Dropout from Cognitive Behavioural Treatment in a Case of Bulimia Nervosa: the Role of the Therapeutic Alliance

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Abstract. Despite the refinement of the cognitive treatment for eating disorders, relatively high dropout rates represent a major problem for therapists and researchers. This study investigated the case of a patient with a diagnosis of bulimia nervosa, who dropped out of outpatient CBT after 28 weekly sessions. In addition to standard clinical outcome assessment, we examined how patient's psychological functioning and therapeutic alliance changed across sessions by applying observer-rating scales to the therapy transcripts. Although the patient reported some improvement at the six-month retest, observer ratings showed persistence of impaired functioning and frequent ruptures in the patient-therapist relationship throughout the treatment. We concluded that a thorough examination of the therapy process might help to understand the factors that lead to premature treatment termination.

Keywords: eating disorders, dropout, multistep cognitive behavior therapy, process research, therapeutic alliance

In an effort to accelerate dynamic psychotherapy, Davanloo began in the 1960s to use more active approaches to identify and handle resistances. He initially worked with low and moderate resistant patients who could be put in touch with avoided unconscious feelings through focal interviewing, active use of interpretation of defenses and interruption of defenses that came into play (Davanloo, 1980).

Many studies have been conducted in order to analyze the specific variables connected to a good outcome of treatment for eating disorders (EDs; Fairburn, 2008a; Yager & Powers, 2007). However, much remains to be done to deepen the knowledge and increase treatment success of a category of diseases that, for its symptomatic heterogeneity, clinical complexity, diagnostic comorbidity, and resistance to change, is still today a real struggle for therapists (Vanderlinden, 2008; Westen & Harnden-Fischer, 2001). Among the

therapeutic options available for EDs, CBT showed good efficacy, especially in the treatment of bulimia nervosa (National Institute for Health and Clinical Excellence, 2004; Shapiro et al., 2007; Wilson, Grilo, & Vitousek, 2007). In particular, Enhanced CBT (CBT-E; Byrne, Fursland, Allen, & Watson, 2011; Cooper & Fairburn, 2011; Fairburn, Cooper, & Shafran, 2008; Fairburn, Cooper, Shafran, Bohn, et al., 2008) and its variants (e.g., CBT-MS Multistep; Dalle Grave, 2003; Dalle Grave, Sartirana, Camporese, Marchi, & Calugi, 2007) are considered as the treatment of choice for EDs.

Despite these valuable therapeutic options, patients' dropout—i.e., a premature interruption of the treatment, due to a unilateral decision of the patient that is not negotiated with the therapist (Bergin & Garfield, 1994)—represents a serious challenge in ED treatments (Björk, Björck, Clinton, Sohlberg, & Norring, 2009; Blouin et al., 1995; Campbell, 2009; Sly, 2009). A review of the literature indicates that dropping out is quite common in both inpatient and outpatient treatments (Carter et al., 2012; Fairburn et al., 2009; Wallier et al., 2009). According to a recent meta-analysis, dropout rates from ED treatment range between 20 and 51% in inpatient settings, and 29 and 73% in outpatient settings (Fassino, Pierò, Tomba, & Abbate-Daga, 2009).

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It is important to study the factors that may influence the dropout from the therapy for several reasons (Carter et al., 2012; Fassino, Abbate-Daga, Pierò, Leombruni, & Rivera, 2003; Fassino et al., 2009). First, dropout patients are supposed to report worse prognosis and clinical outcomes (e.g., Baran, Weltzin, & Kaye, 1995). Second, dropping out is a very expensive occurrence in terms of direct and indirect costs for the mental health system (Mahon, 2000). Third, a high dropout rate decreases the power and generalizability of clinical trial results. Fourth, in the development of new therapeutic interventions, it is crucial to understand why individuals drop out in order to increase their engagement in the therapy and maximize treatment outcomes.

