Nourishing the Whole Person:
A Systematic Review of the Effect of the Therapeutic Alliance on Therapeutic Outcomes for
Patients with Anorexia Nervosa

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Abstract

The purpose of this systematic review was to determine the effect of the therapeutic alliance on treatment participation and treatment outcomes for adolescents and adults with anorexia. Sixteen studies met inclusion criteria and were reviewed. Results indicated that a positive therapeutic alliance is perceived by patients to be an important component of treatment in itself and a positive motivational force. The therapeutic alliance between the clinician and the family of a patient may also be predictive of patient outcomes. Occupational therapists are well-positioned to form strong therapeutic alliances in occupation-based interventions with this treatment-resistant population.
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The psychotherapeutic literature has long recognized that the therapeutic alliance, although difficult to measure, is present and necessary in all therapeutic interventions for persons with mental illness (Bickman et al., 2012; Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012; Summers & Barber, 2003). Bordin (1979) classically conceptualized this alliance as the combination of a shared goal, a task, and a bond between a patient and a therapist. This concept is also central to occupational therapy theory and practice, with the goals and tasks collaborated on culminating in improved occupational performance. Taylor (2008) recently conceptualized the therapeutic alliance for occupational therapy practice as a dynamic interaction between therapist and patient, where the therapist intentionally responds to challenges presented by the patient in such a way that affords them the greatest occupational success. Emerging research in occupational therapy is continuing to establish the centrality of the therapeutic alliance in positive outcomes for patients (Gunnarsson & Eklund, 2009) and occupational therapists recognize its place in their field (Kloczko & Ikiugu, 2006).

Although a positive therapeutic alliance has been associated with improved outcomes for youth and adults with mental health diagnoses (Bickman et al., 2012; Smith et al., 2012), creating an effective therapeutic alliance is particularly challenging with some populations, such as people diagnosed with anorexia nervosa (commonly called anorexia), a prevalent eating disorder with serious health risks (Herpertz et al., 2011). Occupational therapists who serve this population frequently focus treatment on self-care, IADLs and helping the patient improve his or her confidence and body image (Kloczko & Ikiugu, 2006; Lock & Pépin, 2011). However,
because the eating disorder fills a psychological need for control or self-worth for the individual, maladaptive behaviors are not easily changed; persons with anorexia struggle acutely with treatment acceptance and participation (Herpertz et al., 2011; Lock & Pépin, 2011). Service providers, including occupational therapists, are likely to find the growing evidence on outcomes of a positive therapeutic alliance useful in intervening with this treatment-resistant population.

**Background**

**Treating anorexia nervosa.** Anorexia nervosa, as defined by the American Psychiatric Association (APA)'s *DSM IV-TR* (2000), includes the physical reality of self-induced weight loss below or lack of weight gain above 85% of that expected for age and height, and associated amenorrhea in women. In addition, a person with anorexia exhibits the psychological symptoms of using body shape and weight as major factors in self-evaluation, having a significantly distorted perception of body weight and shape, or denying the gravity of being low-weight. Finally, a person with anorexia has a profound fear of gaining weight (APA, 2000). Numerous studies have established that these behaviors are based in cognitive and physical differences from the normal population, which can be heritable (Klump, Bulik, Kaye, Treasure, & Tyson, 2009). People with anorexia may have insecure attachments and exhibit difficulty maintaining close relationships. They often have personality traits clustered around perfectionism, excessive self-control, and limited self-expression and initiative. Family characteristics of over-protectiveness or over-valuing of appearances have also been linked to the development of anorexia. At times, early trauma can be a causal factor (Lock & Pépin, 2011).

Whatever the multitude of factors may be that contribute to a person’s development of anorexia, the illness poses a serious threat to that individual’s health. Young women with anorexia between the ages of 15 and 24 have a mortality risk 12 times higher than all causes of
death combined for that age group, making anorexia the most deadly mental illness and a reducer of life expectancy by 25 years. Most people with anorexia do not receive adequate mental health services, even though the majority of them have comorbid diagnoses of anxiety, mood or personality disorders (Costa, 2009). About 50-60% of people with anorexia never fully recover, failing to maintain normal weight or experience relief of psychological symptoms (Lock & Pépin, 2011).

Beyond the impact of anorexia on individuals, the prevalence and high costs of treating the disease pose significant problems to health care systems. Although anorexia is the least prevalent of the eating disorders, alone it affects about 1% of people in the Western populations (Lock & Pépin, 2011), and the ratio of women to men affected is approximately 10 to 1 (Hoek & van Hoeken, 2003). Young women in late adolescence or early adulthood are at the greatest risk of developing anorexia, but men and women of all races and ages who were previously thought “immune” to the disorder are increasingly being diagnosed in all parts of the world (Lock & Pépin, 2011; National Eating Disorders Association, 2005). Adolescents and adults with eating disorders use more health care services than any other population of people with mental illness, in the U.S. and in other countries (Klump et al., 2009). The estimated cost of one year of treatment for a person with anorexia nervosa is $6,045, higher than that for persons with schizophrenia or obsessive compulsive disorder (Powers & Bannon, 2004). Eating disorders receive less national research funding in the United States than schizophrenia and Alzheimer’s disease (Costa, 2009; Klump et al., 2009), but are much more prevalent than both these diseases.

