Working alliance, task-specific post-session changes and emotion dysregulation in group treatment for eating disorders.

IRYNA V. IVANOVA, M.A., University of Toronto, OISE
JEANNE C. WATSON, Ph.D., C.Psych., University of Toronto, OISE
JOANNE DOLHANTY, Ph.D., C.Psych., The Credit Valley Hospital

Background

There is an ongoing debate about factors that contribute to therapeutic change. While there is substantial evidence supporting the instrumental role of therapeutic alliance in outcome (Hovarth, 2001; Wamplod, 2001), the role of therapeutic interventions in outcome is less clear (Norcross, 2005). Some evidence suggests that treatment factors, such as the role of therapeutic interventions may be a better predictor of outcome, as compared to therapeutic alliance in cognitive-behavioral and process-experiential treatments for depression (Watson, Schein, & McMullen, 2010; Feeley, DeRubeis, & Gelfand, 1999). However, the studies conducted to date involved individual psychotherapy, with little attention devoted to the role of common and treatment factors in group therapy.

The present study sought to evaluate the relative contribution of therapeutic alliance and theory-specific interventions in group treatment for eating disorders. Changes in emotion dysregulation were selected as an outcome variable given the growing literature supporting the role emotion regulation in maintaining eating disorder symptomatology (Whiteside et al., 2007).

Purpose: To goal of this study was to tease out the relative contribution of treatment factors vs. therapeutic alliance in changes in emotion dysregulation in group treatment for eating disorders. Namely, to identify whether treatment factors, such as task-specific post-session changes (CTSC-R) contributed uniquely to changes in emotion dysregulation, as measured by the EDI-3 Emotion Dysregulation Subscale (EDI-3 ED) over and above therapeutic alliance (WAI-S).

**A drawing by one of the clients in group therapy reflecting her difficulty regulating emotions*

Method

This study was based on data collected for another research project comparing Emotion-Focused Therapy (EFT) and Standard Outpatient Treatment (SOT; Motivation + Psychoed + Skill Building) in an outpatient treatment for eating disorders (Tweed, in progress).

32 participants were randomly assigned to either EFT (n = 19) or SOT group (n = 13) and completed 16 weeks of group therapy. There were 17 drop-outs; 25 clients were included in the “intent-to-treat” analyses (EFT = 15, SOT = 10).

Study eligibility included a diagnosis of an Eating Disorder with either binge eating and/or compensatory behaviours at least once a week for duration of 1 month. Clients with AN-R or with a BMI of <16; suicidal ideation, current self-harm behaviour, a psychotic disorder, or a primary substance disorder were not eligible. The clients were all females between the ages of 18 and 59 (*M* = 35.47, *SD* = 12.44); 59.5% were single and 25% were married.

The participants completed the Eating Disorder Inventory (Garner, Olmsted, Polivy, 2004;EDI-3) at baseline and post-treatment, and post-session measures (Working Alliance Inventory-S (Tracey, & Kokotovic; WAI-S); Client Task-Specific Change Measure – Revised (Watson, Schein, McMulllen, 2010; CTSC-R)) at the end of each therapy session. EDI- 3 Emotion Dysregulation Subscale (EDI-ED) scores were used as the outcome variable.

Results

Descriptive Statistics

Means and Standard Deviations for Baseline and Post-Treatment EDI-Emotion Dysregulation Subscale (EDI-ED), Working Alliance Inventory (WAI-S), and Client Task-Specific Change (CTSC – R) are presented below.

Table 1. *Descriptive statistics for all variables for EFT and SOT groups (n = 25)*

	SOT		EFT	
Variables	***M***	***SD***	***M***	***SD***
Baseline EDI - ED	11.25	5.86	8.53	6.60
Post-Treatment EDI - ED	11.75	4.92	7.76	4.83
WAI-S	57.89	7.94	59.46	10.39
CTSC-R	52.70	14.82	55.83	12.16

Table 2. *Intercorrelations between Post-Treatment EDI-ED, mean WAI-S, mean CTSC-R (n = 25)*

Variables	WAI-S	CTSC-R
Post Treatment EDI-ED	-.61*	-.71**
WAI-S	-	.54*

*Note: **p* < .001, **p* < .01

MAIN FINDINGS

With the ED-EDI as the Dependant Variable and controlling for baseline levels of ED-EDI, the unique contribution of therapeutic alliance (WAI-S) and post-session change measure (CTSC-R) were tested. The results showed that alliance was not a significant predictor of EDI-ED, while client-task specific-post session change scores significantly predicted reductions on the emotion dysregulation subscale. See Table 3.

