SOFTA O N</td>
<td>Post-treatment weight gain</td>
<td></td>
</tr>
<tr>
<td>Linder et al., 2011</td>
<td>14 AN 14.0 WAI O N</td>
<td>Early weight gain</td>
<td></td>
</tr>
</tbody>
</table>

DISCUSSION

TRENDS
• The TA in the context of treatment for BN and BED has received the most empirical attention.
• 8/14 studies on BN or BED
• All studies on BN or BED were RCTs
• Mirroring the general adolescent TA literature, results suggest that adolescent- and parent- reports of TA may be differentially related to outcome in ED treatment.10
• Adolescent-report – psychological symptom remission and early weight gain12,13
• Parent-report – dropout and post-treatment weight gain10,14
• In contrast to the general TA literature, treatment modality may be pertinent to alliance development in ED treatment.16
• E.g., Baseline symptom severity associated with TA in CBT but not IPT for patients with BN.3

LIMITATIONS
• Thus far, an insufficient amount of research has been conducted on the TA in ED treatment.
• There is little consensus on measures of TA in the context of ED treatment.

FUTURE RECOMMENDATIONS
• Increase empirical focus on the TA in ED treatment, particularly with studies involving:
  • RCTs
  • Adolescents
  • Patients diagnosed with AN and EDNOS
• Establish consensus surrounding the assessment of the TA in ED treatment
• Assess TA in relation to therapist characteristics and treatment modality, as these factors are under clinical control.
• Conduct more sophisticated analyses, taking into consideration such factors as change in alliance throughout treatment and composite measures of family alliance.16

REFERENCES