Therapeutic Alliance on an In-Patient Eating Disorders Unit.

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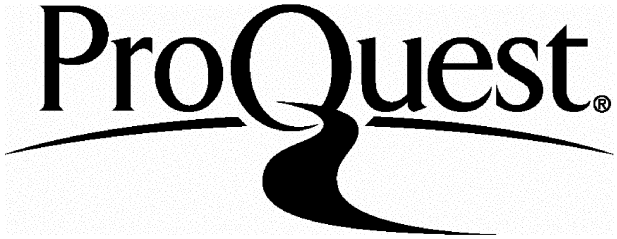

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ABSTRACT

This study aimed to enhance understanding of the therapeutic alliances developed for patients undergoing treatment for eating disorders. The aims were two-fold: Firstly, this study aimed to examine whether family functioning and a number of treatment and pre-treatment variables were associated with the reported alliances and; secondly, this study aimed to explore the congruence between patient and staff ratings of the therapeutic alliance. 21 patients (18 in-patients and 3 day -patients, with a mean age of 20.7 years) participated in this study. All participants were approached individually, and following their consent, filled in the questionnaires. The patients key-nurses and therapists were also given the Working Alliance Inventory.

Neither family functioning nor any of the pretreatment or treatment variables, with the exception of weight from target, were associated with the therapeutic alliance. The therapeutic alliance was found to be related to self-esteem, but only for the patients' ratings of their relationships with key-nurses - those patients who reported poor self-esteem also reported their alliance with the key-nurses as lower. Patients rated their alliances with therapists as better than with key-nurses. There was also a significant difference between the patients' and key-nurses' ratings of their relationships - key-nurses rated the relationship as higher quality than the patients. This difference was not found with patients' and therapists' ratings of the relationship. None of the variables in this study were associated with these discrepancies.

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CHAPTER ONE

Introduction

1.1 Overview of the Topic

This study aimed to investigate the effect of family functioning on the therapeutic alliance in patients suffering from eating disorders. The treatment of patients with eating disorders has been the focus of increasing attention over recent years. As an illness that is often reported as being very difficult to treat (Vandereycken, 1993) it is important to know what factors may help the patient to engage in treatment. The quality of the therapeutic alliance has been repeatedly cited as an important predictor of change in psychotherapy outcome studies (Horvath & Symonds, 1991: Luborsky et al, 1988). Initial results (Gallop, 1994) indicate that the perception of therapeutic alliance by patients on an in-patient eating disorder programme may be a critical factor in the decision to remain in the treatment programme. The therapeutic alliance may be a particularly important area of study for eating disorder patients who often find engaging in therapy very difficult (Vandereycken, 1993). For the benefit of both clinicians and patients, it is important that research develops a better understanding about the precise nature of how treatment and setting variables, and patient and family variables may contribute to the development of the alliance.

This chapter will begin with a review of the literature on the construct of the "therapeutic alliance," with a particular focus on its importance in outcome. The research on

therapeutic alliance in in-patient settings will also be reviewed and a brief review of the literature on the aetiology and epidemiology of eating disorders will be offered. The research on the role of family factors in eating disorders will be reviewed, with a focus on the nature of the possible impact of family relationships on the development of future relationships. Lastly, the literature on the role of therapeutic alliance with eating disordered subjects will be reviewed and the aims and research questions of this study will be outlined.

1.2 The Therapeutic Alliance

Before reviewing the research on the impact of the therapeutic alliance on psychotherapy outcome, it is necessary to begin with a review of the development of the therapeutic alliance construct and to establish a working definition.

The History of the "Therapeutic Alliance" Construct and the Development of a Working Definition.

The influence of the therapist-client relationship on the outcome of psychotherapy is one of the oldest themes in therapy research. As early as 1913, Freud explored the difference between the neurotic aspects of the client's attachment to the analyst (transference) and the friendly and positive feelings that the client has toward the therapist. He felt that the positive, reality based component of the relationship provided the basis for a therapeutic partnership against the common foe, the client's neurosis (Freud, 1958). The interest in the impact of the positive alliance between client and therapist was maintained through

the writings of Sterba (1934), Zetel (1956), and Gittleson (1962). Greenson (1967), suggested that a portion of alliance was based on a rational rapport developed between analyst and patient in contrast to the less conscious, irrational, transferential elements. He was the first to label this bond between client and therapist as the "working alliance". He saw the positive collaboration between client and therapist as one of the more essential components for success in therapy.

A different formulation of the positive relationship factor was developed by Carl Rogers and his associates (Barrett-Lennard, 1962; Rogers, 1957). Their conceptualisation of the effective relationship was based on the hypothesis that it is the therapist's ability to be empathic and congruent and to assume a stance of unconditional positive regard toward the client that was necessary for the client's improvement. The exploration of the beneficial effects of these therapist-offered conditions has generated a significant amount of research (Barrett-Lennard, 1978, 1985). Reviews of this literature (e.g. Gelso & Carter, 1985; Mitchell, Bozart, & Krauft, 1977) have concluded that the therapist-offered conditions probably provide only a partial representation of the complex relationship factors involved in successful therapy.

Two foundations of the working alliance are to be found in the psychoanalytic literature. One of these stems from such views as those of Sterba (1934) on the alliance between analyst and the rational ego of the patient, and of Menninger (1958) on the central importance of the therapeutic contract. The second draws, among others, on Zetel (1956) and especially on Greenson (1967) for the significance of the real relationship in

psychoanalytic work. The term therapeutic alliance has its origin in psychoanalytic theory, but Bordin (1979) writes that it can be formulated in terms generalisable to all psychotherapies. Fusing the contributions of previous authors, Bordin (1976, 1980, 1989) proposed a broader definition of the working alliance. His definition builds mainly on the earlier work of Greenson (1967) and further clarifies the distinctions between the unconscious projections of the client (i.e. transference) and what he defines as the working alliance. This pantheoretical formulation emphasises the client's positive collaboration with the therapist against the common foe of pain and self-defeating behaviour. He identified three components of the alliance: tasks, bonds and goals. *Tasks* refer to the in-counselling behaviours and cognitions that form the substance of the counselling process. In a well-functioning relationship, both parties must perceive these tasks as relevant and efficacious; furthermore, each must accept the responsibility to perform these acts. A strong working alliance is characterised by the therapist and client mutually endorsing and valuing the *goals* (outcomes) that are the target of the intervention. The concept of *bonds* embraces the network of positive personal attachments between client and therapist that includes such issues as mutual trust, acceptance and confidence.

Bordin believes that positive alliance is not, in and of itself, curative, but rather the working alliance is seen as the ingredient that "...makes it possible for the patient to accept and follow the treatment faithfully" (Bordin, 1980, p.2).

During the past ten years a number of investigators have re-examined the working alliance construct, believing that it may provide a more comprehensive conceptualisation of the relationship factor in therapy (Frieswyk et al, 1986). This renewed interest in the working alliance is based in part on the view that *both the therapist and the client* make important contributions to the formation of an effective therapeutic partnership (Horvath & Luborsky, 1993). An adequate representation of the relationship would therefore have to reach beyond the examination of the therapist's contributions and take account of the collaborative aspects of the relationship. A further impetus for research on the alliance came from recent theoretical developments that have extended the basis of the construct of the working alliance and clarified distinctions between it and other relationship variables such as transference, empathy and the "real relationship" (Bordin, 1975; Frieswyk, et al., 1986; Gelso & Carter, 1985; Luborsky, 1976).

Although there are variations among alliance definitions provided by different investigators, there appears to be a general consensus on the central ideas that a) the working alliance captures the collaborative element of the client-therapist relationship and b) it takes account of both therapists' and clients' capacities to negotiate a contract appropriate to the breadth and depth of the therapy (Bordin, 1980; Horowitz & Greenberg, 1989; Luborsky, 1976; Marziali, 1984).

The Relationship Between Therapeutic Alliance and Outcome

Methods for quantifying the alliance opened the way for the empirical exploration of the relation of the strength of the alliance and therapy outcome. The body of current research

includes investigations of the alliance in psychodynamic, cognitive, and experiential therapy (e.g., Greenberg & Webster, 1982; Luborsky, 1976; Rounsaville et al., 1987) across a wide range of client problems (e.g., Frank & Gunderson, 1990; Gomes-Swartz, 1978; Horvath & Greenberg, 1989). The effect of the alliance has been examined in both short and longer term interventions (Frank & Gunderson, 1990; Kokotovic & Tracey, 1990) and from the client's, therapist's and observer's perspectives (Marziali, 1984; Tichenor & Hill, 1989). The quality of the alliance has been related to a broad range of outcome indices ranging from participants' reports to behavioural performance indices (Horvath, 1981; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985).

In a thorough review of the then available studies on therapeutic alliance, Luborsky & Auerbach (1985) noted that 70% of some 85 studies showed evidence of a positive relationship between therapeutic alliance and treatment outcome. These authors identified patient, therapist, and relationship factors and found that relationship factors and the match between patient and therapist were most predictive of successful outcome. In addition, they reported that in short-term therapy, patient factors were most closely related to outcome, but that in longer-term therapy, therapist and relationship factors were most predictive.

In a review of 24 studies which had all conformed to high design standards (Greenberg, 1987; Kazdin, 1986), Horvath and Symonds (1991) examined the relationship between working alliance and outcome in psychotherapy. They found the working alliance to be a relatively robust variable linking therapy process to outcome. Although both the numbers

of subjects and lengths of treatment involved varied considerably, neither of these variables seemed to bias the results systematically. Although the source of outcome evaluation was not found to bias the effect sizes significantly, clients' and observers' reports of the alliance appear to be more predictive of outcome than are therapists' judgements.

Alliance measurements have been used to predict the outcome of therapy with many different problems, ranging from drug use (Luborsky et al, 1985) to social adjustment (Rounsaville, et al, 1987) to clients' and therapists' subjective ratings of global improvement (Eaton et al, 1988). In general, the alliance measures appear to be more efficient at predicting outcomes tailored to the individual client such as the Target Complaints (TC; Battle et al, 1966) than broad range symptomatic change such as the Symptom Distress Checklist-90 (SCL-90; Derogatis et al, 1976). The impact of the alliance has been demonstrated in treatments ranging from 4 to over 50 sessions. The length of treatment, however, does not appear to influence the relation between the quality of the alliance and therapy outcome (Horvath & Symonds, 1991).

The relationship between quality of the alliance during the early stages of therapy versus the latter is less clear. Gaston et al (1992) report that the strength of the alliance remains relatively stable over time when measures are averaged across cases. However, there is evidence that the strength of the alliance fluctuates systematically within individual treatment dyads (Horvath & Marx, 1991). Others (e.g. Adler, 1988) report a positive

slope of the alliance over time, but the incremental gain in the alliance strength is apparently not related to outcome.

Horvath & Symonds (1991) reported that early alliance is a slightly more powerful prognosticator of outcome (ES=.3) than alliance measures averaged across sessions or taken toward the middle of treatment (ES=.2). Although the differences between these values are small, other investigations (e.g. DeRubeis & Freely, 1991; Piper et al, 1991; Plotnicov, 1990) appear to confirm this trend. The apparent anomaly that success is better predicted on the basis of early alliance than by using later assessments may be explained by examining the course of alliance over time. Longitudinal analyses of the levels of alliance in more and less successful therapy (e.g., Horvath & Marx, 1991; Safran, Crocker, McMain & Murray, 1990; Safran, Murran & Wallner Samstag, 1992) appear to confirm a rupture-repair cycle in successful therapies predicted by Zetzel (1956) and Bordin (1989). The alliance in the middle phase of therapy may be, of necessity, quite labile between or even within sessions. This fluctuation in alliance level may account for the modest correlation between outcome and alliance averaged across sessions. The significant index of success in the later phases of therapy may be more related to the degree of success in resolving these ruptures.

One of the important debates concerning the validity and usefulness of relationship variables in general, and the alliance in particular, is whether there is a clear distinction between early session-level benefits and the alliance. The critical question, therefore, seems to be "are what we currently identify as indications of good alliance simply aspects

of early therapeutic progress?" Emerging evidence appears to suggest that the theory of alliance is more than just an artefact. If the alliance is merely a by-product of successful therapy then it's development ought to follow therapeutic progress, but as has already been highlighted, Safran and his colleagues found that positive outcome was most closely associated with successful repairs of alliance ruptures rather than with a linear or parallel development through therapy (Safran, Crocker et al, 1990; Safran et al, 1992). Horvath and Marx (1991) likewise described the course of the alliance in successful therapy as a series of developments, decays and repairs. Similarly, because therapeutic gains accumulate and stabilise over time, early measures of the alliance ought to be less efficient predictors of outcome than measures obtained later in therapy (Gelso & Carter, 1985). As before, this has not been found to be the case. Kokotovic and Tracey (1990) and Plotnicov (1990) reported that very early (first session) alliance measures were predictive of therapy dropouts. Horvath & Symonds (1991) found that the magnitude of the alliance-outcome relation was not a direct function of time: Both the early and late alliance measures predicted outcome better than alliance assessments obtained in the middle phase of therapy.