Despite the importance of this area of research, previous studies examining the factors affecting patient dropout from ED treatment have yielded fragmented and disparate results (Masson, Perlman, Ross, & Gates, 2007). Most dropout studies have focused on specific features of the disease itself (e.g., longer duration and severity of illness, presence of other comorbid disorders; Mahon, 2000) and a few dimensions regarding the patient's personality, such as high levels of impulsiveness and anger, high perfectionism, low self-esteem and self-directedness, strong avoidance and poor cooperativeness (Fairburn, Cooper, Shafran, Bohn, & Hawker, 2008; Fassino et al., 2003, 2009; Franzen, Backmund, & Gerlinghoff, 2004; Hoste, Zaitsoff, Hewell, & le Grange, 2007; Kahn & Pike, 2001; Peake, Limbert, & Whitehead, 2005; Steel et al., 2000). However, these varied and often contrasting findings do not clarify why many of these patients drop out of the therapy and how dropping out can be minimized. Recently, several authors have proposed to move from focusing exclusively on patient characteristics and adopt a broader approach that encompasses the whole process of treatment (Campbell, 2009; Carter, Pannekoek, Fursland, Allen, & Lampard, 2012; Sly, 2009). Kahn and Pike (2001) have also suggested that process-based factors, such as therapist-patient relationship and strength of the therapeutic alliance, may be more predictive of dropping out than individual patient characteristics (see also Carter et al., 2012).

The role of the patient-therapist relationship and therapeutic alliance in promoting psychotherapy change process and reducing the dropout rate is now well supported also for CBT (Gilbert & Leahy, 2007; Katzow & Safran, 2007; Leahy, 2008; Safran, 1998; Safran & Muran, 2000a; Waddington, 2002). This may be the case especially in difficult patients such as ED patients. One clinical trial on CBT for patients with anorexia nervosa (Ball & Mitchell, 2004) showed that the development of a strong therapeutic alliance was correlated with a better outcome. Fairburn, Cooper, and Shafran (2008) noticed a dropout reduction from 29% to 13% as a result of the modification of the CBT-E through a more extensive therapist openness towards dialogue, especially about the rela-

tionship with the patient. Fairburn and colleagues concluded that therapeutic alliance is also crucial for the importance that maintaining control has for ED patients. Also Piper and colleagues (1999) reported that a poor therapeutic alliance was associated with an increased dropout risk.

However, although there is some evidence that good therapeutic alliance in CBT for EDs is associated with better outcome and dropout reduction, less is known about *how* alliance develops and affects the course of this specific treatment. In their study comparing CBT and interpersonal therapy for bulimia nervosa, Constantino and Smith-Hansen (2008) suggested focusing on fluctuations and micro-fluctuations that facilitate or hamper the process of change during the whole therapy as well as each single session. The seminal work of Safran, Muran, and colleagues (reviewed by Safran & Muran, 2000a) has confirmed the existence of a rupture-repair pattern and its relation to session quality and treatment effectiveness (Katzow & Safran, 2007; Safran & Muran, 2000b; Strauss et al., 2006; see Colli & Lingiardi, 2009, for a review). Safran and Muran (1996) defined *ruptures* in terms of "deteriorations in the relationship between therapist and patient" (p. 447) that create a negative alteration in the quality of the therapeutic alliance. There is some evidence that in different therapeutic approaches, including CBT, lower rupture intensity is associated with a better interpersonal functioning, and that higher rupture resolution is connected to better outcomes and retention (Strauss et al., 2006; Waddington, 2002). In many studies, most ruptures resulted from therapists' rigid adherence to a therapeutic technique instead of an exploration of the client's difficult emotional experience and its impact (e.g., Ackerman & Hilsenroth, 2001).

Thus, even though there is some evidence that therapeutic alliance may be involved in outcome and dropping out, the precise manner in which the alliance influences the course of CBT treatment has not yet been explained in detail. The current study is the first to examine, session-by-session, some fundamental process variables—e.g., collaboration levels, ruptures, etc.—that can impair the achievement of a good outcome for ED treatment and, in some cases, lead to dropping out. We assumed that test-retest measurements alone are not sufficient to understand the factors that lead to dropping out, and that a thorough analysis of the changes and microchanges that occur during the therapeutic process, is essential in order to understand the evolution of the problem.

The present study used a single-case approach. Although single-case methodology is not necessarily the design of choice in all circumstances, it is a fundamental research strategy in psychotherapy process research—i.e., the study of the temporal unfolding of patient and patient-therapist variables within and across therapy sessions (Hilliard, 1993; Kazdin, 2010). Further, this approach may be necessary and/or preferable in pilot studies concerning difficult patients,

such as ED patients, for which, because of methodological issues and medical complications, it may be very problematic to have large samples or randomized clinical trials.