Interventions from a variety of disciplines have been successful in overcoming impairment and supporting health for people with anorexia. Medical personnel address the individual’s basic physical decline, usually in inpatient psychiatric services (Herpertz et al.,
2011). Here and in follow-up outpatient services, the patient may also receive occupational therapy, psychotherapy, recreational therapy, speech therapy, and nutritional counseling, depending on their impairments (Kloczko & Ikiugu, 2006). Obvious impairments occur in the areas of feeding, eating, self-care, and meal preparation, defined as activities of daily living (ADLs) and instrumental ADLs in the Occupational Therapy Practice Framework: Domain and Process (AOTA, 2008). Other characteristic impairments include decreased concentration, endurance, strength, cognition, social reciprocity, and emotional self-regulation (Costa, 2009), contributing over time to impaired leisure, work, or educational participation, especially with early onset of the disorder (Herpertz et al., 2011; Lock & Pépin, 2011). Common underlying traits of extreme perfectionism and self-dislike, combined with the belief that one is responsible for being in total control of oneself and/or others, can degrade the person’s ability to accept his or her self and identity (Lock & Pépin, 2011). As one woman recovering from anorexia stated, “sufferers must be constantly reassured that it will be worth finding out who they can be, what their life could be like” (Lock & Pépin, 2011, p. 129).

The treatment of adolescents and adults diagnosed with anorexia nervosa poses particular challenges. A systematic review of the standards for diagnosis and outcomes of treatments for eating disorders as a group culminated in a series of recommendations for diagnosis and treatment of this particular population (Herpertz et al., 2011). The authors asserted that treatment for anorexia nervosa usually requires months of coordinated care between inpatient, outpatient, and day patient programs. Although inpatient treatment is generally best initially, in order to help the individual gain a normal weight as soon as possible, motivation to change is frequently lacking in this population and an interpersonal crisis can easily result. Thus, the authors state that motivating patients is a “central task of the therapist” (Herpertz et al., 2011,
p. 680). In another systematic review of treatments for anorexia nervosa, Bulik, Berkman, Brownley, Sedway, and Lohr (2007) similarly stated that this population's low motivation to continue treatment is a barrier to both research and positive outcomes for the individuals. Low levels of treatment acceptance and maintenance among individuals with anorexia illustrate the need for more effective motivational methods to be developed and implemented by healthcare professionals, before better interventions and more conclusive research can be accomplished. The therapeutic alliance between a care provider and a patient with anorexia may be one of these motivating factors.

**Therapeutic alliance.** The impact of the therapeutic alliance on therapeutic outcomes has been studied through a variety of methodologies, especially in the practice of psychotherapy. At times, the findings of a therapeutic alliance effect have been considered a product of the type of treatment investigated, or the study design. However, a multilevel longitudinal meta-analysis of the role of the therapeutic alliance in individual psychotherapy, by Flückiger, et al., (2012), has indicated that the effect of a strong therapeutic alliance is consistent across many variations between studies. The authors reviewed data from 201 studies examining the impact of therapeutic alliance on patient outcomes, and coded the resulting 1,142 “alliance-outcome relations” with moderators including whether or not: the study was a randomized-controlled trial (RCT), a diagnosis-specific manual was used, outcomes were based on diagnosis-specific measures, the treatment method was cognitive-behavioral therapy (CBT), or the researcher had a history of interest in therapeutic alliance as a predictor of outcomes. The final moderator was the point in the study at which measurements of therapeutic alliance were taken. The overall effect size of the therapeutic alliance on outcomes was $r = .294$, $SE = 0.013$, a moderate effect similar to the findings of previous meta-analyses. None of the moderators analyzed were found to
significantly alter the effect size, except for researcher allegiance. For the early stages of treatment, a researcher history of supporting the importance of therapeutic alliance in treatment was correlated with a greater effect size. However, in the end stages of treatment this difference was no longer significant. The authors concluded that alliance-outcome correlations are strong regardless of the characteristics of the study or the method it examines for individual psychotherapy (Flückiger et al., 2012). Therapeutic alliance can thus be considered an important factor in predicting outcomes for a wide range of individual psychotherapy patients.

Therapeutic alliance has also been correlated specifically with decreased severity of symptoms for youth and adults receiving mental health services. A longitudinal outcome study of pre-existing groups by Bickman et al., (2012) examined the relationship between severity of symptoms for youth receiving mental health services and the therapeutic alliance reported by the youth, their caregivers, and their clinicians over time. The diagnoses of these youth were not reported in this study or in its predecessor from which participants were drawn. The authors compared the responses of 225 youth, 288 caregivers, and 300 clinicians on the Therapeutic Alliance Quality Scale (TAQS) (completed by children and caregivers) and the Therapeutic Alliance Quality Rating (TAQR) (completed by clinicians), with symptoms measured by the Symptoms and Functioning Severity Scale (SFSS). Using a hierarchical longitudinal linear statistical model, the authors reported that the severity of symptoms for all youth decreased over time, \( p = 0.001 \). Analysis of the trajectory of therapeutic alliance across recording times (in 1, 2, or 3 week intervals for an average of 4 months) revealed that therapeutic alliance ratings did show a small but significant increase over time, with an effect size of -0.11 to 0.17, depending on the reporter. Youth with a higher initial therapeutic alliance rating did not experience a significantly quicker improvement. However, clinician report of a favorable or improving
therapeutic alliance at four months was correlated with an increased rate of symptom improvement, with an effect size of 0.10 to 0.21, depending on the reporter (Bickman et al., 2012). This study’s validity is weakened by the influence of social expectations, which may have caused participants to rate therapeutic alliance artificially high, and the linearity of how the therapeutic alliance was measured. Also, the diagnoses of the youth studied were not provided. Still, the diversity of the sample (residing in 10 different states) and the use of three reporting groups in this study support its validity. Therefore, it is likely that the quality of the therapeutic relationship between young people receiving mental health services and their therapists is a beneficial component of therapy and could statistically predict more positive outcomes.