Lastly, evidence against the likelihood of the alliance merely being a by-product of successful therapy is found when examining the work of Gaston and colleagues (1991) who computed partial correlations (controlling for therapy gains) associated with alliance and posttherapy outcome. She found that alliance predicted 36% to 57% of the variance in posttherapy outcome beyond short-term improvements. Similar results were found in a

recent investigation of the impact of the psychodynamic interventions by Barber, Crits-Cristoph, and Luborsky (1992).

In summary then, research confirming the relation between good alliance and positive outcome has underlined the importance of the construct. In order to offer a more focused perspective on the function of the alliance, however, a closer examination of the factors that influence the relation between the alliance and outcome is needed.

Specific Factors Influencing Alliance-Outcome Relations

The empirical psychotherapy research literature generally supports the relationship between the therapeutic alliance and outcome, but the nature of the relationship has proven to be complex.

It seems likely that both clients' and therapists' personal histories have some influence on the capacity to develop a good therapeutic alliance. Moreover, some of these client-therapist qualities could interact to produce particularly poor or strong alliance patterns. Horvath (1991) summarised 11 studies reporting on the impact of client characteristics on the alliance. To make the interpretation of a broad spectrum of potential client variables easier, Horvath sorted factors into three categories: interpersonal capacities or skills; intrapersonal dynamics; and diagnostic features. It appears that both intrapersonal and interpersonal client variables have similar and significant effects on the alliance. Clients who have difficulty maintaining social relationships (e.g. Moras & Strupp, 1982) or who have poor family relationships (e.g. Kokotovic & Tracey, 1990) are less likely to develop

strong alliances. Similarly, patients with little hope for success (e.g. Ryan & Cicchetti, 1985), who have poor object relations (e.g. Piper et al, 1991b), or who are defensive (e.g. Gaston et al, 1988) are often associated with poor alliance in therapy. Severity of symptoms on the other hand, was found to have a small impact on the ability to develop a good therapeutic relationship.

Two things are apparent from studies that have examined the predictive power of pretherapy interpersonal relations. First, the length of time in the patient's life that has been examined for the assessment has differed considerably. Some investigators (e.g. Marmar et al, 1989; Moras & Strupp, 1982) have focused on current or recent interpersonal relations. Others (Piper et al, 1985) have focused on the entire lifespan of the patient. In the former case the assessment may capture the more changeable aspects of interpersonal relations, which may serve better as outcome variables, particularly in the case of short-term psychotherapy. In the latter case, the assessment may capture the more categorical aspects of interpersonal relations, which may serve better as predictor variables of alliance and outcome. Second, ratings of pretherapy interpersonal relations have often been derived from clinical material that has been used to rate a number of different variables. In these cases, particular attention to interpersonal relations in the assessments has been limited.

The one consistent finding in the outcome literature is that therapeutic alliance is established early in therapy, usually by the third session, and is relatively resistant to change (e.g., Luborsky, 1976; Horowitz et al., 1984; Marziali, 1984; Marziali et al.,

1981). The factors that influence this early development are less clear. In a study of therapeutic alliance and outcome, and the impact of treatment length and pre-treatment symptomatology, Eaton et al (1988) also found level of therapeutic alliance, regardless of length of therapy, to be established within the first three sessions and to remain largely constant throughout its course. The finding that the strength of therapist positive alliance was higher in the beginning phase of therapy exemplifies the importance of establishing therapeutic alliance early in psychotherapy. It implies that the therapists' positive contributions may be of critical significance to the development of a working therapeutic relationship. In contrast to findings of other researchers, this study found that the higher the patient's symptomatology upon entering therapy, the lower the patient's positive alliance and the higher the negative alliance. This difference may be due to the fact that in this study patients rated their own symptomatology rather than relying on the ratings of clients or observers. Patients who report many symptoms were found to have the most difficulty forming an alliance, and in turn it may have been that therapists, especially those with less experience may have responded to these symptoms in ways that impaired formation and maintenance of the alliance.

The alliance literature reveals a significant lack of unanimity with regard to *how* the alliance operates and what contributions each participant must provide for the development of a strong working alliance in therapy (Frieswyk et al, 1986; Gaston, 1990; Horvath & Greenberg, 1987; Luborsky et al, 1985). However, the rapid formation of the alliance and its subsequent stability in reported studies (e.g. Eaton et al, 1988; Sexton et al, 1996) suggest that a large proportion of the patient alliance could result from

pretherapy patient and therapist characteristics. In a study designed to examine the effects of Quality of Object Relations (QOR) versus Interpersonal Functioning as predictors of therapeutic alliance and psychotherapy outcome, Piper and colleagues (1991) found that QOR was the only predictor variable that was significantly related to therapeutic alliance as rated by both patient and therapist. That a lifelong pattern of higher quality of object relationships is related to a better working with the therapist and subsequently to better treatment outcome is logically consistent and clinically meaningful. The authors point to the advantages of a pretherapy predictor of outcome over a therapy process predictor.

Similarly, Marziali (1981) found the patient's capacity to engage in adaptive social interactions to be intrinsically associated with the patient's responses to the therapeutic relationship. That is, patients who had experienced positive relationships prior to therapy were able to join with the therapist in evolving a positive interaction. Conversely, patients with a history of highly conflicted relationships added stress to the alliance and demanded from therapists a capacity to absorb and manage responses which were confusing, ambivalent and obstructionistic.

In summary, while pre-treatment personality variables have been found to be related to establishment of therapeutic alliance, no reliable relationship has been found for the patient's level of symptomatology. Although quite limited in their measures of pathology, these studies suggest that alliance formation is not affected by pretherapy symptomatology, but by the patient's capacity to form interpersonal relationships.

However, the evidence on the effect of symptomatology from unselected outpatient samples is less clear.

Therapeutic Alliance in an In-Patient Setting

Much of the research to date has been conducted on out-patient populations, but studies of in-patients also demonstrate that therapeutic alliance is an important factor related to outcome. Allen and associates (1985) focused on general psychiatric patients' active collaboration with the treatment process as a resource for change. Mean alliance ratings at admission collected from several members of the treatment team were highly correlated with the "likeability" and level of functioning (as measured by the Global Assessment Scale - GAS) of the 37 patients in the study. At discharge, the alliance rating was again significantly correlated with level of functioning. However, the alliance ratings at admission and discharge were not strongly correlated, which suggested important shifts during the course of hospitalisation. For some patients ratings improved between admission and discharge, whereas for others they deteriorated.

Allen et al (1988) went on to consider general psychiatric patients' collaboration in an in-patient setting further, increasing the focus of their research to examine the degree to which the patients' perceptions of the working relationships agree with those of the staff. Patients' and staff members' perceptions of their working relationships corresponded to a statistically significant - but modest - degree. Only nurses' ratings of progress related significantly to patients' ratings. The relatively low intercorrelations in this study may in part be answered by three methodological limitations. First, the reliability (test re-test

stability) of the scales developed for the study are open to question. Second, the rating scales designed were relatively global and therefore somewhat ambiguous, leaving room for subjectivity and idiosyncratic interpretation. Third, the authors did not exclude any unwilling participants, which may have allowed some acutely ill or uncooperative patients to provide invalid ratings.

Building on the work of Allen and associates (1985), Clarkin et al (1987) investigated therapeutic alliance in an in-patient sample, using information from multiple members of the treatment team to rate therapeutic alliance. Therapeutic alliance was considered in the context of a broad range of pre-treatment characteristics, diagnoses, lengths of stay, and level of functional impairment. The results indicate that the patient's alliance with the psychosocial treatment in the hospital setting is correlated with a better condition (that is, a higher GAS score) at discharge. No significant relationship was found between demographic or treatment history variables and therapeutic alliance. Similarly, the authors reported non-significant relationships between therapeutic alliance during hospitalisation and gender, education level, age at first treatment, age at first hospitalisation, number of prior hospitalisations, or total amount of previous time spent in hospital. At the time of admission, results indicated a non-significant relationship between therapeutic alliance and general functioning (measured by the GAS) but, at the time of discharge there was a highly significant relationship between level of functioning and therapeutic alliance. Additionally, admission and discharge GAS scores were also modestly but significantly correlated. The authors concluded that therapeutic alliance and admission GAS scores accounted for half of the total predicted variance in discharge GAS scores, with axis I

(affective and anxiety disorders, schizophrenic and other non-affective psychotic disorders, and other disorders such as childhood, adjustment, somatoform and substance abuse disorders) and axis II diagnoses (personality disorders) accounting for the remaining half. A model developed by the authors illustrated that as the therapeutic alliance rating worsened, there was less relative improvement from admission to discharge regardless of the level of admission functioning.

1.3 General Introduction to Eating Disorders Literature

An excessive over-concern with the control of body weight and shape, together with very restricted, irregular or chaotic eating behaviour are the main characteristics of eating disorders (Hsu, 1990). Since this study is concerned with therapeutic alliance with patients suffering from eating disorders, this section will review the features of anorexia nervosa and bulimia nervosa and will attempt to give some idea of the epidemiology and aetiology of the disorders.

Features of Anorexia Nervosa

Dramatic and often life-threatening weight loss is the primary feature of anorexia nervosa that brings it to the attention of health care professionals. The person with anorexia nervosa displays a morbid fear of fat and the pursuit of thinness is expressed through the desire to maintain a suboptimal body weight, by avoiding certain foods and often engaging in rigorous exercise programmes to prevent weight gain. Using the DSM-IV

(A.P.A., 1994) classification schema, anorexia nervosa is diagnosed if each of the following is present:

1. Refusal to maintain body weight at more than 15% below normal weight for age and height.
2. Intense fear of gaining weight or becoming fat or of normal body weight.
3. Disturbed perception or experience of body weight, size or shape.
4. Endocrine disorder manifest by an absence of at least three consecutive menstrual cycles.

Other features frequently noted in anorexia nervosa include perfectionism, obsessive-compulsive symptoms, marked mood disturbance, with depression not unusual and poor self-image (Bryant-Waugh & Lask, 1995). One study (Williams et al., 1993) concluded that the notion of low self-esteem is a characteristic of eating disorder patients that differentiates them from individuals who only display dietary/weight concern features, as well as from normal controls. The physical characteristics are related to self-starvation: emaciation, poor circulation leading to circulatory failure - shown by pallor, slow weak pulse, low blood pressure, cold hands and feet, discoloured skin and mucosa, and a fine downy (lanugo) hair (Bryant-Waugh & Lask, 1995).

Features of Bulimia Nervosa

As with anorexia, fear of obesity and attempts to lose weight are core clinical features of bulimia nervosa. Although individuals with bulimia nervosa also practice caloric restriction, unlike those with anorexia nervosa, these people are usually within the normal weight range and are therefore not forced into treatment by life-threatening weight loss.

Bulimia Nervosa is diagnosed if each of the following is present (DSM-IV, A.P.A., 1994):

1. Recurrent episodes of binge eating (rapid consumption of large amounts of food in a discrete period of time).
2. Feeling a lack of control over eating behaviour.
3. Behaviour aimed at preventing weight gain such as self-induced vomiting, use of laxatives or diuretics, fasting.
4. Persistent over-concern with body shape and weight.

Other common features include mood disorder, particularly depression, and impulsive self-harming behaviour such as chemical misuse, overdosing and self-mutilation (Bryant-Waugh & Lask, 1995). The physical manifestations of bulimia are not as obvious as anorexia because weight tends to remain within the normal range. However, menstrual irregularities are common and self-induced vomiting can become intractable and has accompanying complications such as fluid and electrolyte imbalance and gastro-intestinal bleeding. Other physical features include dental erosion, enlargement of the salivary glands and muscle weakness (Bryant-Waugh & Lask, 1995). Patients with bulimia nervosa may have a history of anorexia nervosa with bulimic symptoms developing concurrently or at a later stage when weight restoration has occurred.

Epidemiology

Although the question "how common are eating disorders?" has been a focus of much epidemiological work, establishing prevalence rates has not been easy. Notable discrepancies have arisen in reported estimates for both anorexia nervosa (Crisp, Palmer

& Kalucy, 1976; Szmukler, 1985; Rastam, Gillberg & Garton, 1989, cited in Szmukler and Patton, 1993) and bulimia nervosa (Halmi, Falk & Schwartz, 1981; Schotte & Stunkard, 1987; Fairburn & Beglin, 1990). For anorexia and bulimia it has been suggested that a large number of people suffer from some but not all of the essential symptoms and therefore do not reach the criteria for formal diagnosis. It has also been suggested that around 5% of all teenage girls develop "subclinical" anorexia nervosa (mild anorexia that never reaches psychiatric attention) after reaching puberty (Button & Whitehouse, 1981). However, it is impossible to gather data about such cases unless they present to professionals. Thus, the estimates of incidence for anorexia and bulimia given below should be taken as rough estimates only.

The often cited prevalence rate of 1% for anorexia nervosa (AN) has been derived from the study by Crisp, Palmer & Kalucy (1976), but this citation is based on a biased sample which reflected their findings at private schools. In a review of the epidemiological studies of anorexia nervosa, Hoek (1993) reported a prevalence rate of between 0.2 and 0.8% of young females. Most of the studies in the review found much higher prevalence rates for partial syndromes of anorexia nervosa. In addition, Hoek also notes that these rates are likely to be minimum estimates since Johnson-Sabine et al (1988) found two cases of anorexia nervosa among non-responders and Meadows et al (1986) detected their only case of anorexia nervosa because she was referred to the authors. In summarising the two-stage surveys (in which a population is initially screened with a self-report questionnaire, and then high scoring subjects are selected for second stage evaluation) of community populations, Hoek reports an average prevalence of anorexia

nervosa (using strict diagnostic criteria) of 0.28% of young females. Hoek (1991) has found a one-year prevalence rate of 0.16% of females aged 15-29 in primary care. In Rochester, Lucas et al (1991) recorded a point prevalence of 0.48% of girls of 15-19 years at 1 January 1985.