A purpose of this study is to present, along with standard test-retest assessment, observer ratings of patient and patient-therapist variables that may be hard to study by means of just self-reports. Moreover, we supposed that by assuming different perspectives (self-report questionnaires, therapist assessments and observer ratings) we would get a better understanding of the factors that lead to dropout.

Among the process variables studied, we focused on the therapeutic alliance and the ruptures in the therapeutic relationship that, if not repaired, may initiate and maintain a negative cycle in which the rupture remains unresolved. In addition, we examined in parallel the evolution of the patient's functioning in different areas (i.e., relationships, body, self-realization). These areas encompass aspects such as present and past family situation, quality of interpersonal relationships, presence of job-related problems, and onset of medical complications or other physical problems (for a review, see Mahon, 2000). In this regard, Sarracino and Dazzi (2007) identified sixteen areas to assess in detail at the beginning of the treatment and in subsequent sessions, in order to obtain a real-time representation of the experiences in patients' life (for a description of these areas, see Method section).

Specifically for the dropout case examined in the present study, our hypotheses were that (a) the patient's functioning would not improve during the treatment; (b) the therapeutic alliance global indices would not improve during the treatment; and (c) the patient-therapist collaboration levels and the rupture indices would show no improvement throughout the treatment.

Method

Case description

This is a single-case study of Emma, an Italian 22-year-old woman, employee, who requested therapy because of her eating difficulties. From 3 to 13 years old, Emma lived in a boarding school, with only occasional contact with her biological parents. The biological father was an alcoholic who, when out of prison, lived as a tramp. During Emma's preadolescence, her natural parents split up and her mother moved to a different city. In this period, her visits to Emma were decreasingly frequent. When Emma was 13 years old, she was fostered by a couple. She perceived her foster parents as hypercritical, ambivalent and, in some cases, overtly unsupportive; however, in order to prevent the risk of being abandoned again, she responded to this new family situation with compliance and obedience. Her eating problems emerged for the first time in this period. In fact, her experience with her family showed a history of insecure attachment, in particular

with her mother, which may have a role in her internalizing and externalizing problems (e.g., Innamorati, Sarracino, & Dazzi, 2010; Sarracino, Presaghi, Degni, & Innamorati, 2011). The situation worsened further during the foster parents' separation, after which Emma chose to live with the foster father.

Before treatment, Emma received from the therapist an Axis-I diagnosis of bulimia nervosa, non-purging type (DSM-IV-TR; American Psychiatric Association, 2000), characterized by the alternation of bulimic and anorexic phases. Her Axis-II diagnosis, according to the Structured Clinical Interview for DSM-IV Axis II (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997), was obsessive-compulsive personality disorder. SCID-II showed abnormal preoccupation with details and rules, exaggerated perfectionism, strict sense of duty in study and work, rigid moralism, and difficulties in interpersonal relationships. Despite these personality flaws, which affected especially the quality and quantity of her relationships, Emma was also very resourceful, and showed interest in dance, arts, cinema, literature, and politics.

Treatment description

Following the advice of a relative, Emma started an outpatient CBT conducted by a therapist with one year of clinical experience, in a specialized ED treatment center. The therapy was conducted on a weekly basis, 28 sessions overall, according to Dalle Grave's (2003) outpatient CBT-MS (multistep) model. Following Fairburn's transdiagnostic theory (Fairburn, 2008b; Fairburn, Cooper, & Shafran, 2003), this step-by-step approach aims at modifying the factors which underlie the whole ED spectrum. The treatment plan consists of three phases. The first phase (first six sessions) deals with problems regarding alimentation, binge-eating, compensatory behaviors, body weight, and other specific maintaining factors. The second phase addresses dysfunctional schemes of self-evaluation and possible additional maintaining factors (e.g., clinical perfectionism, low nuclear self-esteem, intolerance towards emotions, and interpersonal problems). This phase fills most of the time and its duration varies according to the BMI. More specifically, with BMI > 17.5, the therapy should be briefer (from 7 to 21 sessions), while with BMI < 17.5, the therapy requires more sessions (at least 45 sessions). The third phase aims to maintain the change achieved, prevent relapses, and clarify the opportunity of further therapies (last three bimonthly sessions). Consequently, given the low BMI of Emma (< 17.5; see Table 1), the therapist proposed a 48-session therapy clarifying this aspect to Emma as an essential component of the therapeutic contract in terms of positive improvement of her symptoms.