Similarly, Smith et al. (2012) did a secondary analysis of a randomized controlled trial to investigate the relationships between outcomes, attachment styles, and the therapeutic alliance for 70 adult women with major depressive disorder and a reported history of childhood sexual abuse. The authors measured the therapeutic alliance after the third session of treatment (either “treatment as usual” or manualized, goal-oriented, interpersonal psychotherapy [IPT]), using the Working Alliance Inventory, an assessment based on Bordin’s three components of a therapeutic alliance (Summers & Barber, 2003). The quality of the therapeutic alliance was found to be significantly and negatively associated with depressive symptoms for the IPT group, so that a stronger therapeutic alliance was predictive of better outcomes (Smith et al., 2012). The small sample size, lack of control of “treatment as usual,” and lack of longitudinal analysis in this study indicates it should be interpreted with caution, but its results support the therapeutic alliance’s role in treatment of resistant adult populations who have difficulty with interpersonal relationships.
The therapeutic alliance in occupational therapy. Theorists in the field of occupational therapy have also contributed models of the therapeutic alliance to the professional literature. Bordin’s concept of the therapeutic alliance as the combination of a shared goal, mutually agreed upon responsibilities for tasks, and an attachment bond, has been stated similarly in the occupational therapy literature by Taylor in her Intentional Relationship Model (IRM; 2008). She defines the therapeutic alliance in occupational therapy practice as the “socially defined and personally interpreted interactive process between the therapist and the client” (Taylor, 2008, p. 313). In her IRM, Taylor builds on occupational therapy’s history of emphasizing therapist self-awareness and empathy in practice, by illustrating the varied ways or “modes” that therapists can respond to a challenging situation with a patient. Each of these modes (collaborating, empathizing, advocating, problem-solving, instructing, and encouraging) rely on the therapists’ accurate perception of what each patient needs, as well as their own self-knowledge and intentionality in choosing a way to respond therapeutically. In this way, the therapist uses him or herself as a therapeutic tool to help the patient maintain occupational engagement in the task at hand and to experience greater well-being (Taylor, 2008).

Research is emerging on the role of the therapeutic alliance in occupational therapy practice. A Swedish study, using a combined correlational and quasi-experimental pre-test post-test design, supported the importance of the therapeutic alliance in promoting the well-being of patients with mental health pathologies (Gunnarsson & Eklund, 2009). The authors trained nine occupational therapists in the Tree Theme Method, a self-reflection and story-making intervention, and studied this intervention in 35 outpatient adult mental health patients presenting with a range of pathologies, including eating disorders. Engagement in and satisfaction with daily occupations, satisfaction with treatment, and the therapeutic alliance were rated at the
beginning and end of the five-to-nine weeks of treatment. Using Spearman’s rank order correlation, the authors found significant associations between the patients’ positive rating of the initial therapeutic alliance and increased occupational performance, satisfaction, and self-mastery; in order, $r_s = 0.373, p = 0.027$; $r_s = 0.432, p = 0.009$ and $r_s = 0.370, p = 0.029$. In addition, the therapist’s positive rating of initial therapeutic alliance was significantly associated with their patients’ improvements in satisfaction, self-mastery, sense of coherence, and symptoms of mental illness, $r_s = 0.380, p = 0.024$; $r_s = 0.518, p = 0.001$; $r_s = 0.416, p = 0.013$ and $r_s = 0.337, p = 0.048$; respectively (Gunnarsson & Eklund, 2009). These results are particularly significant in their application to the population of people with anorexia, who so characteristically seek self-mastery but experience dysfunctional standards of occupational satisfaction. The design of this study was appropriate for the process factors examined, and the inclusion of 35 participants decreased the statistical error. Therefore, for adult patients with mental illness, a positive therapeutic alliance is likely to be associated with improved occupational outcomes.

**Occupational therapy and the therapeutic alliance with the anorexia population.**

Occupational therapists have voiced the importance of the therapeutic alliance in supporting the motivation and, therefore, progress of their patients with eating disorders. Kloczko and Ikiugu (2006) completed a phenomenological study of three mental health occupational therapists who worked with adolescents with eating disorders in multidisciplinary inpatient settings. These therapists revealed that their patients’ recidivism, manipulative behavior and difficult families posed threats to their progress. The participants felt that occupational therapy had a unique and valuable role in involving patients in meaningful activities that allowed them to explore their identities and gain skills in a non-threatening atmosphere. Some participants noted that,
following treatment, their individual patients would report a positive experience in therapy due to their relationship with an occupational therapist, even after resisting treatment initially (Kloczko & Ikiugi, 2006). The small number of therapists interviewed in this study, although reflective of the lack of occupational therapists on-staff in inpatient settings, limits its generalizability to other occupational therapists and an anorexia-only population. However, a code-recode process, peer review of data, member checks, an audit trail, and reflexive journaling were all used to increase the validity of the findings, which lend support to the role of the therapeutic alliance in occupational therapy practice with this population and its particular challenge of overcoming resistance to treatment.

Occupational therapy is an important service for improving the health, self-concept, and societal participation of adolescents and adults diagnosed with anorexia nervosa. A consistently key component of any treatment, including occupational therapy, is the therapeutic alliance between the service provider and the patient. Unfortunately, research that has addressed the therapeutic alliance, occupational therapy interventions, and persons with anorexia is extremely limited. However, a review of the literature on the use of the therapeutic alliance in a variety of related interventions with adolescents and adults with anorexia could inform an occupational therapy-specific approach to the use of the therapeutic alliance with this highly at-risk group of people. Therefore, the purpose of this study was to determine the effect of the therapeutic alliance on treatment participation and therapeutic outcomes for adolescents and adults with anorexia.
Method

Research Design

This study was a systematic review of the literature that aimed to examine the role of the therapeutic alliance in predicting treatment acceptance and maintenance (expressed in treatment completion) and the therapeutic outcomes of weight gain, decreased symptom severity, and treatment satisfaction for adolescents (ages 12-18 years old) and adults (ages 18+) with diagnosed anorexia nervosa. Systematic searches of the following databases were completed: Academic Search Premier, PsycINFO, PubMed, ProQuest, CINAHL, and The Cochrane Library. The following key search terms were used: anorexia, anorexia nervosa, process factors, alliance, therapeutic relationship, dropout, and treatment satisfaction. Titles and abstracts were reviewed to determine if studies likely met the inclusion and exclusion criteria. Final determinations were made based on full-text review. References of accepted studies were then searched for any additional appropriate articles.