Incidence rate estimates have varied widely. Highest rates from case registers are 4 to 5 per 100 000 population per year in the 1980's. A general practitioner continuous registration study in Holland found 6.3 per 100 000 (Hoek, 1991), while Lucas et al (1991), in a study involving all health services found an incidence of 14.2 per 100 000 per year for the period 1980-1984 in Rochester, Minnesota.

Inconsistencies in case definition of bulimia nervosa (BN) pose difficulties in interpreting studies of prevalence estimates. Bulimic symptoms exist on a spectrum, with individual symptoms being quite common in the general population (Patton, 1988; Whitaker et al, 1989). The different possible definitions can influence prevalence estimates, as was well demonstrated in a New Zealand survey where point estimates for bulimia in women 18-44 years ranged from 0% for Russell's definition to 0.5% using DSM-IIIR (Bushnell et al, 1990). Lifetime estimates were 1.6% for the DSM-IIIR definition.

Two stage surveys of bulimia nervosa have been adopted in a number of settings. Findings are in broad agreement that when bulimia nervosa is defined as a syndrome in which both frequent binge eating and purging occur, around 1% of young western women fulfil this clinical definition at any one time so that bulimia nervosa appears now

to be the most common eating disorder across the ages (Szmukler & Patton, 1995). Recent reported incidence estimates for bulimia nervosa include 9.9 per 100 000 population per year in general practice settings (Hoek, 1991) and 26.5 per 100 000 from Lucas' Rochester study.

Eating disorders are overwhelmingly disorders of young women. General population studies have confirmed gender ratios observed in clinical settings. Rastam's study of adolescents in Gotenborg indicated a gender ratio of 9.1:1 for anorexia nervosa. Clinical and register based studies suggest that these disorders reach a peak of onset in mid to late adolescence (Szmukler et al., 1986).

Aetiology

Although the relationship with age and gender is clear-cut, few other demographic associations have emerged consistently to point to the aetiology of eating disorders. Many different aetiological theories have emerged over the years as researchers have tried to explain *how* and *why* these disorders emerge and persist. Such theories have included research into: genetic factors in eating disorders (e.g. Treasure & Holland, 1995); starvation models (e.g. Fichter & Pirke, 1995); psychodynamic models (e.g. Dare, 1995); cognitive-behavioural models (e.g. De Silva, 1995); family models (e.g. Eisler, 1995); and sociocultural models of eating disorders (e.g. Szmukler & Patton, 1995). Current evidence supports a multidetermined aetiology (Garfinkel & Garner, 1982) in which families can play an important but unpredictable part.

Why study Eating Disorder Patients?

This question has, in part, already been answered by the review of prevalence and incidence rates. It is a significant problem to providers of health care at all levels (Hoek, 1991) and if researchers are correct (e.g. Hoek, 1991), studies of incidence and prevalence are not representative of the problem since so many cases are not reported.

In addition to the 'size' of the problem, eating disorders, and anorexia nervosa in particular, are often referred to as some of the hardest psychiatric disorders to treat (Vandereycken, 1993). As McKenna (1989) notes, these patients are always highly ambivalent about seeking treatment and many times overtly resistant. Bulimics, she reports, are more likely to seek help voluntarily, although this often occurs only after they have been symptomatic for many years (Pyle et al., 1981). Because secrecy is so central to the disorder, there may be enormous shame, hesitancy, or suspicion about opening one's most private self to scrutiny. Anorexia nervosa can have a devastating outcome. After erupting in adolescence it may last a lifetime, sometimes stunting growth, totally excluding social and sexual life, sometimes leading to early death from the condition (Crisp et al., 1991). With very long-term follow-up some report (e.g. Theander, 1985) that nearly 20% of patients will have died. Other investigators (e.g. Hall et., 1984) claim that mortality, at least over a ten year follow-up is much less, at around 2-5%. Such patients, however, will often have received treatment that may have sustained them thus far. The aggregate cost of care of a single patient over the years can become very high as a result of frequent consultations, investigations and long periods of inpatient care coupled with chronic unemployment and strains on the family and its resources.

For all of these reasons, the study of eating disorders is crucial. Continued research is needed in order to give help to clinicians working with this population and in order that help can be offered to the sufferers.

1.4 The Role of Family Factors and Eating Disorders

The role of the family in the genesis and maintenance of eating disorders has prompted research from two main perspectives. Firstly, research has examined the possibility of the role of a number of genetic factors in the illness (e.g. Treasure & Holland, 1995); and secondly, the family environment and the way the family functions has been a focus of research (e.g. Eisler, 1995). This research has revealed conflicting and inconclusive results: many studies report that families with an eating disorder sufferer are significantly different to normal control families, while others report no significant differences. The literature on genetic and family factors in eating disorders will now be briefly reviewed.

Review of Genetic Factors in Eating Disorders

A biological model of the aetiology of anorexia nervosa, although currently out of fashion, is not new (Russell, 1970). Standard methods used to determine the genetic contribution to aetiology are to determine prevalence rates in families, in adoptees and their families, concordance rates between MZ and DZ twins, and finally chromosomal studies.

Strober et al (1990) found that female relatives of probands with anorexia nervosa had a ten-fold greater risk of developing an eating disorder than the control population, and that bulimia nervosa was more common in the families of bulimia nervosa probands. Strober and colleagues (1985) also found that the risk of anorexia nervosa was increased among second degree relatives. Clustering of an illness within families is necessary if a proposed trait is to be considered genetic, but it is not enough. Family studies do not discriminate between inherited factors and environmentally transmitted factors. Twin or adoption studies have been used to tackle this problem.

In a study by Holland and colleagues (1984) a large sample of twins were recruited. Results found that 55% of the monozygotic (MZ) and 7% of the dizygotic (DZ) pairs were concordant for anorexia nervosa, the significant difference in the concordance rate suggesting that genetic factors contributed to anorexia nervosa in this study. However, structured interviews to ascertain the form of the eating disorder were not used and only in 18 out of the 30 pairs were both sisters seen. In a study of concordance in bulimia nervosa by Treasure and Holland (1989) the proportions of MZ and DZ twins was less marked than in anorexia nervosa. The authors argue that the larger discrepancy between the proportion of MZ as compared to DZ pairs concordant for anorexia nervosa as opposed to bulimia nervosa suggest that genetic factors are of more relevance in the aetiology of anorexia nervosa.

Review of Family Functioning in Eating Disorders

The interactions of families of patients with anorexia nervosa have been studied since the earliest description of the disorder (Lasegue, 1873). The environment of the family may act as a potential protective buffer from internal and external stresses and as potential risk factor for aberrant development. More recent authors have observed families in detail (Selvini Palazolli, 1974; Minuchin et al., 1978) and proposed that aspects of family functioning are important in the aetiology of the disorder. They suggest that communication and problem solving are often areas of particular difficulty. Their theories, while widely accepted in the clinical context, have not been extensively tested in a systematic way (Thienemann & Steiner, 1993). Studies using a standardised self-report measure of family functioning have, however, shown abnormalities in families with an eating disordered member, compared to normal controls (Kog & Vandereycken 1985). Subjects with anorexia nervosa and bulimia nervosa have scored similarly, those with bulimia simplex have reported more family dysfunction (Waller et., 1989, 1990).

Although they have yielded interesting results, studies investigating the effects of the functioning of a family are not without their problems. Firstly, many of the studies use self-report measures only. Secondly, many do not use a psychiatric control group and it may be that the findings are not specific to eating disorders. Thirdly, previous reports have often been concerned with subjects from a broad age range. Family functioning is complex. Clinical impression, self-report and use of a standardised measure may all contribute to an assessment. Caution is required in interpreting any results as families with an anorexic member may deny their difficulties (Crisp, 1980). The chief difficulty

with drawing conclusions from this research, however, is that different studies have used a wide variety of assessment methods, thus making the results difficult to compare.

In an attempt to rectify some of these methodological problems, North et al (1995) compared 35 adolescents with anorexia nervosa, with 35 age/sex matched psychiatric and community controls. A diagnostic interview and a questionnaire, the Family Assessment Device (FAD) were administered to subjects and their mothers. In contrast to the findings of Waller et al (1989, 1990) this study found that there were no significant differences between subjects with anorexia nervosa and controls recruited from General Practitioners. The results are not strictly comparable, however, since the mean ages of the anorexic group in Waller et al's studies were 25.3 (s.d. not reported) and 26.3 (s.d. 6.5) years, whilst in the North study it was 14.9 (s.d. 1.7) years. The finding that family functioning does not differ in families where an adolescent member has an eating disorder, from psychiatric and normal control families has previously been reported in a study by Thienemann & Steiner (1993). The authors used another measure of family functioning (The Family Environment Scale -FES). In this study the authors found that it was those patients with a high level of self-reported depression, independent of diagnosis, who described family environments that were significantly different. Subjects in the eating disorder group did not differ significantly from each other or from a normative sample.

Kog and Vandereycken (1989) matched 30 eating disorder patients with 30 controls and tested whether the age (adolescent or young adult) and the symptomatology of the patient (restricting anorexic, bulimic-anorexic, and normal-weight bulimic) had a significant effect on a behavioural and self-report measure of cohesion, adaptability and

conflict. The age of the patient proved to be non-significant. Through their comparisons, the authors consistently found that parents and children in eating disorder families discussed disagreements less than children and families in non-eating disorder families. This is labelled "conflict avoidance" by Minuchin (1978). The eating disorder families also showed significantly more stability in their family organisation, which is again support for Minuchin's concept of rigidity (Minuchin et al., 1978).

Schmidt and colleagues (1993) found evidence that patients with restricting anorexia and bulimia nervosa have different childhood experience antecedents, with bulimia nervosa patients experiencing more childhood adversity than those with anorexia nervosa.

The Importance of Family Functioning on Therapeutic Alliance

Regardless of the fact that research on the effects of family functioning on the development and maintenance of an eating disorder remains unclear, intergenerational family theory considers the family of origin as the most important social group affecting a person's development (Harvey & Bray, 1991; Williamson, 1991). Kerr and Bowen (1988) proposed that this influence continues with or without family contact. A person's perception of current family relationships rather than perceptions of past family relationships is viewed as having the greatest effect on current functioning (Harvey & Bray, 1991; Williamson & Bray, 1988). It was also reported by Kokotovic and Tracey (1990) that those patients reporting poor family relationships were less able to form strong alliances with their therapists. Whether or not family factors are believed to be

important in the development of an eating disorder then, the family is clearly an important system for investigation in any alliance research.

1.5 Therapeutic Alliance and Eating Disorders

It has already been noted that very few studies have examined the therapeutic alliance in the hospital setting. It is perhaps not surprising then that only one paper was found which attempted to evaluate formally the importance of staff-patient relationships during hospital treatment for AN or BN and the possible effects on outcome (Gallop et al, 1994). The authors noted in their clinical setting that some patients were leaving the structured programme prematurely and the authors were interested in the patients' perception of the alliance. Three questions provided the structure for this study: 1) is premature discharge related to variation in patients' perception of the alliance?; 2) is premature discharge related to the agreement between staff and patient perceptions of the therapeutic alliance? and; 3) given the structured nature of the program was there concordance between staff perceptions of the alliance?

The findings from this study must be viewed with caution given the small sample size (n=33) and multiple tests utilising small subsamples. However, for this in-patient programme, results do suggest that when those patients who left prematurely were contrasted with those who remained in hospital there was a significant difference in the patients' perception of therapeutic alliance between the two groups. The Working Alliance Inventory (Horvath & Greenberg, 1986) was administered at 3 weeks following

admission for all patients, and relevant staff. Those patients who remained in the programme perceived the therapeutic alliance with staff to be significantly stronger than patients who left. The authors concluded that premature discharge may be related to patient perception of the therapeutic alliance within the first three weeks.

This study also reported a significant difference in staff/patient overall perceptions. At 3 weeks, the staff rating of the alliance was significantly higher than the patients, whereas at 8 weeks, it was significantly lower. This represents an increase in perception of alliance over time for the patients, but the staff perception remained constant. The authors note that the changing perception of the alliance may be in part due to the programme structure. During the initial phase of the programme, patients are on partial bed rest and have a great deal of contact with the staff. Because the philosophy of the unit suggests that little psychotherapeutic work can be commenced until basic re-feeding occurs, the in-patients role in this phase is less directive and less active. The authors note that many patients find this phase difficult and frightening and that this may account for the lower alliance scores in this phase. However, it would seem that the decision to stay in treatment is not related to this incongruence since although patients reported lower alliance scores than the staff at 3 weeks, the majority of them remained in the programme.