Emma initially agreed to this recommendation, but after 28 weekly sessions, she dropped out of the treatment. The therapist reaffirmed the importance of carrying on the therapy, because of the endurance of

the eating symptomatology. However, Emma disagreed with the clinician and decided to interrupt the therapy because she was overwhelmed by family and financial problems.

After one year and three months, Emma returned to the therapist to "express gratitude for the work done" and update her about her decision to spend a period abroad, in order to distance herself from her family. In these last three sessions, the therapist encouraged the patient to reconsider her decision to drop out of therapy because of the persistence of serious eating problems (the patient reported both periods of restrictive diet and bulimic conduct) along with a significant withdrawal from social interactions. Regardless of this suggestion, Emma reaffirmed her strong intent to drop out permanently. At this point, the therapist asked Emma to keep her updated about future developments, but she never received any feedback.

Test-retest measures

Test-retest measures (0-6 months) were part of a standard assessment protocol of the clinical center and included standard instruments such as:

Symptom Checklist-90-Revised (SCL-90-R; Derogatis, 1994). It is a 90-item self-report instrument designed to measure current psychological and psychiatric symptoms. Each item is assessed on a Likert scale (from 0 to 4). Nine primary symptom dimensions are measured: Somatisation, Obsessive Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. Also 3 global indices are obtained: the Global Severity Index (GSI), the mean Positive Symptom Total (PST) and the mean Positive Symptom Distress Index (PSDI). Most studies establish a T score > 62 for scales and global indices as a cut-off for clinical caseness. Overall, the instrument have shown good psychometric properties (Derogatis, 1994).

Eating Disorder Inventory (EDI-2; Garner, 1991). The EDI-2 is widely used in diagnosis of anorexia, bulimia and eating disorders not otherwise specified. It is made up of 11 scales assessing behavior, symptoms and personality traits of individuals with eating disorders: Drive for Thinness, Bulimia, Body Dissatisfaction, Ineffectiveness, Perfectionism, Interpersonal Distrust, Interceptive Awareness, Maturity Fears, Asceticism, Impulse Regulation, and Social Insecurity. A score higher than 14 in the Drive for Thinness scale is usually considered as a clinical cutoff point. The instrument showed good internal reliability (alpha ranging from .65 to .91 across scales in a clinical sample; Ebrenz & Gleavs, 1994), and a good test-retest reliability (*r* ranging from .81 to .89 in an ED group; Thiel & Paul, 2006).

Toronto Alexithymia Scale (TAS-20; Bagby, Parker, & Taylor, 1994). The TAS is a 20-item instrument commonly used to measure alexithymia. Items are rated using a 5-point Likert scale whereby 1 = strongly disagree and 5 = strongly agree. The 20-item version of the scale has 3 subscales: Difficulty Describing Feelings, Difficulty Identifying Feelings, and Externally-Oriented Thinking. The cut-off scores are: < 50 non-alexithymia; 51-59 possible alexithymia; > 60 alexithymia. The overall scale demonstrated good internal consistency (alpha = .81) and test-retest reliability (.77).

Sense of Belonging and Sharing Questionnaire (SBS; Procacci, Conversano, Semerari et al., 2002). The questionnaire consists of 90 items organized in a 7-point Likert format. It assesses the individual's feeling of belonging to a social group, and the belief to share values, objectives, interests, experiences etc. with the other members of the group. The assumption is that the sense of belonging is related to lower prevalence of metacognitive failures, social and emotional problems. Furthermore, two control scales (Lie and Frequency) are assessed. The questionnaire showed good internal reliability (alpha ranging from .68 to .93) and 40-day test-retest reliability (mean *r* = .70). Three indicative cutoffs are available: normal (T < 60), at risk (T = 61-64), and critical (T > 65).

Process measures

The process were evaluated including both the patient's functioning and the therapeutic alliance.