Systematic reviews and quantitative studies were included if they were 1) peer-reviewed, 2) published no earlier than 1997, 3) available in English, and 4) investigated the therapeutic alliance or therapeutic alliance-based therapies as a predictor of treatment acceptance, maintenance (expressed in treatment completion), weight gain, change in psychological symptom severity, or treatment satisfaction for 5) only adolescents and/or adults diagnosed with anorexia nervosa. Qualitative studies were included if they fulfilled criteria 1-3 above and either 4) specified therapeutic alliance as a topic of interest in the recovery process, and/or 5) results included themes related to therapeutic alliance in the recovery process, and 6) regarding only adolescents or adults diagnosed with anorexia nervosa. Studies of any methodology with clinician or caregiver report were only considered when patient report was also included.
Taylor’s definition of the therapeutic alliance as the “socially defined and personally interpreted interactive process between the therapist and the client” (2008, p. 313) was used in the application of inclusion criteria.

**Review Process**

The selected studies were then labeled with their corresponding levels of evidence from the traditional hierarchy of evidence (Arbesman et al., 2008), which ranks the quality of research designs in a single structure of five levels, with the highest quality studies being meta-analyses and randomized controlled trials (Level I), followed by a progression of two-group, nonrandomized studies (Level II), one-group nonrandomized studies (Level III), descriptive studies with outcomes analysis (Level IV), and case studies or expert consensus statements, including qualitative studies (Level V). Studies were also labeled with their corresponding levels of evidence from the research pyramid model (Tomlin & Borgetto, 2011), which views varied study designs as four different “sides” (descriptive, qualitative, experimental, and outcome) of the same body of evidence, each with different contributions made to clinical practice. Within each broad evidence category, distinctions are made for lesser or greater rigor in a design. For example, a one-group pre-test post-test design is a fourth-tier outcome study, while a controlled clinical trial is a third-tier experimental study. Qualitative studies are chiefly described as more or less rigorous based on the number of strategies used to increase their quality (member checking, prolonged engagement with participants, or triangulation of data).

Each individual quantitative study was then entered into a table with the following information: author(s), year published, purpose of the study, evidence levels, study design, description of participants (ages, number, setting, etc.), interventions and outcome measures used, and study results. Qualitative studies were described in a separate table by similar
characteristics, but with results/themes replacing interventions, outcome measures, and study results. The tables were reviewed for completeness and accuracy by two experienced occupational therapy researchers. Levels of evidence for the reviewed studies and their corresponding limitations and strengths were considered to evaluate the strength of results found. Conclusions were then made about the role of the therapeutic alliance as a factor in predicting treatment participation and outcomes for adolescents and adults with anorexia nervosa, as well as directions for future research and applications of this information to the practice of occupational therapy with this population.

Results

A total of 29 studies were found which appeared to fit the inclusion and exclusion criteria based on a review of their abstracts. Figure 1 details the process of full-text review and reasons for exclusion of articles. A search of the references of the accepted 12 articles yielded four more studies (all qualitative) that fit the inclusion and exclusion criteria. A total of 16 studies were then analyzed and included in the results.

Four quantitative studies were included, consisting of three outcome studies and one experimental design (three Level III's and one Level IV). Most of the relevant results, however, from these three outcome studies were secondary correlational analyses (Level IV evidence). Twelve qualitative studies were included, consisting of one meta-synthesis, and 11 group studies of varied rigor (one Level I and 11 Level V's). The represented research was chiefly conducted in the Western World, including Australia, Canada, the U.S.A., the U.K., Denmark, Sweden, Norway, and The Netherlands. One qualitative study (Ma, 2008) was conducted in Hong Kong.

The participants in the included studies were similar demographically to the greater population of people diagnosed with anorexia. Eleven out of the 16 studies specifically
investigated the experiences of adolescents with anorexia or women who had been diagnosed in adolescence, reflecting the average age of onset (Hoek & van Hoeken, 2003). Only three studies included males in their samples or the samples of their reviewed studies, reflecting the approximately 10:1 ratio of females to males in the population of people with anorexia. Finally, most participants were reported as White.

The quantitative evidence for the role of the therapeutic alliance in predicting treatment participation and outcomes for people with anorexia is summarized in Table 1. Of the four studies included, three investigated the therapeutic alliance and outcomes in family therapy for adolescents with anorexia. These three studies found that adolescents receiving family based therapy who reported better quality therapeutic alliances with their therapists had increased early weight gain and decreased symptom severity at the end of treatment (Halvorsen & Heyerdahl, 2007; Isserlin & Couturier, 2012; Pereira, Lock, & Oggins, 2006). The fourth quantitative study reviewed also indicates a possible link between the therapeutic alliance and kilocalorie consumption, (or, essentially, weight gain), in individual psychotherapy (Satir et al., 2011).

The qualitative evidence on the role of the therapeutic alliance in treatment acceptance and success for people with anorexia is summarized in Table 2. These results included one metasynthesis of adolescent studies, five group qualitative studies with substantial rigor and six group qualitative studies with little or some rigor. Of these studies, seven included only adolescent participants and three of these focused solely on the experience of inpatient treatment. The other four studies of adolescents included patients who were or had recently received outpatient, self-help, or inpatient treatment. Each of these studies found that adolescents viewed the therapeutic alliance as an encouraging and empowering force in recovery (Boughtwood & Halse, 2010; Colton & Pistrang, 2004; Offord, Turner, & Cooper, 2006; Roots, Rowlands, &
Gowers, 2009; Tierney, 2008; Van Ommen et al., 2009; Westwood & Kendal, 2012). Studies that explored the views of adults with anorexia alone or in combination with adolescent sufferers found similar themes related to the therapeutic alliance’s positive role in recovery (Federici & Kaplan, 2008; Ma, 2008; Lamoureux & Bottorf, 2005; Ross & Green, 2011; Wright & Hacking, 2012).