The Contributions of Theory to Understanding the Therapeutic Alliance with Eating Disorder Patients

For patients with an eating disorder, control is a core issue (Sanger & Cassino, 1984). Their dread that they will lose control over their eating is sometimes cited as reflecting

early disturbances within the parent-child relationship (Bruch, 1982). In 90%-95% of reported cases, the individual with an eating disorder is a female (Bryant & Kopeski, 1986). These women attempt to regain or maintain control of their food and weight by using characteristic maladaptive behaviours, which may include denial, minimisation, splitting, and projection (Stern, 1986).

Often families in which one member has an eating disorder have increased their level of involvement by striving to control what she eats, as her health deteriorates to a potentially life-threatening status. Minuchin and Rosman (1978) suggest that the family organises around the symptoms (anorexia and bulimia) and focuses on the disorder to the extent that other interpersonal conflicts are avoided. The symptoms thus serve to stabilise a dysfunctional family through the development of a psychosomatic illness.

Stern (1986) suggests that in-patient treatment becomes necessary when potential life-threatening behaviours of purging and restricting food need to be monitored and interrupted. During the early stages of treatment, when eating symptoms are out of control, these patients require a therapeutic holding environment to provide the self-structuring and self-regulating functions that the symptoms have been serving.

When a person enters the in-patient treatment unit, Stern (1986) believes that she will tend to replicate the family conflicts with which she is most familiar. She subjects the treatment system to unconscious tests to determine whether it is more benign than the early familial environment in which the symptoms developed. These "transference tests"

occur most frequently within the context of the patients' need for external control and regulation, support for autonomy, tolerance of aggression, and acceptance of the "true-self."

If the patient finds herself in a setting that promotes the replication of the dysfunctional communication patterns used within her family, she will avoid significant behavioural and intrapsychic changes. She will also tend to exhibit behaviours that disrupt the treatment system in a fashion similar to that which occurred in her family. Unconsciously, these clients discover that their symptomatology is a perfect fit for any unresolved enmeshment, overprotectiveness, rigidity, and lack of effective conflict resolution that may exist within the treatment system (Minuchin & Rosman, 1978).

Treasure and colleagues (1995) state that ambivalence about treatment in anorexia nervosa is usual and is what sets it apart from many other conditions. A challenge in developing a therapeutic alliance is therefore to be expected. As Bruch (1985) has put it: "On principle, these patients resist treatment: they feel that in their extreme thinness they have found the perfect solution to their deep-seated unhappiness." The deceits which are used to maintain control over weight are to be expected as part of the illness and should not be interpreted as an attack upon treatment. Treasure (1995) notes that the therapeutic relationship should be collaborative, with a kind, firm and consistent approach.

1.6 Implications of the Literature for the Present Study

The relationship between patient and therapist is the medium through which verbal, expressive psychotherapy is conducted. Whether one attributes healing power to the relationship itself, e.g. a corrective emotional experience, and/or to the technical skills of the therapist, e.g. the judicial use of interpretations, there is general agreement that the quality of the therapeutic alliance is an important predictor of change in psychotherapy (e.g. Horvath & Symonds, 1991; Luborsky et al., 1988).

Initial results (Gallop et al., 1994) indicate that the perceptions of therapeutic alliance by patients on an in-patient eating disorder programme may be a critical factor in the decision to remain in the treatment programme. It is commonly believed that patients differ in their ability to form a good working relationship with their therapist and that one indicator of that ability is the quality of their relationships with past important figures in their lives (Kokotovic and Tracey, 1990). Because of these strongly held assumptions it had been puzzling that psychotherapy researchers have had such difficulty in demonstrating such relationships between the quality of the patients' pretherapy relationships and therapy outcome. However, research is beginning to emerge that offers some insight into the pretherapy factors that may influence the development of a strong or poor relationship. Despite this, little is still known about the precise nature of how treatment and setting variables, and patient and family variables may contribute to the development of the therapeutic alliance. The identification of variables that have a bearing on the quality of staff-patient interactions is important to create the optimal conditions for

therapeutic success. The ability to detect prior to therapy, those patients who are likely to have difficulty forming a good alliance and therefore are more likely to have a poor outcome is of great value.

The literature that has been reviewed on therapeutic alliance suggests that the ability to predict therapy process and outcome is likely to be enhanced if attention is given to specific factors that may play a part in ability to form a good alliance. The consideration of the participants' perspective of long-term patterns of their relationships, particularly those with their families is one such specific factor, and the one chosen as the focus of investigation in this study. The reasons for studying patients with eating disorders has already been noted. In addition to the reasons outlined above, the particular focus that family factors have received in the eating disorders literature make this population even more interesting to study in relation to the interaction between alliance and family functioning.

1.7 Aims of the Present Study

This study will attempt to examine the relationship between family functioning and an individuals ability to form a 'good alliance' with the staff of an eating disorders unit. This study will not attempt to examine whether or not family pathology is responsible for the disorder, but whether or not family functioning has an impact on ability to form an alliance.

1. Previous studies have not used well validated, reliable measures of alliance. This study will use a measure with good reliability and validity.

2. By focusing on one specific potential pre-therapy influence i.e. family functioning, this study will aim to gain more information into the way this factor influences a patients ability to form an alliance. Other factors such as self-esteem and previous treatment history will also be considered.

3. The literature available on therapeutic alliance with eating disorder patients has been found to be scarce. This study is indicated in order to expand current knowledge, both empirically and clinically. The value to the clinician in being able to identify those patients for whom forming alliance is likely to be more difficult is important.

4. Previous research has noted differences in the alliance when reported by different members of a staff team. This study will aim to investigate the nature of such differences.

Hypotheses/Research Questions

1) Is there a relationship between family functioning and the quality of the therapeutic alliance? It is hypothesised that the more healthy the reported family functioning, the better the reported quality of the therapeutic alliance formed.

2) Are some aspects of family functioning more strongly associated with the quality of therapeutic alliance reported than others?

3) To what extent do other factors related to the participants eating disorder and treatment history affect current ability to form a good alliance?

4) Are there differences between the therapeutic alliance as reported by different members of the team and the patient participants?

CHAPTER TWO

Method

Overview of Chapter Two

This study surveyed the quality of therapeutic relationships that were reported by 21 adolescents and young adults who were currently receiving treatment for an eating disorder. In order to assess any possible influences of family functioning on reported alliance, the participants were only approached if they were under 25 years old and still living within their families of origin. This age range was selected because it might be expected that any family pathology would exert a more potent effect in this young age group. Reports of therapeutic alliance were also collected from therapists and key nurses.

2.1 Research Setting

Participants were recruited from 3 psychiatric hospitals (2 in the private sector, and 1 NHS Hospital) which all provide specialist services for the treatment of eating disorders, and which all subscribe to a similar treatment regime.

2.2 Participants

Patient Participants

21 participants, 18 (85.7%) in-patients and 3 (14.3%) day-patients who were all day-attending following a period of in-patient treatment, were recruited from 3 psychiatric

units which all provide a service for the treatment of eating disorders. Participants with a formal diagnosis (DSM-IV, as diagnosed by the Consultant Psychiatrists) of an eating disorder (anorexia nervosa, bulimia nervosa and eating disorders not otherwise specified), who were between the ages of 14 to 25, were either an in-patient or previous in-patient and now a day-patient attending the unit for more than 3 days a week and who were still living within their families of origin were invited to take part in the study. All other patients involved with the units and those with a diagnosis of Personality disorder or Psychosis were not approached.

30 participants were approached to take part in the study (Female:30). 1 (3.3%) participant did not wish to take part and 3 (9.9%) did not return a consent form. 26 participants, all of whom were voluntary patients, consented to take part in the study. During the course of the study, 1 (3.8%) participant requested to be removed from the study, 1 (3.8%) dropped out of treatment and 3 (11.5%) did not return the questionnaire package. 21 participants, ranging in age from 16 years 11 months to 24 years 11 months (mean age 20 years 7 months) eventually participated in the study.

Staff Participants

The co-operation of each of the participants key nurses and therapists was also required for this study. All of the key-nurses (100%) filled in and returned the questionnaire but responses were only received from 10 (52.6%) of the patients therapists. 1 (4.85%) of the patients did not have an allocated therapist.

Ethical Considerations

Ethical Committee Approval for this study was given by the joint UCL/UCLH Ethics Committee (See Appendix 1).

Every participant qualifying for inclusion in the study was met by the researcher and given a verbal explanation of the study as well as an information sheet detailing the outline of the study (see appendix 2). A consent form was included with this information and in each of the units a sealed boxfile was left at the nurses station for responses. Once signed consent had been received from participants (and from parents where the participant was under 18 years, see appendix 3) all questionnaires were coded to protect the identity of the participants and to ensure that all responses remained strictly confidential. Therapists and key-nurses had to be matched to client participants by name, but once therapist and key-nurse participants had been told in a sealed letter who they were required to fill in the questionnaire about, all returned questionnaires were coded to protect theirs and their clients identity and to keep their responses confidential. Sealed envelopes were provided for all participants to return their responses in and participants were assured that at no time would their responses be shared with any members of the teams.

2.3 Measures

The Working Alliance Inventory (WAI), Horvath & Greenberg (1989)

This self-report instrument for measuring the quality of alliance is based on Bordin's (1976) pantheoretical, tripartite (bonds, goals and tasks) conceptualisation of the

alliance. Participants are required to rate according to a 7 point likert scale whether they agree or disagree with the 12 statements. Both positive and negative items are presented in order to reduce the effect of respondent set. Examples of the items of this scale are 'My therapist and I agree about the things I will need to do in therapy to help improve my situation,' and 'My therapist does not understand what I am trying to accomplish in therapy.' The scale is adapted for use with both client and therapist/key-nurse participants by carrying out minor word changes.

The scale is scored using a 1-7 system where a higher score is indicative of a good quality of alliance. The scale provides a general alliance score computed from the total of the 12 items, as well as 3 specific factors (tasks, bonds and goals) which are computed from the 4 questions in each of them.

This 12-item version of the WAI was chosen as the measure of alliance for a number of reasons: it is a self-report instrument easily administered to all participants (i.e. both clients and therapists or key-nurses); it was developed to apply across theoretical orientations; previous studies have reported successful use; and results of studies provide support for the validity and reliability of the general factor (overall alliance score) and the 3 specific factors of the 12-item version of the WAI (e.g. Tracey & Kokotovic, 1989).

The Family Assessment Device (FAD), (Epstein et al, 1983)

The FAD is a 60-item self-report questionnaire, designed to evaluate family functioning according to the McMaster Model of Family Functioning (Epstein, Baldwin & Bishop,

1978). It consists of 60 questions in its revised form (Kabacoff et al, 1990) and generates six subscale scores based on the six dimensions of the McMaster Model of Family Functioning. These are: the family's style of resolving problems (problem solving, PS); clarity of information transmission (communication, C); differentiation of tasks (roles, R); experience of emotions (affective responsiveness, AR); concern for each other (affective involvement, AI); and clarity of rules (behaviour control, BC). A seventh, "General Functioning" (GF) subscale provides a measure of overall family health/pathology. Participants are required to rate each question according to one of four categories: 'strongly agree;' 'agree;' 'disagree;' and 'strongly disagree.' Examples of the questions in this measure are: "There are lots of bad feelings in the family" and "We feel accepted for what we are."

Each question is scored from 1-4, and both negative and positive items are presented in order to reduce the effect of respondent set. Scores for all questions on each subscale are averaged to generate the subscale score which is again between one and four, the higher the score, the more severe the family dysfunction.

This measure of family assessment was chosen because of ease of administration, because it provides a variety of information about 6 subscales of functioning as well as an overall measure, and because it is designed to be completed independently by any family member over the age of 12 years. Waller et al (1990) demonstrated the value of the FAD as a measure of 'pathology' in the families of anorectic and bulimic women and using the ability to predict the eating disorder as an index of concurrent validity, concluded that the

sufferers themselves had the most realistic perceptions of their families interactional styles. Because of this finding, FAD's were filled out by patient participants only. The FAD's acceptable reliability and validity have been demonstrated (Epstein et al, 1983; Miller et al, 1985; Kabacoff et al, 1990).

Rosenberg Self-Esteem Scale, Rosenberg (1989).

This 10-item, Guttman scale measure of self-esteem was constructed according to 4 theoretical and practical considerations: unidimensionality; face validity; economy of time; and ease of administration (Rosenberg, 1989). Respondents are asked to rate whether they 'strongly agree,' 'agree,' 'disagree,' or 'strongly disagree' with 10 statements. Negative and positive items are presented in order to reduce the effect of respondent set. Examples of items of this scale are: 'I feel that I have a number of good qualities' and 'I certainly feel useless at times.' The scale is scored using a 0-3 system where higher scores are indicative of low self-esteem. Rosenberg (1989) defines low self-esteem as implying self-dissatisfaction, self-contempt and self-rejection, where the individual lacks respect for the self he or she observes.

This measure of self-esteem was chosen because of its ease of administration and because it is one of the most widely used measures of self-esteem. Despite this, however, there has been very little investigation into the reliability and validity of the scale. Rosenberg (1989) has demonstrated that the scale is internally reliable and has face validity.

Demographic Questionnaire

A demographic questionnaire was constructed for use in this study and required participants to give details about their age, length of admission or contact with the unit, weight and history of eating problems and previous contact with psychiatric services. The questionnaire was constructed to avoid consulting participants case files and it was anticipated that the participants would be able to easily recall the data requested. The format of a data collection form already being used on one of the in-patient units was used as a guide when constructing this form.

