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Alliance, technique, both, or more? Clinicians' views on what works in cognitive-behavioral therapy for eating disorders

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Abstract

Objective: This study examined clinicians' views of the roles of two elements of cognitive behavioral therapy (CBT) in explaining treatment outcomes - CBT techniques and the therapeutic alliance.

Methods: Ninety-eight clinicians who reported delivering CBT for eating disorders completed measures addressing their beliefs about what is effective in CBT, their use of specific techniques, and their own anxiety levels.

Results: Clinicians substantially overestimated the role of both therapeutic techniques and the alliance in explaining treatment outcomes in CBT. Weak but significant correlations were found between therapist anxiety levels and their beliefs about the value of therapeutic techniques or the alliance. However, these associations were in different directions, with higher levels of clinician anxiety associated with more belief in the effects of the alliance but with less belief in the role of CBT techniques. Belief in the role of the therapeutic alliance was associated with a lower likelihood of encouraging the patient to change their eating pattern, while belief in the role of techniques was linked to greater use of case formulation, cognitive restructuring, behavioural experiments and body image work.

Discussion: Clinicians overestimate the value of both the alliance and therapy techniques in explaining treatment outcomes in CBT for eating disorders. Their beliefs about the strength of these factors is related to their own anxiety, and to their choice of techniques. Clinicians and supervisors should attend to the evidence regarding the impact of a range of elements of therapy, and work with all of those factors to enhance outcomes.

Key words:

Eating disorders; clinician views; cognitive-behavioral therapy; therapeutic alliance; therapeutic techniques

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While cognitive-behavioral therapy (CBT) has clear evidence of effectiveness in treating adults and adolescents with a range of eating disorders (NICE, 2017), relatively few clinicians adhere to such models when treating such cases (Tobin et al., 2007). Even where they offer a form of CBT, clinicians routinely omit key elements of that therapy, particularly where the clinician has higher levels of anxiety (Mulkens et al., 2018; Waller et al., 2012). It has been suggested that anxious clinicians might rely more on the therapeutic alliance as an agent of change, so that they do not have actively to encourage behavioral change in the patient (Waller & Turner, 2016). However, it is important to consider whether a greater emphasis on therapy techniques or the alliance is more appropriate for delivering strong therapy outcomes.

While not specific to eating disorders or to CBT, there has been considerable study of the factors that are associated with therapy outcomes. Lambert and colleagues (e.g., Lambert & Barley, 2001) have summarised this diverse literature, and have concluded that therapeutic techniques account for only 15% of therapy outcomes. However, while they show that common factors account for 30% of outcomes, only part of such common factors is related to the alliance. Horvath et al. (2011) found that the alliance and outcomes correlate at $r = .275$, equating to only 7.4% of variance in therapy outcomes. Thus, it appears that the alliance and therapy techniques jointly account for less than a quarter of the variance in treatment outcomes. Other factors (e.g., therapist factors, patient characteristics, expectancy) appear to account for more, though they are less controllable in therapy settings. However, therapy choices made by clinicians are likely to be driven by their beliefs about what works rather than being informed by such findings. Where such beliefs encourage clinicians to prioritise issues such as the alliance, it is likely that the result will be a lowering of fidelity to the effective techniques, resulting in poorer outcomes. Therefore, it is important to understand the degree to which clinicians believe that the alliance and therapeutic techniques drive therapy and why they hold those beliefs, so that training and supervision can help clinicians to focus

appropriately on using the core techniques of that therapy, to enhance clinical effectiveness.

To summarise, when considering the reasons that clinicians do and do not use key therapy methods in treating eating disorders, it will be important to determine what clinicians believe is effective in therapy for eating disorders and the characteristics that might explain why they hold those beliefs. Therefore, this study has two aims. First, it examines the importance that CBT clinicians attribute to the alliance and therapeutic techniques when working with eating disorders, to determine whether those attributions are at a level that is compatible with the literature. Second, it considers whether those attributions are associated with clinician characteristics (e.g., anxiety), with the potential role of supervision, and with the use of specific techniques (e.g., exposure to new eating patterns) when working with eating disorders.