**Discussion**

People diagnosed with anorexia have been characterized as poorly motivated to recover and prone to dropout (Bulik et al., 2007; Herpertz et al., 2011). Based on the evidence, especially qualitative explorations of the experiences in treatment of patients themselves, these characteristics appear to be accurate general descriptions that signify a deeper characteristic of the disorder. Patients themselves characterized anorexia as a disorder of self-concept (Lamoureux & Bottorf, 2005); they experienced major internal conflicts about their identity and place in the world. These conflicts included wanting freedom from the disorder but feeling controlled by the feeling of not deserving better, knowing they need assistance but not trusting others to give it, wanting to avoid food but wanting to please their families, and others. One patient report described this ambivalence towards recovery in simple terms: “I can’t win really... if I eat I feel guilty, if I don’t eat I feel guilty ‘cause I’m disappointing my family...” (Colton & Pistrang, 2004, p. 311). Furthermore, lacking readiness or hope for change was reported by participants to be a major obstacle to healing. Recovered and recovering patients consistently reported that the internal drive and daily decision to get better was their primary agent of change in recovery, and the evidence suggested that a secure, individual, empathic therapeutic alliance with a care provider aided people with anorexia in developing the confidence to discover who they are without the disorder.
Each study reviewed indicated, with varying levels of rigor, that, in treating anorexia nervosa, the quality of the therapeutic alliance was an important factor in predicting positive outcomes. The results of each study also suggested that the therapeutic alliance effected change in two ways: as a specific modality and as a motivating factor. First, it appeared the therapeutic alliance was, in and of itself, a treatment modality that could improve a patient's sense of self and self-confidence, providing the baseline awareness and concepts required for successful recovery. Secondly, the therapeutic alliance was a motivating force that encouraged the patient to engage in the behavioral, physical, and psychological changes needed to recover. These conclusions are primarily supported by the strikingly consonant qualitative reports of adolescents and adults in a variety of treatment settings and stages of recovery, but are also suggested by the quantitative correlations found between the therapeutic alliance and adolescent outcomes in family-based therapy.

The particular characteristics of an effective therapeutic alliance were also illustrated in the reviewed qualitative literature. Taken as a whole, it painted a consistent portrait of this ideal and the clinicians who achieve it: they are compassionate, authentic listeners who are able to instruct and counsel their patients knowledgeably while seeing them as unique persons with a variety of psychosocial, spiritual, physical, occupational, and mental needs. Some studies further emphasized the importance of client-centered and collaborative care, where the clinician skillfully adapts to the patient's needs throughout the phases of treatment (Federici & Kaplan, 2008; Roots, Rowlands, & Gowers, 2009, Van Ommen et al., 2009). Taylor's (2008) work on therapeutic modes in occupational therapy supports this concept of therapist responsibility for skillfully adapting their approach to a patient based on the patient's personality, needs and resources, and stage of recovery.
of the therapeutic alliance in predicting outcomes for this population beyond family-based therapies with adolescents. Inpatient and general outpatient settings, as well as adult treatment, should be investigated.

Because the population of individuals diagnosed with anorexia is predominantly female, no studies provided information about differences between sexes in most phenomena related to the disease. Studying males with anorexia as a comparison group to their female counterparts would help determine if any significant differences between the two exist in regards to the therapeutic alliance and outcomes of treatment. Also, there is still insufficient evidence for the prevalence and treatment of anorexia in populations other than White people living in the Western world. In order to better serve all members of the population of people with anorexia, a broader racial and geographic perspective must be taken up in research. Finally, it would be useful to further define whether or not there are significant differences between the role of the therapeutic alliance or the form this alliance should take in early anorexia treatment vs. later recovery stages, or early onset of the disease vs. later onset, as people at different developmental stages of life and their illness may respond favorably to different approaches.

Conclusion

People diagnosed with anorexia nervosa frequently must undergo a long and difficult journey of recovery, receiving treatment repeatedly in a variety of programs. One of the factors that could contribute to their recovery is a positive therapeutic alliance with their clinicians – marked by respect, collaboration, empathy, and externalization of the disorder. The therapeutic alliance between the clinician and patient, or even between the clinician and the patient’s family, can motivate the patient to engage in therapy and act as a treatment directly, supporting a healthy sense of self. As one woman recovering from anorexia stated, “sufferers must be constantly
Interestingly, the therapeutic alliance between the clinician and patient is not the only relationship that can support the patient’s positive outcomes. Two of the three quantitative studies of family therapy reviewed found that the parent-clinician therapeutic alliance was greater than the patient-clinician and was more predictive of the patient’s outcomes, including total weight gain (Pereira et al., 2006), treatment completion, symptom severity, and remission (Isserlin & Couturier, 2012). In family therapy (a branch of psychotherapy), patients and their families (usually parents and sometimes siblings) are treated together. The therapist works to educate parents about the reality and seriousness of the disorder as a separate entity from their child, and encourages them to focus on helping their child regain normal weight. Second, the therapist helps the adolescent regain control of eating more independently. Thirdly, adolescent psychosocial issues as impacted by the anorexia are addressed (Isserlin & Couturier, 2012; Pereira et al., 2006). The evidence for the predictive power of parental therapeutic alliance regarding adolescent outcomes in this therapeutic context may be explained by the role that parents have in bringing their children to therapy and structuring their eating habits. Also, it is reasonable to assume that if families are invested in treatment and support patients’ participation in recovery based on a positive therapeutic alliance with therapists, patients may feel more supported in their recovery. Therefore, while the focus of the therapeutic alliance is necessarily the patient, it may be beneficial (especially in working with adolescents with anorexia) to invest in building a therapeutic alliance with the parents and other close family members of the patient, as well.