A pilot of the demographic questionnaire on the first 10 participants involved in the study revealed that participants appeared to find the questionnaire easy to fill in. In every case, every question was answered fully and no further details were needed from the case files. No changes were made to the questionnaire. (See Appendix 4 for a copy).

2.4 Procedure

Following meetings with team members of the units a list of participants qualifying for inclusion in the study was drawn up by the researcher. This list was compiled using patient data from the bed charts and case files in each of the units. Each participant was approached by the researcher in order that the researcher could explain verbally about the study as well as offer the opportunity for questions to be asked and answered. Every participant was given an information and consent form and where a participant was under the age of 18 the participant was asked if they minded their families being contacted for

their consent also. Participants gave the researcher the address of where they wanted the family information and consent form to be sent to.

Once written consent had been obtained and as soon as participants had been resident in, or day attending one of the units for more than 3 weeks, they filled out the questionnaires. The time period of 3 weeks was selected in line with reviewed research findings, which have shown that alliance is developed and stable by this time (e.g. Eaton et al, 1988; Horvath & Symonds, 1991; and Sexton et al, 1996). At the same time as the client participants were given the questionnaire packages, the relevant key-nurse and therapist were also given the key-nurse and therapist version of the WAI. This was done to minimise the chance that client-key-nurse and client-therapist participant pairs were filling out the WAI according to different sessions. Staff of the units had all been told about the study, in staff meetings, but letters were sent to all of the key-nurses and therapists involved, with the questionnaire (see appendix 5).

Returned questionnaires were then scored and responses were analysed using the 'SPSS' for windows statistical package.

CHAPTER THREE

Results

Overview of Chapter Three

This study aimed to address 4 main research questions. These were: 1) Is there a relationship between family functioning and the quality of the therapeutic alliance?; 2) Are some aspects of family functioning more strongly associated with the quality of therapeutic alliance reported?; 3) To what extent do other factors related to the participants eating disorder and treatment history affect current ability to form a good alliance? and; 4) Are there differences between the therapeutic alliance as reported by different members of the team?

This chapter begins by describing the characteristics of the sample (section 3.2) before moving on to detail the results of the statistical analyses of the questionnaire responses. Results of the first three research questions, which are all concerned with the extent to which a number of factors may interact with the quality of the therapeutic alliance formed, are presented first (Section 3.3). These are followed by the results of the fourth research question, which examined the therapeutic alliance when reported by the patients and different members of the staff team (Section 3.4).

3.1 Characteristics of the Sample

Characteristics of the 21 participants were collected by means of a demographic questionnaire (appendix 4). Data collected from these questionnaires are given below:

Table 1. Data about age, abnormal eating patterns, length of time in treatment, weight from target and number of previous admissions.

	Mean	SD	Minimum	Maximum
Age	20.7	2.43	16.9	24.9
Length of abnormal eating patterns (months)	61.8	35.28	14	144
Length of time in treatment (days)	81.9	91.21	21	420
Kgs from target weight	7.9	6.28	0	18
Number of previous admissions	.81	1.12	0	4

The mean age of the sample was 20.7 years (SD=2.43), spanning 8 years (minimum age 16.9 years, maximum age 24.9 years). Participants were asked to give details about the length of time that they had experienced abnormal eating patterns. The mean length of time reported for abnormal eating patterns was 61.8 months (SD=35.28), which incorporated a large range of time from 14 to 144 months. The length of time that the

participants had been in-patients ranged from 21 days to 420 (M=81.9, SD=91.29) and distance from target weight ranged from 0kgs (the patient was already at target weight) to 18kgs (M=7.9, SD=6.28).

The mean number of previous admissions was 0.81 (SD=1.12) which ranged from 0 to 4 previous admissions. This revealed that 11 (52.4%) of the sample had never had a previous admission, 6 (28.6%) reported 1, 2 (9.5%) reported 2, 1 (4.8%) reported 3 and 1(4.8%) reported 4 previous admissions. Therefore, over half (52.4%) of the sample had never previously received in-patient treatment for an eating disorder whilst 47.6% of the sample had undergone one or more previous admissions.

Table 2. Data regarding previous abnormal eating patterns and current diagnoses

	Anorexia Nervosa	Bulimia Nervosa	AN & BN
Previous abnormal eating patterns	16 (76.2%)	3 (14.3%)	2 (9.5%)
Diagnosis	20 (95.2%)	1 (4.8%)	0

Participants reports concerning previous abnormal eating patterns revealed that 16 (76.2%) of the sample had anorexic eating patterns, 3 (14.3%) had bulimic, and 2 (9.5%) had both anorexic and bulimic eating patterns. 20 (95.2%) of the participants had been diagnosed as having anorexia nervosa by the Consultant Psychiatrists and 1 (4.8%) with bulimia nervosa, during the current admission.

Table 3. Data regarding nature of previous contacts with therapy.

	Individual therapy only	Family therapy only	Group therapy only	All	None
Contact with previous therapy	13 (61.9%)	0	0	5 (23.8%)	3 (14.3%)

Participants were asked to give details about any types of previous therapeutic contacts. 61% of the sample reported receiving individual therapy prior to this admission. None of the participants reported any contact with only either family or group therapy, but 23.8% of the participants reported that they had received input from individual, family and group therapies. 14.3% of the sample reported that they had not received any form of therapy prior to this admission.

3.2 Relationship Between Family Functioning, Pretreatment Variables and WAI Scores.

This study set out to explore the potential relationship between family functioning as well as a number of other pretherapy factors, on the formation of therapeutic alliances with the staff of in-patient eating disorder units. This section will present the results of the first three research questions, which are all concerned with the relationships between the selected variables and the responses of the WAI (Working Alliance Inventory). Firstly,

the descriptive data obtained from the responses of the WAI and the FAD (Family Assessment Device) questionnaires are presented in tables 4 and 5 below.

Table 4. Mean scores for the WAI

	Patient ratings (n=21)				Therapist ratings (n=10)		Key-nurse ratings (n=21)	
WAI	therapist		nurse					
sub-scale	M	SD	M	SD	M	SD	M	SD
TOTAL	61.1	15.9	52.5	16.6	59.8	10.25	65	6.9
TASK	19.5	6.5	17.4	4.9	20.5	3.92	22.3	2.5
BOND	20.3	5.5	16.5	6.8	19.7	2.9	21.6	3.3
GOAL	21.25	4.7	18.6	6.1	19.6	4.2	21.1	3.1

Note: Possible scores for the WAI total range from 12 to 84, and for the sub-scales from 4 to 28. A higher number represents a stronger therapeutic alliance.

The above table (table 4) represents the WAI responses of both the patient and staff participants. It is of note that for the patients' ratings, the mean scores of the WAI are greater for their therapists than their key-nurses. This difference was evident on the total and each of the 3 sub-scales of the WAI. The mean therapist rating of the WAI total (59.8) is less than the patients rating of the therapists (61.1) whereas the mean key-nurse rating of the WAI total (65) is more than the patients mean total rating of the nurses (52.5). The key-nurses consistently rated alliance with their patients as higher than the patients - mean scores for all sub-scales are greater than patients ratings. The therapists, however, consistently rated the alliance as lower than their patients with the exception of

the task sub-scale when they rated it as higher. The results of the statistical analyses of these findings are presented later in this chapter.

Table 5. Mean scores for the FAD

FAD sub-scale	M	SD
problem solving	2.46	.74
communication	2.5	.6
roles	2.43	.58
affective responsiveness	2.47	.91
affective involvement	2.3	.61
behaviour control	2.21	.53
general functioning	2.37	.82

Note: Possible sub-scale scores range from 1 to 4, where a higher number represents more reported dysfunction.

Table 5 gives the results of the scores of the FAD. Since possible scores range from 1 to 4 it is of note that all of the sub-scale means are higher than 2. The communication sub-scale of the FAD was found to have the highest mean (2.5) and the behaviour control sub-scale the lowest (2.21).

Questions 1 and 2. Are there any relationships between family functioning and therapeutic alliance?

Correlations were computed to test for any associations between the WAI and the FAD. Correlations between the WAI mean (mean score of the patients ratings of the WAI with therapists and key-nurses) and the seven sub-scales of the FAD ranged from r=-.08 to .22. None of these correlations were found to be significant. The reports of family functioning are not associated with the WAI mean.

The patients ratings of the WAI with key-nurses were also not associated with the FAD. Correlations ranged from -.40 (p=.07) to .01 (p=.97) and with the exception of three these were all in the negative direction. Although none of the correlations reached statistical significance the direction of the correlation requires attention since they are interesting when compared with the patients ratings of the WAI for the therapists. Although, as with ratings of the key-nurses, all of the correlations with the FAD were found to be non-significant (ranging from r=.05 to r=.40), with the exception of 3, in these instances, they were all positive. Although not reaching significance, the tendency is for a more dysfunctional rating of family functioning (higher FAD score) to be associated with a poorer WAI rating with key-nurses, but a higher WAI rating with therapists.

Interestingly, although the key-nurses ratings of the alliance were also not significantly associated with the FAD, as with the patients ratings of the key-nurses, with the exception of one, all of the associations were negative. The tendency here replicates that

of the patients ratings of the key-nurses, that as FAD scores increase (there is more reported dysfunction) WAI scores decrease. Correlations could not be computed for the therapists ratings because of their poor response rate (N=10).

Question 3. Are there any relationships between pretreatment variables and therapeutic alliance?

The associations between the pretreatment variables and the WAI mean are shown in table 6 below.

Table 6. Correlations between WAI mean score and pretreatment variables.

	No. of previous admissions	age	abnormal eating	length of time in treatment	wt from target
WAI mean	.12	.14	.04	.24	-.44*

*p<.05
Note, WAI mean is the mean WAI score of patients ratings of therapists and key-nurses.

The WAI mean was found to be significantly associated with the number of kgs from target weight ($r=-.44$, $p<0.05$). The greater the number of kgs from target weight, the lower the WAI mean. In other words, a lower body weight is associated with a poorer alliance score. The correlations between the WAI mean and number of previous admissions, age, length of abnormal eating patterns, and length of time in treatment all revealed non-significant results.

The number of previous contacts with therapy (individual, family, group, all of these or none of these) and diagnosis were tested for any associations with the WAI mean using analyses of variance (Anova's). The results of the Anova's reported non-significant associations in all cases.

Is there a relationship between self-esteem and therapeutic alliance?

The associations between the WAI and self-esteem are shown in Table 7.

Table 7. Correlations between WAI score and self-esteem.

patient ratings of WAI	self-esteem
key-nurses:	
WAI total	-.47*
task	-.38
bond	-.48*
goal	-.45*
therapists:	
WAI total	-.26
task	-.22
bond	-.33
goal	-.19

*p<.05

The degree to which patients rated their self esteem was correlated with alliance with their key-nurses for the WAI total, bond and goal sub-scales of the WAI. Those who reported poorer self esteem (a higher rating on the measure) also reported a poorer quality of overall alliance with their key-nurses as well as lower scores on the bond and goal sub-scales. The degree to which patients rated their self-esteem was not, however,

correlated with their ratings of therapists. Those who reported a poorer self-esteem did not also report a poorer quality of alliance with their therapists.

3.3 Patient and Staff Perceptions of the Therapeutic Alliance.

Previous studies have reported discrepancies between alliance scores when patients are rating different staff members, and when they are reported by different members of the staff team (Gallop, 1994). This study also examined the nature of the differences and associations between patients ratings of different staff members as well as the nature of differences and associations between patient and staff ratings. The results of the nature of these different rater perceptions will now be reported.

Are there discrepancies between the patients ratings of key-nurses and therapists?

The mean score for the patients ratings of total alliance with therapists was 61.1, and for the key-nurses 52.5 (see table 4). This difference was significant ($t(19) = 2.64$, $p<.05$). Patients were rating alliance with their therapists as significantly higher than with their key-nurses.

Patients ratings of their key-nurses and therapists were also highly correlated ($r=.59$, $p<.01$), revealing a linear relationship between the ratings. A higher rating of alliance with a therapist is correlated with a corresponding higher rating of alliance with a key-nurse. Associations between the patients ratings of alliance with therapists and key-nurses for

the total and sub-scales are given below in table 8.

Table 8. Correlations between patient ratings of WAI scores for therapists and key-nurses.

	key-nurse			
therapist	WAI total	task	bond	goal
WAI total	.59**	.62**	.55*	.50*
task	.56*	.6**	.52*	.47*
bond	.6**	.61**	.55*	.52*
goal	.51*	.55*	.47*	.44

*p<.05 **p<.01

The patients alliance ratings of therapists and ratings of the key-nurses are significantly correlated on all of the sub-scales, with the exception of the goal sub-scale, which was approaching statistical significance (r=.44, p=.053). The relationship between the patients ratings for the different staff members is cross-situationally stable, across the different nurses and therapists with whom the patients are involved and across the WAI sub-scales. In all cases, a patient rating one member of staff highly meant rating the other member of staff correspondingly.

Are there discrepancies between patients ratings of staff, and staff ratings of patients?