Method

Ethics

This study received ethical approval from the University of Sheffield Research Ethics Committee. Each participant gave informed consent.

Design

A correlational design was used, determining what factors (anxiety, supervision, temporal factors, and use of specific techniques) were associated with the two key variables – attribution of therapy outcomes to the alliance, and attribution of therapy outcomes to therapy techniques.

Participants

The participants were 98 clinicians (91 female; 7 male) who reported that they delivered CBT to patients with eating disorders. They were a convenience sample, recruited at CBT training events, but completed the measures before the training proceeded. All were practicing in the UK or in the USA. A small number of clinicians failed to complete some items, as demonstrated by variation in the *N*s in Table 1.

The clinicians' mean age was 41.2 years (*SD* = 10.8). and their mean time in clinical practice was 10.2 years (*SD* = 9.38). They represented a range of professions, with the most

common being psychologists (32%), CBT therapists (25%), and nurses (19%). Others included social workers (3%), dietitians (5%) and occupational therapists (6%). The group reported working a mean of 33.3 hours per week (*SD* = 8.18), delivering CBT-ED face-to-face for over half of that time (*M* = 18.5 hours, *SD* = 7.50), supervising CBT-ED work for a mean of 3.17 hours/week (SD = 6.21), and being supervised in CBT-ED work for a mean of 2.70 hours/week (*SD* = 1.64). Therefore, these figures indicate that CBT-T was their main therapeutic modality, and therefore the treatment that their patients would have received..

Measures and Procedure

Measures were completed by the clinicians in person, using paper and pencil questionnaires. Each clinician completed the following:

a) A **demographic questionnaire**, including details about age, profession, duration in that profession, supervision received and delivered.

b) **Intolerance of Uncertainty Scale – Short Version** (IUS-12 - Carleton, Mulvogue, Thibodeau, McCabe, Antony, & Asmundson, 2012; Carleton, Norton, & Asmundson, 2007). The IUS-12 measures a key component of anxiety – intolerance of uncertainty. It is a 12-item version of the original 27-item scale. It has a stable two-factor structure, reflecting inhibitory and prospective intolerance of uncertainty (respectively, the likelihood of not acting due to uncertainty about the outcome, and the level of fear of not knowing what the outcome of action will be). The IUS-12 has excellent internal consistency (*alpha* = .91), high correlation (*r* = .96) with the 27-item version, and satisfactory test-retest reliability (*r* = .77) (Khawaja & Yu, 2010). In this study, the internal consistency levels were acceptable (Cronbach's *alpha* = .787 for the Prospective anxiety scale and .739 for the Inhibitory anxiety scale). Scores on the two scales in this study (Table 1) were slightly lower than Carleton et al.'s (2012) non-clinical norms [Prospective anxiety score = 13.6 in this group vs 18.5 for Carleton's community norms; Inhibitory anxiety score = 7.50 in this group vs 11.0 for Carleton's community norms].

c) **Beliefs re impact of general elements of therapy outcome.** Clinicians were asked

to estimate the impact on therapy outcome of the alliance and of general therapy techniques (each as a percentage). It was stressed that these two aspects of treatment were not expected to be the only factors that contributed to therapy outcomes. Specifically, the clinicians were asked:

> "We would like to know your view on the impact of two different aspects of treatment for the eating disorders – therapy techniques (whatever therapy model you use), and the therapeutic alliance. Please state what percentage of therapy outcome is due to each aspect of treatment. These do not have to add to 100%, as you might believe that other factors play a part (e.g., patient or therapist characteristics)."

d) **Use of specific therapeutic techniques in CBT.** Therapists were asked to describe their likelihood of focusing on specific and general techniques used in CBT for eating disorders. The question ("With how many of my patients do I address the following topics regularly?") was answered on a seven-point Likert scale (1 = 'None at all'; 7 = 'All my patients'). Items included evidence-based methods (e.g., body image work), general care (e.g., monitoring risk), and techniques that are unevidenced or counter-theoretical in CBT for eating disorders (e.g., transference and countertransference), even though they are reported to be used by some CBT clinicians (e.g., Cowdrey & Waller, 2015). The full list of items is presented in Table 1.