Motivational Areas Rating Scale (MARS; Sarracino & Dazzi, 2007). The MARS is an observer rating scale that provides a brief but wide-ranging research instrument for assessing patients' psychological distress from a trans-theoretical point of view. It consists of 16 macro-items, which cover the issues in four *motivational areas*—active relational (A), passive relational (B), corporeal (C), and self-realization (D), from four different perspectives—objective object (1), subjective object (2), objective self (3), and subjective self (4). For example, the A1 sub-area includes any act of hostility from others that is reported by the patient (e.g., physical or sexual assaults, offenses, injuries, threats, etc.), A2 includes problems in how patient subjectively experiences others (e.g., he/she feels anger, hatred, or suspicious towards others), A3 includes the patient's acts of hostility towards others, and so on (see Figure 2). These areas are defined *motivational* because they are related to the experiences in individuals' life that can motivate their behavior, affects, mental states, and contribute to their well-being and adjustment (for a complete description of motivational areas and their theoretical background, see Sarracino & Dazzi, 2007). The rater has to read the transcript regarding 2-session chunks and, based on the MARS manual, respond to the 16 items of the scale, assigning a score based on his or her perception of the salience and severity of the problem, from 0 (= absent) to 4 (= very high). In this way, we obtained a graph that illustrates Emma's functioning areas and their change over time (see Figure 2). In preliminary studies (Sarracino & Dazzi, 2007), MARS showed a good inter-rater reliability (ICCs from .52 to .81; p < .000).

Vanderbilt Therapeutic Alliance Scale - Short form (VTAS-R; Shelef & Diamond, 1998). This observer rating scale is composed of five items, which measure to what extent the patient: (1) Indicates that he/she experiences the therapist as understanding and supporting him/her; (2) Seems to identify with the therapist's method of working, so that he/she assumes part of the therapeutic task; and (3) Acts in a distrustful or defensive manner toward the therapist. Moreover, the scale assesses to what extent the therapist and patient together: (4) Share a common viewpoint about the definition, possible causes, and potential alleviation of patient's problems; and (5) Agree upon the goals and/or tasks for the session. The VTAS Short Form showed good psychometric properties, as regards validity and reliability, which are comparable to those of the 26-item version (Shelef & Diamond, 1998). Specifically for inter-rater reliability, ICCs ranged from .55 to .87. The scores of the 5 items, derived from chunks of two sessions, were summed to obtain a global scale distributed on 5 levels of increasing gravity: 0 = very high alliance (VTAS-R = 21-25); 1 = high (16-20); 2 = medium (11-15); 3 = low (6-10); 4 = very low (0-5).

Collaborative Interactions Scale (CIS; Colli & Lingiardi, 2009). This observer rating system is composed of two main scales: (a) The CIS-P, which assesses patient's direct rupture markers (DRMs; 9 items), indirect rupture markers (IRMs; 9 items), and collaborative processes (CPs; 3 items); and (b) The CIS-T, which assesses the therapist's positive interventions (PIs; 12 items) as well as negative interventions (NIs; 8 items). The rater assesses the presence, in each patient utterance, of a DRM, IRM, or CP and, in each therapist utterance, of a PI or NI. For each patient and therapist utterance, a rupture vs. collaboration score is also assessed from –3 (high rupture) to +3 (high collaboration). For each session, several global indices were obtained, each ranging from 0 to 30: index of direct ruptures (IDR), index of indirect ruptures (IIR), index of collaborative processes (ICP), index of negative interventions (INI), and index of positive interventions (IPI). CIS demonstrated good inter-rater reliability (average Cohen's k = .66-.81).

Procedure

The present study included three steps:

(1) A phase of psychodiagnostic assessment preceded the treatment and involved the administration to the patient of several self-reports (see *Test-retest measures* Section). Moreover, the patient reported (a) her current weight, (b) her greatest and lowest weight ever, and (c) her desired weight. After six months from the beginning of the treatment (after session 22, considering the summer holidays; see Figure 1), the same measures were retested. The Italian version was utilized for each self-report. Self-report questionnaires were part of the standard evaluation protocol of the clinical center, consequently they had been selected be-

fore the objectives of the present study were defined.

(2) The test-retest study was followed by a detailed analysis of the therapeutic process, based on a series of relevant therapeutic variables that were congruent with the aims of this study. Our aim was to tap possible divergences between the self-report results and the process analysis of the patient's functioning (MARS). Moreover, in this phase we used VTAS-R to achieve a quick screening of the level of therapeutic alliance reached during the treatment, in order to identify the most problematic moments of the therapy. In the light of the fact that MARS guidelines suggest clustering the sessions in 2-session chunks (Sarracino & Dazzi, 2007) we also decided to cluster VTAS-R scores in blocks of two, in order to facilitate comparisons between the two measures. Therefore, we obtaining a total of 14 codes (see Figure 2).