In addition to exploring the nature of the patients ratings of alliance with their therapists compared to their key-nurses, this study also examined the nature of the patients ratings of alliance with the staff member, compared to the staff members rating of the alliance. The ratings between patients and key-nurses will be reported initially, followed by the

ratings between therapists. Lastly the differences between the therapist and key-nurses ratings will be reported.

The mean score for the patients ratings of total alliance with key-nurses was 52.5, and the mean score for the key-nurses 65 (see table 4). This difference was highly significant ($t(20) = 3.4$, $p<.01$). Patients were rating their relationships with key-nurses as significantly lower than the key-nurses were rating the same relationships. Correlations between these different rater perspectives for the WAI total and the sub-scales were all non-significant. There were no significant associations between the patients ratings of alliance with key-nurses and the corresponding key-nurses ratings of alliance with their patients.

Further reference to table 4 reveals that the mean score for the patients ratings of the WAI total with therapists was 61.1 and the mean for the therapists ratings, 59.8. This difference was not significant ($t(9) = .46$, n.s). There was not a significant difference between the patients ratings of alliance and the therapists ratings of alliance with their patients. Correlations could not be computed on the WAI scores because of the poor response rate of the therapists (N=10).

What factors are associated with this discrepancy?

In order to examine which factors may have been contributing to the reported discrepancies in reported alliance scores between the therapists and their key-nurses, the difference between the scores were correlated with the FAD and pretreatment variables. The results of the correlations were all non-significant. Neither family functioning nor any of the pretreatment variables were associated with the difference between alliance scores between patients and key-nurses.

To examine the interdisciplinary differences between ratings of alliance the means of the therapists and key-nurses ratings were compared. The mean of the therapists ratings (59.8) was not significantly different to the mean of the key-nurses ratings (65) when the means were compared using a t-test ($t(8) = 1.86$, n.s). Statistical tests of association between the two disciplines ratings were not possible given the poor response rate of the therapists.

The results that have been presented in this chapter will be discussed in chapter four.

CHAPTER FOUR

Discussion

Overview of Chapter Four

This chapter begins with a brief summary of the research questions, methods and main findings of this study. It then interprets the findings in the context of the research questions, the existing literature concerning therapeutic alliance particularly in in-patient settings and the literature concerning family functioning and eating disorders, cited in Chapter One. Other areas of psychological literature which may also help to enhance understanding of the findings are also addressed. Limitations of the study are described, and the clinical and research implications are outlined. Some suggestions for further research are made, and finally, the conclusions of the study are offered.

4.1 Summary of the Aims, Methods and Findings.

This study aimed to enhance understanding of the therapeutic alliances developed for patients undergoing in-patient treatment for eating disorders. Details about the functioning styles of the patients families were collected, as well as a number of pretreatment and treatment variables, to explore any possible relationships between them and the therapeutic relationships formed. A secondary aim of the study was to explore any differences or similarities between the patients and staff ratings of the alliance. A sample of 21 patients participated in this study. All participants were approached

individually, and following their consent, filled in the questionnaires. The patients key-nurses and therapists were also given the Working Alliance Inventory. Responses were collected and the data analysed using qualitative analysis.

Family functioning was not associated with the therapeutic alliance, when reported by either the patients or the staff. Similarly, with the exception of number of kilograms from target weight, none of the pretreatment or treatment variables were associated with the therapeutic alliance. The therapeutic alliance was found to be related to self-esteem, but only for the patients ratings of their relationships with key-nurses. Patients with poor self-esteem also reported their alliance with the key-nurses as lower. Patients rated their alliances with therapists as better than with key-nurses. There was also a significant difference between the patients' and key-nurses' ratings of their relationships - key-nurses rated the relationship as higher quality than the patients. This difference was not found with patients' and therapists' ratings of the relationship. Neither family functioning, nor any of the pretreatment and treatment variables were associated with these discrepancies.

4.2 Interpretation of the Research Findings

The findings of this study are based on a small sample size (N=21) and must therefore be considered with caution. Studies involving small sample sizes are more likely to involve Type I errors, where a true hypothesis is rejected, and Type II errors, where there is a failure to reject a hypothesis. However, research has not previously examined the issues that were explored in the current study, and the results are of potential interest.

This section will return to the original research questions, and use them as the format for interpreting the results. The results that were concerned with the relationship between family functioning and therapeutic alliance will be considered first, followed by the results of the analysis that examined the potential relationships between pretreatment and treatment variables and the therapeutic alliance. Lastly, this section will offer possible explanations for the discrepancies that were found between the patients and the staff ratings of the alliance.

Questions 1 and 2. Are there any relationships between family functioning and therapeutic alliance?

Results of the correlations that were computed to test for any associations between the general level, and sub-scales of the FAD and the WAI were all non-significant. This was found to be the case when the alliance was measured by the patients or the nurses. Family functioning was not associated with the quality of the therapeutic alliances formed. This is contrary to the findings of Kokotovic and Tracey (1990) who examined the therapeutic alliance in the early phases of therapy and found that clients with poor family relationships were less likely to develop strong alliances.

Although the results of this study did not reach levels of statistical significance, it is possible that the small sample size may have compromised the findings. In addition, it may also be that patients under reported family dysfunction within their families. In a study which examined the ratings of different family members perspectives, where one member had an eating disorder, Waller and colleagues (1990) concluded that the sufferers

themselves had the most realistic perceptions of their families interactional styles, and that their scores most accurately predicted the presence of an eating disorder. Interestingly, the mean FAD sub-scale scores in the Waller study were very similar to the mean sub-scale scores found in the current study, giving support to the use of the patients perspective. These results are not strictly comparable, however, as the mean of the sample in Waller et al.'s study was 26.3 (SD 8.25) and patients were largely diagnosed with what Waller termed 'bulimia simplex'. In the current study the mean age was 20.7 (SD 2.43) and 20 out of the 21 patients (95.2%) were diagnosed with anorexia nervosa. In addition, absence of results from a control group mean it is not known if the FAD scores in either study represent family dysfunction.

A study by North et al (1995) found conflicting results. In this study the authors found that family functioning was reported as normal by self report (by both patients and their mothers) but not by an objective measure obtained during interview. Possible reasons for this are biased judgement, and the unconscious denial of difficulties in a family where one individual has an eating disorder. This unconscious denial is often noted clinically and held to be important in the aetiology of the disorder (Crisp , 1980). Thus the interpretation of any results requires caution, since the participants may deny their difficulties. The current study did not control for possible 'halo' effects because it used only the participants views of family functioning. Family functioning is complex. Clinical impression, self-report and an objective view may all be necessary to gain a complete picture.

For these reasons, and since it is possible that any dysfunction may have been under-reported, closer examination of the directions of the correlations is important. When the patients' ratings of the alliance with key-nurses are compared to ratings of the therapist, an interesting phenomenon is evident. With the exception of three, all of the correlations computed between the patients' ratings of key-nurses were negative, whereas for the therapists' (again with the exception of 3) they were all positive. In other words, the relationships between patients' ratings of key-nurses and family functioning reported a tendency in the expected direction, that higher scores on the FAD (more dysfunction was reported) were associated with poorer alliance. This tendency was confirmed when the key-nurses' ratings of alliance were correlated with the FAD. Contrastingly patients' ratings of therapists revealed a tendency in the opposite direction to that expected. In this case, the greater the family dysfunction, the stronger the alliance formed. Multiple correlations are likely to increase the associations that occur by chance, but the consistency with which this tendency occurred would seem to suggest that the relationship with a key-nurse is fundamentally different to that with a therapist. This issue will be returned to later in this chapter.

A further reason that this study did not find any significant associations between family functioning and therapeutic alliance may be the lack of consideration of the co-morbidity of depression with an eating disorder in this study. This has previously been found to be important in the reporting of family dysfunction, where one member has an eating disorder.

Thienemann and Steiner (1993) attempted to refine previous findings which had suggested a relationship between the qualities found in family environments and specific eating disorders, by adding an additional psychiatric contrast group of patients suffering from major depression. Subjects in each of the diagnostic groups (anorexia nervosa, restrictor type; anorexia nervosa with bulimic symptoms; normal weight bulimia; and major depression) did not differ statistically from each other or from a normative population with regard to family environments. However, when the subjects were tested by self-reported level of depression, those with a high level of depression described family environments which were significantly different, independent of the severity of illness or diagnosis.

Blouin et al (1990) also found similar results. In their study, the depressed sub-group of women with bulimia rated their families as different to the normal control group whereas the non-depressed sub-group did not. Both of these studies used the self-report questionnaire The Family Environment Scale (Moos & Moos, 1981., cited in Thienemann & Steiner, 1993). Although this is different to the measure used in the current study, the role of depression would appear to be important. This study did not collect any information about depressive symptomatology.

Question 3. Are there any relationships between pretreatment variables and therapeutic alliance?

Results of correlations and ANOVA'S to test for associations between pretreatment variables and therapeutic alliance also largely reported non-significant results. This

replicated the findings of previous researchers (e.g., Clarkin et al., 1897; Horvath et al., 1991) who have reported that the therapeutic alliance is not related to pretreatment symptomatology. It contrasts the view of Eaton et al (1988), however, who found that pretreatment symptomatology was related to alliance when the patients in this study rated their own symptomatology. Patients in the current study also rated their own pretreatment symptomatology but this was not found to be associated with the alliances formed. This was true for all variables except for weight from target and self-esteem.

Weight from target (kgs) was significantly associated with the mean therapeutic alliance score. The further the patient was from target weight (i.e. the lower the body weight) the poorer the therapeutic alliance that was associated. This finding gives support to the idea that weight gain should be a critical component of treatment. Not only, however, because a low body weight brings with it many physical complications, for example, emaciation and poor circulation (Bryant-Waugh & Lask, 1995) but also because this study has found that low body weight was associated with increased difficulty in forming a strong alliance for the eating disorder sufferer. This finding cannot be compared with previous research since the only previous study to consider therapeutic alliance with eating disorder patients (Gallop et al., 1994) did not report on the relationships between alliance and any pretreatment or treatment characteristics.

The reasons why a low body weight may interact with an individuals ability to form a good alliance are not clear. The early studies of neuropsychological functions in low weight patients with anorexia nervosa were largely uncontrolled, and the use of different

tests, different samples of patients, and methodological problems limit the conclusions that can be drawn from more recent research. Deficits in attention, particularly in the focusing/execution, aspect have been reported as the most convincing (e.g., Jones et al., 1991, and Szmukler et al., 1992, in Treasure & Szmukler, 1995). Memory and visuospatial analysis are also thought to be impaired (Jones et al., 1991 and Szmukler et al., 1992), and new learning is though to be less affected, but some individuals may stand out with poor performances. The magnitude of the deficits is small compared to brain damaged subjects, but may still be large enough to significantly affect judgement and problem-solving in daily life, or the ability to use psychotherapy in treatment. Weight restoration in these studies was found to result in an improvement in neuropsychological functioning. It is thus possible that a lower weight is associated with poorer alliance because of the neuropsychological deficits associated with low weight that curtail new learning and flexibility in thinking that are required in psychological treatments. However, research in this area is limited and it seems unlikely that low weight is associated with poorer alliance solely on the basis of neuropsychological deficits. Rather, it is more likely to be a function of these factors alongside the psychological distress that is aroused shortly after admission when target weight and re-feeding are a particular focus of treatment.

Patients with anorexia nervosa will feel panic at the prospect of weight gain. In the short term, change leads to an increase in distress. Anxiety and despair are common at the early, weight gain stages of treatment, when concentration is impaired because of starvation and the preoccupation with weight gain may be at its greatest. The struggle to

accept weight gain and to continue to increase nutrition can become harder. Patients who are further from their target weight may feel overwhelmed at the prospect of how much weight they have to gain and this despair and preoccupation may interact with their alliances with their nurses in particular, who are likely to have more of a direct role in their weight. This study did not explore the nature of the patients' reports of alliance with their nurses and therapists separately for weight from target. It may have been interesting to do so in light of the differences between patients' ratings that were reported in the results section, and earlier in this section.

Self-esteem was also found to be associated with the therapeutic alliance. Interestingly, the previously noted discrepancies between patients' ratings of therapists and nurses was found with self-esteem also. The degree to which patients rated their self-esteem was correlated with alliance with their nurses but not with the therapists. Those participants who reported poorer self-esteem also reported a worse quality of overall alliance with their key-nurses, as well as a lower score on the bond and goal sub-scale of the WAI. Those participants who reported lower self-esteem did not, however, also report a worse rating of alliance with their therapists. As was noted before, this would seem to give more support to the relationships with nurses and therapists on the in-patient unit as being fundamentally different.

Question 4. Are there differences between patient and staff perceptions of the therapeutic alliance?

Previous studies have reported discrepancies between alliance scores when measured by different raters (e.g., Bachelor, 1991; Horvath et al, 1991) and by different members of the staff team (Gallop et al, 1994). This study aimed to investigate further the nature of such discrepancies between staff, but also to further understanding of the patients' ratings of their relationships with different members of staff. Discrepancies between different rater perspectives have already been noted in this chapter, and these will now be discussed fully.

Are there discrepancies between the patients' ratings of alliance with key-nurses and therapists?