Data analysis

Descriptive analyses were used to determine the level of importance attributed to the alliance and to the overall use of therapeutic techniques. There was no data replacement of missing data or removal of outliers. Each of those ratings of importance was correlated with clinician characteristics, supervisory experience, and use of specific therapeutic techniques. These analyses were conducted using Spearman's *rho* (one-tailed), because some of the variables were not normally distributed. Because there were a large number of therapeutic techniques used, the significant alpha for these correlations was corrected to $P < .01$, to reduce the risk of Type 1 errors.

Results

Table 1 shows mean scores on each measure, and associations with the clinicians' beliefs about the impact of the alliance and of therapeutic techniques. It is noteworthy that the mean impact of the alliance (34.6%) and of therapeutic techniques (60.2%) totalled nearly 100% of the factors that clinicians saw as explaining therapy outcome. Both figures are approximately four times higher than the literature would suggest (7.4% and 15%, respectively), and the clinicians did not appear to assume that other factors might play a part, despite the specific mention in the instructions that the figures did not have to add to 100%, given the potential role of other factors (e.g., patient and therapist characteristics). It is also noteworthy that clinicians did not treat the alliance and techniques as contributing jointly to therapy outcomes, as they were moderately strongly negatively associated (*rho* = -.459), suggesting that the clinicians saw the alliance and techniques as conflicting treatment elements rather than additive ones.

Insert Table 1 about here

The importance attributed to the alliance and to therapeutic techniques was unrelated to temporal factors or to supervision. However, each was related (differently) to anxiety levels. Clinicians who experienced less prospective anxiety were more likely to believe that therapeutic techniques explain treatment outcomes. In contrast, clinicians with higher levels of inhibitory anxiety were more likely to believe that the alliance explained outcomes.

Considering the clinicians' in-session focus, belief in the importance of therapeutic techniques was associated with a greater likelihood of using case formulation, cognitive restructuring, behavioural experiments and body image work. In contrast, greater belief in the value of the alliance was associated with less use of dietary change. In summary, stronger beliefs in the alliance or therapeutic techniques were associated with different patterns of implementation of core CBT methods.

Discussion

This study has examined the perspectives of CBT clinicians regarding the relative importance of the alliance and therapeutic techniques as contributors to the outcome of therapy, and factors that are associated with those beliefs. The first finding of note is that the clinicians attributed far more outcome variance to both the alliance and therapeutic skills than seems to be justified by the broader literature. While Horvath et al. (2011) suggest that 7.4% of variance in therapy outcomes is attributable to the alliance, and it is possible that this is lower in CBT for eating disorders (Crits-Christoph et al., 1990; Graves et al., 2017), these clinicians were far more positive about the impact of the alliance (34.6%) than those figures would suggest. Similarly, figures for the impact of therapeutic techniques in clinical practice suggest that their impact on outcomes is c.15% (Lambert & Barley, 2001), rather than the 60.2% suggested by these clinicians. The conclusion appears to be that clinicians see treatment outcomes in eating disorders as being entirely attributable to these two facets, discounting the potential role of therapist, patient and extra-therapeutic characteristics (Lambert & Barley, 2001). This pattern emerged even though such possible effects were mentioned explicitly in the instructions, suggesting that the potential role of these factors might be discounted in routine practice. The reason for this overvaluation of both alliance and techniques needs consideration in further research. However, it appears that clinicians focus on the elements of therapy that they see as controllable (implementing techniques; forging a positive alliance with the patient), rather than accepting that there are influences on treatment outcome that are beyond their control (e.g., their own and patients' characteristics, and totally external factors). Therefore, it might be concluded that clinicians have an internal locus of control, making them less accepting of other factors.