Although it appears that the therapeutic alliance with patients or their parents can motivate and effect positive change, it is important to note that motivation to engage in therapy may be a third variable that brings about both a good therapeutic alliance and good outcomes.
People who are more motivated to develop a positive relationship with the therapist may also be more motivated to recover, leading to better outcomes. Still, the qualitative reflections of former patients, describing how positive therapeutic alliances contributed to their recovery even when they did not feel initially motivated to change, support the role of the therapeutic alliance as a change-agent itself.

**Implications for Occupational Therapy**

To our knowledge, no study has been published in the occupational therapy literature investigating the therapeutic alliance in recovery from anorexia. Indeed, only one study in this review noted the presence of an occupational therapist on staff in the investigated treatment (Boughtwood & Halse, 2010). However, the evidence reviewed here from the psychotherapeutic and nursing literature has powerful implications for occupational therapy practice.

The American Occupational Therapy Association (2008) has declared the therapeutic use of self, the basis of a therapeutic alliance, as an intervention in and of itself. This current systematic review, in accord with occupational therapy theorists, has illustrated that the therapeutic alliance can and should be applied to all populations, even those that are often resistant to change and to treatment (Davis, 2007; Taylor, 2008). Davis (2007), in a paper on patient resistance in occupational therapy, discussed how patients with anorexia may benefit from learning to view their own resistance as ambivalence to change that is caused by the disorder itself. If therapists can help their patients externalize their self-loathing and fear of change, people with anorexia can begin seeing themselves as worthy of change and recovery.

Occupational therapists have been reported as being valued by their colleagues specifically because of their ability to establish therapeutic relationships with the “difficult” eating disorders population (Kloczko & Ikuigi, 2006). This may be due to the unique
contribution of occupational therapy to mental health practice: engaging patients in meaningful tasks to help patients explore new roles and identities instead of being passive recipients of services (AOTA, 2008). For patients with anorexia, these activities may be mapping out a healthy daily routine, exploring leisure activities that are social and affirming for the person, developing skill in using stress management strategies, or practicing assertive communication (Lock & Pépin, 2011). Engaging patients in meaningful activities can furthermore be a springboard or means for self-discovery and non-threatening conversation between the patient and clinician (Klozcko & Ikiugi, 2006). Because the goal of occupational therapy is to help the patient participate more fully in meaningful and healthy daily activities, the occupational therapist is prepared to consider a variety of ways to reach that goal through collaborative and client-centered care (AOTA, 2008). Thus, occupational therapy is fertile ground for the growth of a positive therapeutic alliance.

Finally, occupational therapists are mindful of the patient’s contexts, including their support systems (AOTA, 2008). The emphasis on family and caregiver involvement in occupational therapy should, based on the evidence in this review, be consciously applied to patients with anorexia. Even physically positive outcomes, such as weight gain, may be predicted by the parent’s therapeutic alliance with the therapist. Therefore, in planning and providing treatment, occupational therapists should consider the motivations and needs of the family members to help their loved one and engage them in the recovery process.

Limitations

The limitations of this study include the use of only one reviewer to search the literature and select articles, as a different researcher may have considered some articles appropriate that the primary investigator rejected. The exclusion of articles published more than 15 years ago and published in languages other than English also limited results. The results of this study should
not be applied over-generously beyond the categories of White, Western females, as other populations have not been sufficiently studied to be included in this review. Also, no effort was made in this review to differentiate between binging/purging and restrictive subtypes of anorexia, and the differences between these populations could impact a particular patient’s development of and response to the therapeutic alliance. Finally, the published research on anorexia and the therapeutic alliance is primarily qualitative and, therefore, exploratory. Many of the relevant analyses in the reviewed quantitative studies were secondary correlations and also did not allow inference of cause and effect. Thus, the current base of evidence makes a clear analysis of outcomes and predicting factors difficult.

**Future Research**

The impact of the therapeutic alliance on people with anorexia in occupational therapy practice should be investigated specifically, perhaps in mental health settings where occupational therapists provide group and individual interventions for this population. The definition of the therapeutic alliance should also be determined more specifically and applied consistently across studies for this population. As one of the more salient outcomes in the quantitative research appears to be symptom severity (commonly measured by the interview-administered Eating Disorders Examination or its companion self-report questionnaire), this or similar outcomes should also be considered for use in these new studies.

The relevant portions of the quantitative studies included in this review did not address cause and effect. Although the difficulties of designing rigorous studies with this population is acknowledged, more controlled or randomized studies would contribute to the possibility of determining causation in the relationship between the therapeutic alliance and therapeutic outcomes for people with anorexia. Also, quantitative evidence should be conducted on the role
reassured that it will be worth finding out who they can be, what their life could be like” (Lock & Pépin, 2011, p. 129). An occupational therapist working with a patient with anorexia should consciously and skillfully convey respect and care for that patient in the context of collaborative and patient-centered treatment, in order to enable the occupational participation and continual recovery of the individual.
References

References marked with an asterisk indicate studies included in the systematic review.