Table 3. *Hierarchal regression predicting changes in EDI-Emotion Dysregulation Subscale at post-treatment using WAI-S and CTSC-R, while controlling for Baseline EDI-ED scores.*

Variables	B	*SE B*	*β*	R^2	ΔR^2
Step 1				.45**	.45**
Baseline EDI-ED	.53	.12	.67*		
Step 2				.53	.08
Baseline EDI-ED	.38	.14	.48*		
WAI-S	-.19	.10	-.34		
Step 3				.66*	.13*
Baseline EDI-ED	.29	.13	.36*		
WAI-S	-.10	.09	-.17		
CTSC-R	-.18	.07	-.44*		

*Note :*p* < .05, ** *p* < .001; Baseline EDI-ED = Baseline Eating Disorder Inventory, Emotion Dysregulation Subscale; WAI-S – Working Alliance Inventory, Short Form; CTSC-R = Client Task Specific Change Measure – Revised.

Discussion

This study provided preliminary evidence regarding the predictive ability of specific treatment factors and therapeutic alliance in two types of group psychotherapy for eating disorders.

Clients' reported changes in emotion dysregulation that would be expected from theory-specific interventions accounted for a significant amount of variance (13 %). Interestingly, therapeutic alliance was not a significant predictor of variance in outcome.

The findings are consistent with the literature on the role of therapeutic treatment factors in predicting outcome in individual therapy for depression (Watson, Schein, & McMullen, 2010; Watson & Greenberg, 1996; Feeley, DeRubeis, Gelfand, 1999) and with group therapy for eating disorders (Ivanova & Watson, 2012).

The results suggest that theory-specific group interventions could play an important role in reducing emotion dysregulation in clients with eating disorders.

Replication with larger samples of group therapy is needed to investigate the relative contribution of common and treatment factors.

References

Feeley, M., DeRubeis, R. J., & Gelfand, L. A. (1999). The temporal relation of adherence and alliance to symptom change in cognitive therapy for depression. Journal *of Consulting and Clinical Psychology, 67*, 578-582.

Garner, D. M. (2004). *Eating Disorder Inventory-3. Professional Manual.* Lutz, FL: Psychological Assessment Resources, Inc.

Horvath, A. (2001). The Alliance. *Psychotherapy, 38*, 365–372.

Ivanova, I., & Watson, J. C. (2012). The process of change in Emotion-Focused Therapy: Relating in-session resolution to post-session change and outcome. *Second International Conference on Counselling, Psychotherapy and Wellness and the Third Congress of SithCp3*. Bangalore, India.

Norcross, J.C. (2002). Empirically supported therapy relationships. In J.C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 3-16). New York: Oxford University Press.

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment, 1,* 207-210.

Tweed, S. (in porgress). *Group-based Emotion-Focused Therapy (EFT) for Women with Eating Disorders in an Outpatient Setting.* Unpublished doctoral dissertation York University, Toronto, Ontario, Canada.

Watson, J.C., Schein, J., & McMullen, E. (2010). An examination of clients' in-session changes and their relationship to the working alliance and outcome. *Psychotherapy Research, 20*, 224-233.

Watson, J.C. & Greenberg, L. S. (1996). Pathways to change in the psychotherapy of depression: Relating process to session change and outcome. *Psychotherapy, 33*, 262-274.

Wampold, B (2001) The Great Psychotherapy Debate: Models Methods and Findings. Hillsdale,NJ: Erlbaum.

Whiteside, U., Chen, E., Neighbors, C., Hunter, D., Lo, T., & Larimer, M. (2007). Difficulties regulating emotions: Do binge eaters have fewer strategies to modulate and tolerate negative affect? *Eating Behaviors, 8*,162-169.