The second finding is that the level of such attributions is not universal, as it is associated with clinician anxiety (though not with temporal or practice/supervisory factors). Clinicians who experience higher levels of inhibitory anxiety (less likely to undertake a task due to fear of the outcome being negative) are more likely to attribute therapeutic change to the alliance. This finding suggests that clinicians who are fearful about the outcome of trying

a therapeutic method might justify inaction on that front by assuming that it is less relevant than building a good working relationship with the patient. In contrast, clinicians who experience less prospective anxiety are more likely to see the implementation of therapeutic techniques as explaining change in therapy. These clinicians appear to be less affected by Meehl's (1973) 'spun glass theory of the mind', as they are less worried about the possibility of distressing the patient by asking them to change their behaviors.

Finally, clinicians' beliefs about therapy effects matter, as well as their anxiety. The attribution of outcomes to the alliance or to techniques was related to what CBT and other techniques clinicians used. Those clinicians who see the alliance as more important report that they are less likely to implement the core CBT technique of helping the patient to change eating patterns. In contrast, those who see techniques as more important were more likely to use a range of CBT techniques (formulation, cognitive restructuring, behavioural experiments, body image work) when working with eating disorders. However, it should be remembered that the relevant correlations were relatively small, so other factors clearly need to be considered in explaining clinicians' decisions about what CBT techniques to use when addressing eating disorders.

Despite these links, there is more to be understood when considering clinicians' preferred approach in CBT-ED. While these associations between clinicians' anxiety/use of techniques and their beliefs are significant, they are relatively small, with anxiety potentially accounting for only approximately 5% of variance in clinician beliefs, and similar proportions accounted for by the use of specific techniques. Thus, whatever the causal direction of these associations, it is clear that there are other factors that are as yet unaccounted for in understanding potential explanations for clinicians' beliefs. Substantial further research is likely to be necessary to understand fully why clinicians' hold the beliefs that they do about the importance of the alliance and of the use of CBT techniques.

It will also be necessary for further research to address the diversity of clinical practice in more detail, to be sure that the mode used was CBT-ED (or any other therapy), and whether beliefs vary across individuals who deliver different therapies or a mixture of them. Such work

would also benefit from a more purposive sampling method, rather than using a sample of convenience, as was the case here. A further limitation is that the term 'outcome' was not defined (e.g., cessation of behaviours; change in cognitions; weight normalisation if underweight), meaning that the participants' responses were subject to variance according to how they defined the term. Future research in this field should aim to reduce that diversity of definitions by offering clearer definitions of outcome. Finally, it should be noted that the measures used here were mostly unvalidated ones, devised for this study. The one validated measure was the IUS-12, where the clinicians' scores were lower than those for a comparable community sample. An area for development of this research is to implement more strongly validated measures or indices that more closely reflect clinical reality. For example, the weighing of the patient is treated as a dimensional behaviour in this study, whereas it could be argued that it would be better td as a categorical variable (was the patient weighed or not?), whereas clinical activities such as exposure would be better treated dimensionally. Similarly, it is possible that the phrasing of the questions contributed to the size of effect that clinicians attributed to techniques and the alliance, as other elements were mentioned in the questioning but not specified. Therefore, the availability heuristic might mean that their effects here were over-inflated. Future research could ask about a wider range of the elements identified by Lambert and Barclay (2001) and others.

Therapist drift is not a new concept (e.g., Waller & Turner, 2016). However, this research has operationalised one potential factor underlying why such drift occurs. It suggests that clinical practice in CBT for eating disorders is influenced by clinicians' beliefs about what drives therapeutic effectiveness, and that such distortions are moderated by their anxiety levels. In particular, clinicians who believe more in the potency of the therapeutic alliance are less likely to use the more evidence-based methods in CBT for eating disorders. These are novel findings, which require replication and extension into other therapies and disorders.