Table 1

Summary of Quantitative Evidence on the Role of the Therapeutic Alliance in Treatment of Anorexia Nervosa

<table>
<thead>
<tr>
<th>Author, year</th>
<th>Purpose</th>
<th>Evidence Levels/Design</th>
<th>Participants</th>
<th>Interventions/Outcome Measures</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isserlin &amp; Couturier (2011)</td>
<td>To explore the effect of the TA on completion, weight gain, and symptom severity for adolescents with AN in FBT.</td>
<td>Trad.: III (IV) Pyr.:</td>
<td>N = 14 + families 100% female M age = 14 yr Most ill for &lt;1 yr Consecutive recruitment from eating disorders clinic M 80.4% (±3.6%) of ideal body weight Country: Canada</td>
<td>Intervention: Treatment with FBT (all three phases, ~16 sessions)</td>
<td>DO: 6 C: 8 No sig. differences in adolescent ETP and SSP scores between DOs and Cs, except SSP in final session (p &lt; .01). Sig. higher parental ETP for C in mid and final sessions (p &lt; .02 and p &lt; .04, respectively).</td>
</tr>
<tr>
<td>Satir, et al. (2011)</td>
<td>To compare outcomes of TA-focused treatment (AFT) and behavioral change treatment (BCT).</td>
<td>Trad.: IV Pyr.:</td>
<td>N = 1 26 yo female diagnosed with AN, major depression, and social phobia BMI = 18.1 Country: U.S.</td>
<td>Interventions: 4-week sessions of 1) baseline, 2) AFT, 3) Behavior Change Treatment (BCT), 4) AFT.</td>
<td>a. significant increase in second phase of AFT (b = 24.74, t(1) = 3.91, p &lt; .01). b. no substantive change c. rated high throughout, appeared highest during AFT sessions.</td>
</tr>
<tr>
<td>Study</td>
<td>Design/Methodology</td>
<td>N</td>
<td>Intervention</td>
<td>Outcome Measures</td>
<td></td>
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<tr>
<td>Halvorsen &amp; Heyerdahl (2007)</td>
<td>To investigate whether or not the perceptions of former AN patients of their therapists was associated with symptom severity post-treatment.</td>
<td>$N = 33$</td>
<td>Conjoint family therapy in inpatient or outpatient treatment.</td>
<td>Time since treatment not sig. associated with POT scores for parents or FPs. a, b, c. FP and parent POT ratings not sig. related to presence of eating disorder in FP at follow-up. FPs global EDE score not sig. related to mother or father POT scores. Global EDE score sig. negatively correlated with FPs total POT score ($r = -.30, p = .047$) and with POT item referring to therapist expertise ($r = -.45, p = .001$).</td>
<td></td>
</tr>
<tr>
<td>Pereira, Lock, &amp; Oggins (2006)</td>
<td>To examine the role of the TA in predicting weight gain and symptom severity of adolescents with AN in FBT.</td>
<td>$N = 41$</td>
<td>12-month treatment with FBT</td>
<td>DO: 10  C: 31</td>
<td></td>
</tr>
</tbody>
</table>

### Table 2

**Summary of Qualitative Evidence on the Role of the Therapeutic Alliance in Treatment of Anorexia Nervosa**

<table>
<thead>
<tr>
<th>Author, year</th>
<th>Purpose</th>
<th>Evidence Levels/Design</th>
<th>Participants</th>
<th>Results/Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Westwood &amp; Kendall (2012)</td>
<td>To synthesize qualitative evidence on adolescent perspectives of their AN treatment.</td>
<td>Trad.: I Pyr.: Qualitative: Meta-synthesis of related studies</td>
<td>11 Studies Majority of female participants Setting: ~half inpatient treatment 2 community settings 2 in/outpatient Country: U.K., U.S.A., Norway, China, The Netherlands, Sweden, and Australia</td>
<td>Of three major themes, one related to TA and treatment satisfaction. Empathy and perceived expertise of staff contributed greatly to the TA and client satisfaction. One factor that negatively impacted the therapeutic alliance was that clients desired control but tended to experience tension between their personal goals and the goals of the clinician.</td>
</tr>
<tr>
<td>Wright &amp; Hacking (2012)</td>
<td>To describe the experience of TA between women with AN and their healthcare professionals.</td>
<td>Trad.: V Pyr.: Qualitative: Group study with substantial rigor</td>
<td>Patients, N = 6: 21-44 yo Length of contact with eating disorder services = 11 years Receiving community day services, most previously inpatient. Professionals, N = 7 (five nurses, one psychotherapist, one dietician): 33-51 yo Female, White</td>
<td>All six themes related to the TA. Authentic relationships between patients and professionals created a “safe place” to be oneself and provided a sense of hope and optimism for patients. Externalizing AN as separate from the patients underlying identity was also helpful. Weight gain was very difficult for patients to discuss and work towards unless they could work with a professional with whom they had developed a TA.</td>
</tr>
<tr>
<td>Ross &amp; Green (2011)</td>
<td>To determine the valuable therapeutic components of inpatient treatment for chronic AN.</td>
<td>Trad.: V Pyr.: Qualitative: Group study with some rigor</td>
<td>N = 2 100% female Setting: psychodynamic-based outpatient therapy connected to general inpatient treatment Country: U.K.</td>
<td>One of three themes described the TA. Later admissions were experienced with greater openness to advice from clinicians and the supportive understanding of care providers. The clear boundaries set by the hospital and its staff gave participants a sense of belonging and safety.</td>
</tr>
<tr>
<td>Boughtwood &amp; Halse (2010)</td>
<td>To explore the TA in hospitalization for AN through the perspectives of adolescent girls</td>
<td>Trad.: V Pyr.: Qualitative: Group study with</td>
<td>N = 25 100% female, 12-18 yo Age = 14.8 yo Setting: inpatient treatment (5 participants treated with same program</td>
<td>All three themes suggested that a poor therapeutic alliance led to poor outcomes. Hospitalization was experienced as demanding and inflexible. Providers were viewed as prejudiced, insincere, callous, and inexperienced. Provider and patient goals rarely matched. Participants were not</td>
</tr>
<tr>
<td>Study</td>
<td>Objective</td>
<td>Methodology</td>
<td>Sample Details</td>
<td>Findings</td>
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</tr>
<tr>
<td>Roots, Rowlands &amp; Gowers (2009)</td>
<td>To examine factors contributing to parent and patient satisfaction with a variety of treatment settings for adolescents with AN.</td>
<td>Trad.: V Pyr.: Qualitative: Group study with substantial rigor</td>
<td>$N = 215$ adolescents + parents for open-answer questionnaire</td>
<td>The common and most commented theme across treatment settings was the importance of an individual relationship that the patient could return to for support and advice. Clinician expertise (conveyed compassionately) and the trust it engendered was important to parents and patients. Listening, understanding, and viewing the patient holistically were mentioned as positive traits of particular, helpful, clinicians.</td>
</tr>
<tr>
<td>van Ommen et al. (2009)</td>
<td>To determine which aspects of nursing care adolescents with AN consider helpful in reaching positive outcomes.</td>
<td>Trad.: V Pyr.: Qualitative: Group study with substantial rigor</td>
<td>$N = 13$ 100% female</td>
<td>Adolescents described three treatment phases in which the TA between nurses and patients was skillfully orchestrated. Nurses gradually gave less firm direction and allowed the patient more control, always remaining available for emotional support and to challenge negative thoughts. They consistently conveyed respect and equality. These processes were all indicated by participants as being central to their recovery.</td>
</tr>
<tr>
<td>Federici &amp; Kaplan (2008)</td>
<td>To investigate the patient’s view of relapse and recovery over the first year after intensive treatment for AN.</td>
<td>Trad.: V Pyr.: Qualitative: Two-group study with some rigor</td>
<td>$N = 15$ (8 relapsed, 7 recovered) 100% female, White, 18+yo</td>
<td>Of six themes, one was specific to patient views of treatment factors. Recovered participants reported feeling safe, supported, and understood by staff of their treatment centers. Relapsed participants reported that their treatment was overly focused on biological/behavioral modification and did not include psychological and emotional preparation for “life after treatment.”</td>
</tr>
<tr>
<td>Ma (2008)</td>
<td>To assess treatment effectiveness of family therapy as perceived by patients and families.</td>
<td>Trad.: V Pyr.: Qualitative: Group study with little rigor</td>
<td>$N = 24$ (18 adolescents, 6 young adults) 100% female, Chinese</td>
<td>One of five major themes related to TA. TA of clinicians with patients and families built by mutual respect and trust, and the clinician’s clear genuine concern for the patient’s well-being. Patients felt encouraged by the support and confidence of their clinicians. Patients and families attributed some success in treatment to the TA of the patient with the therapist.</td>
</tr>
<tr>
<td>Tierney (2008)</td>
<td>To explore the experiences and</td>
<td>Trad.: V Pyr.:</td>
<td>$N = 10$ 90% female, White</td>
<td>All three major themes were relevant to the TA. Prejudiced and distant staff who overly focused on physical symptoms</td>
</tr>
</tbody>
</table>
## Therapeutic Alliance and Anorexia