Results of this study found that patients were rating therapeutic alliance with their therapists as significantly higher than with their key-nurses. These ratings were also found to be significantly correlated. This means that although the difference between ratings was significant, patients were rating the alliance with both staff members in a similar way. If a patient rated alliance with a therapist highly, then they would also rate alliance with the key-nurse correspondingly. This association was evident on all sub-scales of the WAI. These associations were evident despite the fact that there were a number of different nurses and therapists involved in the study.

The consistent way in which patients rated their alliance with therapists as higher than nurses and the way in which all of the sub-scale scores of the WAI were highly associated

between the patients' ratings indicates that there is something in the way in which the patients rate their alliances that is unrelated to staff variability or the treatment ethos of the three units. It is not for example, that a disliked nurse or therapist, or a particular treatment regime is effecting alliance ratings since patients' ratings follow a consistent pattern across different members of staff in different units. Comparisons with other research findings are not possible since at the time of writing no studies were found which had examined the nature of participants' ratings of their relationships with different staff members.

The difference between the patients' ratings of key-nurses and therapists is likely to be a function of the very different roles that these disciplines have in the in-patient programme. The nurses are involved in the aspects of treatment that patients with eating disorders are likely to find the most difficult and probably the most confrontational - re-feeding and weight gain. It seems likely that the goals of treatment regarding such treatment issues as target weight and calorie intake may not be shared by the patient and nurse. In addition. nurses on these units are required to sit with the patients while they eat and are involved in the routine weigh-ins, again, being involved in probably the most difficult day to day elements of treatment for the patient. Therapists, on the other hand take on a traditional psychotherapeutic role, meeting with the patients for weekly sessions of psychotherapy. Issues of weight tend not be the focus of such work, and in such sessions individuals are free to explore areas of intrapersonal functioning with a therapist who offers the 'space' in which they can do this.

Comparisons of the results of this study with research that has examined incongruence between staff and patient ratings can be made, however. This section will now move on to review these findings.

Are there discrepancies between the patients' ratings of staff, and the staff ratings of patients?

Replicating the trend reported by Gallop and colleagues (1994), this study also found a significant difference between the patients and key-nurses rating of the alliance - the patients rated the alliance as lower than the nurses. In their study, the authors combined the ratings of the staff involved because of missing data for some of the disciplines. The mean staff rating was found to be significantly higher than patients' ratings. However, this means that specific comparisons of patients' ratings for different disciplines is not possible. In addition, Gallop reported that no significant association was found between patient and mean staff perceptions on any of the sub-scales or the total WAI for those patients who then left the treatment programme early. There was a modest correlation between staff and patients' ratings for those who remained in treatment. This would seem to suggest that in their study, for those patients who remained in treatment, there was significant association between the staff and patient ratings. However, when the authors of the Gallop study examined associations within disciplines it was only the nurse perceptions that were found to be correlated with the patients perceptions of the alliance, this correlation being primarily determined by the correlation on the bond scale. This finding is in contrast to the findings of the present study which did not find a significant association between the rating of the patient and key-nurse about their alliance, on any of

the WAI sub-scales or the total. It must be noted that although the Gallop et al study also used the WAI that the 36 item version was used whereas the 12 item version was used in the current study. In addition to this, the mean age for the participants in the Gallop et al.'s study of 27.6 years (SD not given) which was considerably older than the mean age of 20.7 (SD=2.43) in the current study.

The degree to which the patient's perceptions of the working relationships agree with those of the staff of an in-patient unit was also examined by Allen et al (1988). None of the correlations between patient collaboration and staff members' ratings of the working relationships was significant. Although this trend is replicated in the findings of the current study, a number of factors make direct comparison problematic. As before, the current study reports a mean age that is considerably lower than the Allen study's of 27.4 (SD=9.4). Participants in the Allen study were all long-term psychiatric in-patients representing a wide range of diagnostic categories, and a different measure of the working relationships was employed. In fact, the authors developed the measure for a previous study and it was designed to look at the collaboration aspects of the relationship only.

The reasons why the key-nurses consistently rate the alliance as higher than the patients are not clear. Results of correlations and ANOVA'S to test for the factors that may have been associated with the discrepancies between the patient and nurse ratings of the alliance were all non-significant. None of the variables in this study were associated with the divergence between the nurse and patient ratings of their therapeutic relationships.

As has already been noted the different roles undertaken by the different staff disciplines of an eating disorders unit are likely to be important in this regard. Additionally, Vandereycken (1993) has reported that individuals suffering from eating disorders can be some of the most difficult to treat and this can make working with the most severe of such cases challenging and, frequently confrontational for the staff involved. The day to day management of the in-patient may feel like a constant battle for the nurses who are involved, and the idealisation of their relationships with these young women may provide an avenue for the justification of their work. There may thus be a resulting difficulty in acknowledging the difficulties in the relationship. In addition, it is possible that the presence of a researcher investigating their relationships was seen as threatening. The need for responding in a way that was viewed as being socially desirable may have been very compelling, especially where their ratings of alliance were seen as a measure of competence.

It is possible, however, that the nurses' ratings of the alliance represent their genuine views and it is infact the WAI that fails to pick up the differences between rater perspectives. The different versions of the WAI involve very minor word changes for the staff and patient versions and it is possible that these minor word changes do not encompass the necessary components that are required to capture a realistic perspective of the ways in which different disciplines formulate an understanding of the therapeutic alliance.

Although correlations could not be computed on the associations between therapist and patients' ratings of their alliance because of the reduced number of participants, a t-test revealed that the differences between the ratings was not significant. In contrast to the ratings with the patient-key-nurse pairs, where the key-nurses rated the alliance as higher than the patients, no such difference was found between the therapist-patient pairs. This cannot be compared with the Gallop study since the low response rate by the different disciplines involved meant that comparisons between disciplines was not possible.

The Gallop study also examined congruence between the different disciplines and found that there were no significant associations between them - the ratings of different disciplines were all unrelated. This study is unable to comment on the congruence of the nurses and therapists but a non-significant difference was found for their ratings of alliance with their patients. Clearly, perceptions of the therapeutic alliance are not objective. This would appear to be true in units where the patients all have eating disorders and the treatment programmes are formalised and thus have many similarities for all the patients. It seems possible that each discipline may have its own unique expression or value system for the therapeutic alliance.

The poor response rate of the therapists is interesting, if somewhat puzzling. It is possible that this is because none of the therapists involved in the study were full-time members of staff and do not feel as if they are an integral part of the units, or that the researcher only met one of the therapists on one of the units, whereas the majority of the nurses were met in person. Reasons for this poor response rate remain unclear.

The limited convergence between the patients' ratings of the key-nurses and therapists, and the limited convergence between the ratings of patients and staff about the same relationship is important. Clearly the measurement of the patient's detached and objective view of the therapeutic relationships is not possible. Rather, these perceptions are value laden with transference distortions, and the discrepancies go both ways between both patients' and staff' ratings, reflecting both idealising as well as negative transferences. Patients and staff clearly view working relationships differently. In the in-patient setting the patient's alliance with a unit is multi-dimensional, and it is supported or impeded by many different treatment relationships, often quite divergent from one another in terms of perceived therapeutic quality. Zee (1985, cited in Allen et al, 1988) points out that as patients progress in hospital treatment, they are increasingly able to form an alliance with a psychotherapist, who can take on more and more of the psychological work. In addition, as the psychotherapeutic relationship deepens, and the patient begins to internalise an alliance (Horwitz, 1974) he or she will be better able to benefit from a range of other treatment relationships. Although this study found that length of time in treatment was not associated with the quality of alliances formed, it is possible that as noted by Allen (1988), alliance perceptions may change over time as participants move through different phases of therapeutic work. A poorer reported relationship with the key-nurses may not be stable throughout the course of an in-patient admission. Weight from target may play an important role in this. As weight increases and alliance improves it is possible that this improvement will in turn lead to ability to engage in other relationships and thus improve further.

4.3 Limitations of the Study

The limitations of this study will now be considered. As a starting point, this section will consider the limitations of the sample, acknowledging issues relating to both the patient and staff participants. Secondly, the limitations associated with the design and procedure of this study will be considered before highlighting issues related to the chosen measures of the study.

Limitations of the sample

The patient participants

In any study, the major concern regarding the sample is about its representativeness. Although it is important to note that anorexia nervosa and bulimia as seen in the specialist in-patient setting are not representative of the eating disorders seen in the community, this does not affect the representativeness of the sample used in this study. As an in-patient population, and thus possibly representing the most severe of cases, this sample would appear to be representative of an in-patient eating disorders sample. It represents both private and NHS sector patients, the total proportion are women, and there are more anorexia nervosa sufferers than bulimia (e.g. Hoek, 1993). However, specific details were not obtained on the ratios of private Vs NHS patients.

The diagnostic categories that were used in this study are open to question. Because three units were involved in the study, and the diagnoses of five different Psychiatrists were involved, this study used only the categories of anorexia nervosa, bulimia nervosa or

both anorexia nervosa and bulimia nervosa. This may not be representative of the eating disorders population as a whole, and the use of more specific categories i.e. anorexia nervosa-restictor type, or with bulimic symptoms, may have yielded different results.

All of the patients in the study were voluntary patients, and all of the units assess the patients for their motivation to undergo treatment before they are admitted. The inclusion of only motivated patients is likely to exclude the very resistant eating disordered patient who is likely to find forming an alliance extremely difficult, especially under the conditions of Section 3 of the Mental Health Act. This may not always be the case since some patients may feel pressured to accept help, for example by their parents, even though they do not really wish to change. This would have obvious implications on the forming of an alliance.

The age range for this study (14-25) was selected in the belief that family relationships may be considered more likely to exert an influence during this life stage, particularly where the individual is living at home. This may not be the case. A broader age range may have allowed for a larger sample and for comparison between different age groups.

Studies to date have shown that the therapeutic alliance is formed, and remains relatively stable after the third session (e.g. Eaton et al, 1988). However, this study found that low weight was associated with a lower alliance, and since low weight is associated with the beginning of treatment, it is possible that individuals suffering from eating disorders may not be able to establish a good therapeutic alliance by 3 sessions. The correlation between

length of time in treatment and alliance formed was not found to be significant but a larger sample size would allow clarification of this point.

The most fundamental limitation of this study is its sample size. A larger sample was planned, but recruitment proved to be very difficult. It is possible that this sample is not large enough to be representative of in-patient eating disorder sufferers, and the size certainly had implications for the statistical analyses that were possible. This said, however, the exploration of the relationships between family functioning and therapeutic alliance has never been attempted before. Despite the sample size, interesting findings have been reported and important directions for future research identified. These will be presented later in this chapter.

The staff participants

Characteristics of the staff were not collected in this study, and thus there is no available information about age, experience, levels of stress and support or theoretical orientation. All of these variables may interact with the way the staff interact with the young women in their care.

The selection of only the participants key-nurses and therapists was based on ease of collection of data, as well as the belief that these were the two most significant relationships for the patients. Interaction with the three units has revealed that this may not in fact be the case. For example, two of the units utilise what is called a log-book, a structured book that guides and monitors the patients' goals and progress, and each of

the patients has an allocated log-book partner with whom they work for the whole of their admission. Several of the staff on these two units commented that it was a pity such relationships were not included in the study since anecdotal evidence from the patients and staff cites these relationships as very important. Clearly, details about other relationships may have been helpful.

Limitations of the procedure

Although it was the intention to ensure that patients and staff were filling out the WAI's for equivalent sessions, this was not always the case. Shift work meant that relevant nurses were not always working at the time that the questionnaires were given to the patients, and all of the therapists worked on a sessional basis. In addition, some of the patients and staff had to be contacted a second time for their responses. It was noted that the responses for the patients and staff were returned at different times on a number of occasions. The impact of this on the reported alliance is not known.

Questionnaire packages were given out to patients who had been on the units for more than three weeks, or for new admissions during the course of the study, once they had been on the unit for three weeks. This meant that there was variation in the length of time that people had been in-patients. Related to this is the fact that people will have had variations in family therapy received, which may in turn have affected the reported family functioning. Although this does not affect the possible link that was being explored between family functioning and alliance, it may have been useful to have had details about

the different stages of treatment people were at, and the possible changes of reported alliance over time.

The results of this study would seem to suggest that therapeutic relationships are far more complex than can be revealed by simple correlational investigations only. Although this may be an interesting starting point, a larger sample, studied longitudinally, would have allowed for statistical analysis of some of the potential causal relationships between different variables and the therapeutic alliance, and changes over time. This, however, was not possible given the time limit of this study.

Limitations of the measures

The 12-item Working Alliance Inventory was chosen for its ease of administration and because of good reported reliability and validity. Although it was designed as a pantheoretical measure at least one of the therapists clearly disagreed with this, telephoning the researcher to discuss the fact that she could not fill it in because "It's not the way that I work." Although designed to be pantheoretical it may not be perceived as such by different therapists.

A search of the literature revealed that the WAI had not been previously used with individuals under the age of 18. It is possible that this may have had an impact in this study, but it would seem unlikely since the language used is fairly straight forward and none of the young women reported any difficulties. Infact, all of the participants were high achieving, intelligent young women.