These findings have clear clinical implications. First, clinicians working with eating disorders need to be better educated about the factors that explain therapy outcomes, so that they are better aware of therapist effects, patient effects, and the factors that we do not yet

understand. Clinician overvaluation of the value of therapeutic techniques and of the alliance means that we are less likely to consider how we might use other factors to improve those outcomes. Second, supervision should address this level of overvaluation, but supervisors need to be aware that this is a common issue among clinicians working with eating disorders, and that they might share that pattern of cognitive and emotional effects. Of course, it is clear that clinicians need to be aware that the alliance and therapeutic techniques are not as powerful as is assumed here (Lambert & Barley, 2001). It would be valuable if educators and supervisors were to stress for clinicians that elements such as patient and therapist variables play a wider part in explaining outcome, and therefore merit greater attention than the clinicians in this study seemed to believe. Finally, while clinicians appear to see the implementation of therapeutic techniques and the development of the alliance as being conflicting elements of CBT for eating disorders, that is not necessarily a valid conclusion. As demonstrated by Graves et al. (2017), the successful implementation of CBT-ED techniques results in an improved alliance, possibly through the development of trust in the clinician having the patient's interests at heart. Therefore, clinicians should be educated to the fact that working on early behavioural change is a positive step towards a stronger therapeutic alliance, rather than a step away from it.

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Table 1.
Characteristics of clinicians and their clinical practice, and associations (Spearman's *rho*) with their attribution of therapy outcomes to the alliance and to therapeutic techniques.

				Correlations (r) with therapy elements	
Measure	*N*	*Mean*	*(SD)*	Alliance	Techniques
Beliefs re impact of therapy elements					
Impact of alliance (range = 0-100%)	88	34.6	(15.8)	-	-
Impact of techniques (range = 0-100%)	90	60.2	(17.3)	-.459***	-
Clinical work and supervision					
Hours of face to face work per week	97	18.5	(7.5)	-.115	.084
Hours of supervision received per month	97	2.7	(1.6)	-.150	.068
Hours spent supervising per month	97	3.2	(6.2)	-.017	-.027
Demographics					
Age	98	41.2	(10.8)	.122	.137
Years qualified	95	12.2	(9.38)	.092	.077
Therapist anxiety scores					
IUS Prospective anxiety (range = 5-35)	94	13.6	(3.8)	.186	-.214*
IUS Inhibitory anxiety (range = 5-25)	96	7.5	(2.3)	.223*	-.084
Proportion of patients where each technique is used regularly (range = 1-7)					
Use of the therapeutic relationship	91	5.4	(1.8)	.001	.012
Work with transference/countertransference	88	3.4	(1.9)	-.039	.040
Addressing interpersonal issues	89	4.4	(1.7)	.126	-.130
Exploring past history	92	5.6	(1.6)	.205	-.027
Motivational work	89	4.1	(1.6)	.243	-.137
Monitoring physical risk	90	6.2	(1.3)	-.093	.142
Psychoeducation	92	6.6	(0.9)	-.009	.162
Case formulation	90	6.1	(1.6)	-.133	.326***
Managing emotions	89	6.3	(1.0)	-.110	.138
Changing eating patterns	90	6.6	(1.1)	-.268**	.241
Cognitive restructuring	90	6.4	(1.0)	-.196	.338***
Behavioral experiments	91	6.6	(0.8)	-.159	.257**
Body image treatment	90	5.2	(1.6)	-.214	.253**
Mindfulness	89	3.9	(1.7)	.204	-.166
Weighing the patient in the session	89	5.4	(2.5)	-.122	.083
Homework	90	6.4	(1.3)	-.089	.084
Monitoring eating and symptoms	92	6.3	(1.4)	-.122	.061

* $P < .05$; ** $P < .01$; *** $P < .001$