<table>
<thead>
<tr>
<th>Study</th>
<th>Authors</th>
<th>Research Questions</th>
<th>Traditional Hierarchy (Trad.)</th>
<th>Research Pyramid (Pyr.)</th>
<th>Sample Characteristics</th>
<th>Setting</th>
<th>Country</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Offord, Turner, &amp; Cooper (2006)</td>
<td>To understand the views of young adults on the treatment they previously received for AN in a general adolescent psychiatric unit.</td>
<td>Trad.: V</td>
<td>Qualitative: Group study with some rigor</td>
<td>Median length of illness = 24 months (range = 6-60 months)</td>
<td>Setting: general inpatient unit and self-help group (recruited from)</td>
<td>Country: U.K.</td>
<td>The participants valued clinicians seeing the whole person as unique and separate from their disease. Some participants noted the discouraging effect of frequently changing therapists and re-building trust with different clinicians.</td>
</tr>
<tr>
<td></td>
<td>Lamoureux &amp; Bottorf (2005)</td>
<td>To describe the process of recovery from AN from the patient’s perspective.</td>
<td>Trad.: V</td>
<td>Qualitative: Group study with some rigor</td>
<td>Diagnosis: AN (self-reported as recovered)</td>
<td>Setting: general adolescent psychiatric unit (discharged 2-5 yrs prior to study)</td>
<td>Country: U.K.</td>
<td>All five major themes were relevant to the TA. An essential component of recovery was experiencing validating, genuine, unconditionally accepting relationships that the participants could trust and set their own boundaries within. Effective clinicians provided equality, commitment, and respect to patients as well as an outside perspective to help them self-explore.</td>
</tr>
<tr>
<td></td>
<td>Colton &amp; Pistrang (2004)</td>
<td>To describe how adolescents with AN experience their treatment in inpatient specialist eating disorder units.</td>
<td>Trad.: V</td>
<td>Qualitative: Group study with substantial rigor</td>
<td>Illness duration: &lt;3-24yrs</td>
<td>Setting: 2 inpatient specialist eating disorder units</td>
<td>Country: U.K.</td>
<td>Of five major themes, two were relevant to the alliance. Participants experienced a variety of internal conflicts (wanting vs. not wanting to get well) and conflicts regarding external issues like needing structure in treatment vs. wanting more freedom. They expressed that when care providers were willing to listen, encourage and collaborate with them as an individual their motivation to participate and recover increased.</td>
</tr>
</tbody>
</table>

**Note:** AN = anorexia nervosa. BMI = body mass index. M = mean. N = number. Pyr. = the Research Pyramid model of evidence. TA = therapeutic alliance. Trad. = the Traditional Hierarchy of evidence. yo. = years old.
29 selected for full-text review

17 quantitative

14 excluded

Criterion 4: 9 excluded

Criterion 5: 5 excluded

12 met criteria

4 added after review of references

16 total studies included in review

12 qualitative

12 met criteria

3 excluded

Criterion 4/5: 2 excluded

Criterion 6: 1 excluded

Figure 1. Review process for selection of studies