The main potential problem of the Family Assessment Device in this study has already been considered, earlier in this section. It concerns the problem of a 'halo' effect, where raters idealise their families and thus under-report dysfunction. This issue of response bias is evident in all self-report measures. One of the issues that this measure cannot address is the question of "which came first, the family dysfunction, or the eating disorder?" In other words, was the family dysfunctional before the onset of the eating disorder, or has the eating disorder put strain on the family resulting in dysfunction? Either way, this study was looking at any link between family functioning and alliance and not at causality. Regardless of which came first, the problems that the family arrived into treatment with will still require addressing.

It may have been fruitful to have used a depression inventory to examine the effects of depression on alliance. In addition no measure of functioning (e.g. the GAS) was employed and no measures of staff characteristics were collected.

4.4 Implications of the Study

This section will consider both the clinical and research implications of this study, as well as making some suggestions for areas of future research.

Clinical implications

This study did not find family functioning to be associated with the therapeutic alliances formed. However, possible reasons for these associations not reaching significance have

been discussed and it seems likely that family functioning should be considered by the clinician working with the individual with an eating disorder.

Of particular importance is the consideration of the difficulty that the low weight patient may have in forming an alliance. Clinicians will need to be aware of this and since the patient's perspective has been found to be crucial, will need to continually check out with the individual that they are working together on mutually agreed goals. As Hougaard (1994) reported, the effectiveness of treatment is dependent on the client's view of the appropriateness of the therapy structure to what he or she wants to achieve.

Results from this study also found that self-esteem is an important factor in the individual's ability to form a therapeutic alliance. This is something that can easily be monitored with patients, and it is possible that some work that specifically addresses low self-esteem may be of value with this population. Enhancing the self-esteem of patients may allow the earlier formation of a stronger therapeutic alliance, which in turn will be important in the individuals outcome.

The differences between the patient's perception of alliance with nurses and therapists, and the incongruence between staff and patients' perceptions of the alliance is something that needs to be carefully monitored. With a population who have been described as some of the most difficult to work with (Vandereycken, 1993) and who arrive on the in-patient unit and submit the unit to unconscious tests to determine whether or not it is more benign than the early familial environment (Stern, 1986), multidisciplinary team

discussion is crucial. Staff on a unit can easily be separated into "good" and "bad" by the patients and open discussion is necessary to avoid this splitting.

The research implications and suggestions for future research

The results of this study clearly indicate that the area of therapeutic alliance must be examined in greater depth with this population. The importance of self-esteem in eating disorders has previously been noted (Bryant-Waugh & Lask, 1995) but no previous study has examined its impact on therapeutic alliance. In order to further our understanding of the way in which self-esteem interacts with ability to form an alliance, the replication of the finding that low self-esteem is associated with a poorer alliance is necessary. The study, and comparison of different populations will advance our understanding of the role that self-esteem plays in the formation and maintenance of a therapeutic alliance.

The long-term study of the therapeutic alliance of patients as they progress through an admission would provide invaluable information into the ways in which alliance develops over the course of the admission. Different variables could be monitored for their associations and effects over this time and effects on outcome could also be clarified. In terms of patients suffering from eating disorders, it may be interesting to compare the therapeutic alliances of those receiving in-patient treatment in a specialised eating disorders unit with those individuals receiving treatment within a general psychiatric unit, since the debate around the pros and cons of each approach continues. In addition, qualitative research could begin to address the question of why alliance is reported as stronger with therapists than with key-nurses.

Further research needs to continue to examine the factors that may influence the individual's ability to form a good alliance. In addition to this, research needs to examine the staff factors, as well as the possible role of the family's alliance with the unit, that may be important influencers of the alliance formed. Previous research (Sexton et al, 1996) has indicated that patient factors are important in the beginning phase of therapy, and that therapist and relationship factors become more important in the later stages. This finding needs to be considered across the course of an admission. For all of the above suggestions, comparison with control groups would give additional information into the specific factors that are relevant with eating disorder patients.

CONCLUSION

This study aimed to enhance understanding of the therapeutic alliance developed for patients undergoing in-patient treatment for eating disorders. 21 patients (mean age 20.7 years, SD 2.43) participated in the study. Details about the functioning styles of these participants' families were collected, as well as a variety of pretreatment and treatment characteristics. The associations between these variables and therapeutic alliances formed were tested, and the congruence or incongruence between the patients' ratings of their key-nurses and therapists as well as with them was explored.

Family functioning was not found to be associated with the therapeutic alliance when reported by either the patients or the staff, for any of the seven sub-scales of the FAD. Weight from target was the only treatment variable that was found to be associated with alliance, with a lower body weight being associated with a poorer rating of therapeutic alliance. Poor self-esteem was also found to be associated with a lower rating of therapeutic alliance, but only for the patients' ratings of the nurses. Incongruence was reported between both patients' ratings of nurses and therapists and between patient and staff ratings, although not between patients and their therapists. Neither family functioning nor any of the pretreatment or treatment variables were associated with these discrepancies.

The in-patient experience is clearly about more than just the sum of the relationships on it, and more research is necessary to investigate this further.

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APPENDICES

Appendix 1 Letter granting ethical approval

Appendix 2 Information sheet and consent form sent to patient participants

Appendix 3 Information sheet and consent form sent to patients families

Appendix 4 Demographic questionnaire

Appendix 5 Letter sent to therapists and key-nurses

UCL HOSPITALS

The University College London Hospitals

The Joint UCL/UCLH Committees on the Ethics of Human Research

Committee Alpha Chairman: Professor André McLean

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26 August 1997

Ms A Cooke
Lecturer in Psychology
Sub Dept of Clinical Health Psychology
University College London
Gower Street
London WC1E 6BT

Dear Ms Cooke

97/0285 Therapeutic alliance on an in-patients eating disorders unit

I have now had the opportunity to review the above application and have been able to grant it Chairman's Action. You may now proceed with your study.

Yours sincerely

Professor André McLean
Chairman

Sub-Department of Clinical Health Psychology

UNIVERSITY COLLEGE LONDON

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CONFIDENTIAL

Patient Information and Consent Form

Investigators: Anne Cooke (Clinical Psychologist)
& Katie Russell (Clinical Psychologist in Training).

Therapeutic Alliance on an In-Patient Eating Disorders Unit

Has it ever felt as if lots of professionals are making big decisions about your life that you have little or no control over? Suffering from an eating disorder means that life is going to be difficult for you anyway - being admitted to an inpatient unit for treatment may mean that life feels even more difficult.

More and more research is suggesting that what you, the client, think and feel about different aspects of your treatment is crucial in relation to your recovery. Your views about how you feel about the work you and your therapist and key worker do together, for example, has been found by recent research to have important influence on your likelihood of remaining in treatment. One way of measuring the 'fit' between client and therapist is by something known as the 'Therapeutic Alliance.' This is a way of looking at the agreement between therapists and clients in relation to the aims of treatment as well as how understood you the client feels by your therapist and other members of the team.

In addition, since the quality of these relationships between clients and staff have been found to be so important in treatment outcome, this study will be looking at some of those factors which are thought to have an influence on the quality of the relationships formed. For example: the way in which you and your family talk to each other may have an influence on how you talk to members of the inpatient team; the length of time that you have been on the unit and any previous admissions may also effect these relationships.

You are invited to participate in a study that aims to look at your views as well as those of your therapist and key-worker, about the work that you are doing together. This study will be important in helping professionals to identify what things make the relationships between staff and clients more difficult. This information will help professionals in the future to work out which clients are more likely to find making good relationships a problem and to change their styles to help each client individually. All that you will be asked to do is to fill in 4 questionnaires which should take no more than 45 minutes. All information will be kept strictly confidential - no members of the team or your family will be shown any of your responses and names will be replaced with codes to protect your identity.

You do not have to take part in this study if you do not want to. If you decide to take part you may withdraw at any time without having to give a reason. Your decision whether to take part or not will not effect your care and management in any way. Should you need to, you can contact any of the investigators at the above address or phone number. All proposals for research using human subjects are reviewed by an ethics committee before they can proceed. This proposal was reviewed by the Joint UCL/UCLH Committees on the Ethics of Human Research.

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Consent form

Please read the following questions and circle as appropriate:

Have you read the information sheet about this study? yes no

Have you had the opportunity to ask questions and discuss this study? yes no

Have you received satisfactory answers to all your questions? yes no

Have you received enough information about this study? yes no

Which doctor have you spoken to about this study?

Do you understand that you are free to withdraw from this study
- at any time? yes no
- without giving a reason for withdrawing? yes no
- without affecting your future medical care? yes no

Do you agree to take part in this study? yes no

Your signature: _____

Please print name: _____

Thankyou for your co-operation,

Katie Russell

Anne Cooke

Anne Cooke & Katie Russell
(ptinfo1)

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CONFIDENTIAL

Family Information and Consent Form

Investigators: Anne Cooke (Clinical Psychologist)
Katie Russell (Clinical Psychologist in Training)

Therapeutic Alliance on an In-Patient Eating Disorders Unit

For a person suffering from an eating disorder it can often feel as if family members and professionals are making decisions about their lives over which they have little or no control.

More and more research findings are suggesting that what a person thinks and feels about different aspects of their treatment is crucial in relation to their recovery. A person's views about the work she/he and her/his therapist and key worker do together, for example, has been found (by recent research) to have an important influence on the likelihood of remaining in treatment. One way of measuring the 'fit' between client and therapist is by something known as the 'Therapeutic Alliance.' This is a way of looking at the agreement between therapists and clients in relation to the aims of treatment as well as how understood the client feels by her/his therapist and other members of the team.

Since the quality of these relationships between clients and staff have been found to be so important in treatment outcome, this study will be looking at some of those factors which are thought to have an influence on the quality of the relationships formed. For example: the way in which families talk to each other may have an influence on how a client talks to members of the inpatient team. In addition, the length of time that your child has been on the unit and any previous admissions may also affect these relationships.

Your son/daughter has been invited to participate in a study that aims to look at their views as well as those of her/his therapist and key-worker, about the work that they are doing together. This study will be important in helping professionals to identify what factors make the relationships between staff and clients more difficult. This information will help professionals in the future to work out which clients are more likely to find making good relationships a problem and to change their styles to help each client individually. All that your son/daughter will be asked to do is to fill in 4 questionnaires which should take no more than 45 minutes. All information will be kept strictly confidential - no one except the investigators will have access to the specific responses obtained and names will be replaced with codes to protect their identity.

You do not have to consent to your child taking part in this study if you do not want to. If you decide to consent to your child taking part you may withdraw at any time without having to give a reason. Your decision whether to agree to your child taking part will not affect their care and management in any way. Should you need to, you can contact any of the investigators at the above address or phone number. All proposals for research using human subjects are reviewed by an ethics committee before they can proceed. This proposal was reviewed by the Joint UCL/UCLH Committees on the Ethics of Human Research.

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Consent form

Please read the following questions and circle as appropriate:

Have you read the information sheet about this study? yes no

Have you had the opportunity to ask questions and discuss this study? yes no

Have you received satisfactory answers to all your questions? yes no

Have you received enough information about this study? yes no

Which doctor have you spoken to about this study?

Do you understand that you are free to withdraw from this study
- at any time? yes no
- without giving a reason for withdrawing? yes no
- without affecting your future medical care? yes no .

Do you agree for your child to take part in this study? yes no

Your signature: _____

Please print your name: _____

Please print your son/daughter's name: _____

Thankyou for your co-operation,

Katie Russell
Anne Cooke

Anne Cooke & Katie Russell
(faminfo1)

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Therapeutic Alliance on an In-patient Unit.

Demographic Data Form.

Please fill in the following information as best as you can, Thankyou.

1) Today's date:

2) Admission date:

3) Date of Birth

4) Height:

5) Weight:

6) Date of last menstrual period:

7) Status: married_____ Single_____ Divorced_____ Separated_____ Widowed_____

8) Maximum ever weight: At age:

9) Minimum ever weight at present height: At age:

10) Age at which eating pattern first abnormal:

11) At that time was it: Anorexic_____ Bulimic_____

12) How many previous admissions of longer than 2 weeks to hospital for an eating disorder: 0 1 2 3 4 5 >5

13) Have you been involved in any of the following treatments for longer than 4 weeks during the last 2 years? If so, please give details:

Individual Counselling_____
Family Therapy_____
Group Therapy_____

14) How near/far from target weight are you? _____Kgs

15) Diagnosis, if known:

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Therapeutic Alliance on an Eating Disorders Unit

January, 1998

Dear

Re:

As part of the above study I would be most grateful if you would fill out the enclosed questionnaire for your work with the above named client.

I am hoping that you are all in the position to know about this study which I am conducting as part of my Doctorate in Clinical Psychology, and with the help of Dr Rowan. However, if for any reason you do not know about this study and have any questions or concerns please to not hesitate to contact me. I can be found on the EDU on Tuesdays or alternatively have a 'Green Box File' that is permanently placed on the nurses desk there, in which you can leave me a note.

If, as I hope is the case, that you are aware of this study and the importance of your responses and involvement in it, I would be most grateful if you would fill in the enclosed questionnaire according to the guidelines provided and return it in the envelope enclosed to the green box file at the nurses station. You will notice that these envelopes do not have any names on them - either yours or your clients' - they have been coded to maintain confidentiality of all involved in the study and ensure answers remain anonymous.

Thankyou for your co-operation.

Yours sincerely,

Katie Russell
Clinical Psychologist inTraining.