(3) Finally, we focused specifically on the therapeutic alliance between patient and therapist, in order to explore possible ruptures that might affect patient's decision to drop out of the treatment. For this purpose, CIS was used to analyze in detail sessions that resulted particularly critical and/or interesting in view of the therapeutic alliance through a preliminary analysis with the VTAS-R. Specifically, we focused on sessions 5, 18, and 23.

Process measures were coded separately by two graduating students in clinical psychology, who were trained and assisted in all phases of the assessment process by two expert researchers in this field. At the end of the assessment, any questions were discussed with the research assistant. The interrater reliability, in terms of intraclass correlation coefficients (Shrout & Fleiss, 1979) of the two judges for the three measures, was good to excellent (MARS: ICCs from .57 to .82; VTAS-R: ICCs from .60 to .81; CIS: average Cohen's k from .61 to .79).

Results

Test-retest comparisons

Table 1 shows Emma's height, weight, and T scores of self-report measures before treatment, and after six months. After 6 months, Emma reported a decrease of 15 kg in her current weight, to the extent that the cutoff score for underweight was reached. At the same time, the self-reported greatest weight increased, surpassing the overweight cutoff. The self-reported lowest weight however remained unchanged.

Before treatment, all SCL-90-R scales (except somtization) and global indices exceeded the cutoff point (T > 62). After 6 months, all scales were below the cutoff. Alexithymia scores (TAS-20) were below the cutoff both at test and retest assessments, and decreased substantially at the retest. At last, all SBS scales were below the cutoff, except the lie control scale—which reflects the tendency of the patient to give a positive, agreeable and socially desirable image of herself—which was high at both test and retest. Therefo-

Table 1. Emma's height, weight, and T scores of self-report measures before treatment, and after six months

Measure	Test	Six-month retest
Height (cm)	171	–
Self-reported current weight in kg (BMI)	66 (23[a])	51 (17[b])
Self-reported greatest weight ever in kg (BMI)	69 (24[a])	75 (26[c])
Self-reported lowest weight ever in kg (BMI)	48 (16[b])	48 (16[b])
Self-reported desired weight in kg (BMI)	57 (19[a])	55 (19[a])
SCL-90-R		
Somatization	59	49
Obsessive-compulsive	64[d]	48
Interpersonal sensitivity	85[d]	43
Depression	71[d]	45
Anxiety	72[d]	47
Hostility	76[d]	47
Phobic anxiety	69[d]	46
Paranoid ideation	73[d]	46
Psychoticism	76[d]	44
Global severity index (GSI)	76[d]	45
Positive symptom total (PST)	64[d]	46
Positive symptom distress Index (PSDI)	71[d]	45
TAS-20		
Difficulty describing feelings	10	7
Difficulty identifying feelings	19	8
Externally-oriented thinking	17	15
Global alexithymia score	46	30
SBS		
Self-reflection	59	40
Representation of others' mind	49	39
Relational strategies	47	39
Painful feelings	63	47
Sense of superiority	40	41
Sense of detachment/indifference	55	50
Sense of belonging/sharing	51	40
Lie	66[d]	66[d]
Frequency	48	36

Note. BMI classification according to the WHO criteria: [a] Normal; [b] Overweight; [c] Underweight. [d] T scores higher than cutoff scores, according to the following criteria (see Method section for references): SCL-90-R: T > 62; TAS-20 global score: T > 60; SBS: T > 65.

re, the scores obtained by the patient at the SBS and other self-report measures, should be considered in the light of this bias.

Figure 1 shows Emma's EDI-2 profile before treatment, and after the first six months of treatment. This self-reported measure also shows a dramatic improvement in all the subscales. At the test, most scores were largely over the medium score obtained by the ED patients normative group. At the retest, only the perfectionism score exceeded the clinical cutoff. All the other self-reported measures were not only below the ED patients' normative group mean, but also below the female college normative group, resulting in a complete absence of symptoms for six scales.

Process analysis

Figure 2 shows a graphical, session-by-session representation of Emma's therapeutic process, including the evolution of the patient's functioning (MARS) and the therapeutic alliance (VTAS-R global index). The MARS indicates a moderate, pervasive presence of themes connected to real and perceived hostility from others (A1-2), which are particularly present in early and central sessions. The passive relational area (B) (i.e., issues of separation, withdrawal, and relational passivity) is very critical throughout the treatment, without remarkable improvements. The dysregulation of the corporeal area (C), as expected, is pervasive during all the therapy sessions, except for a brief moment (sessions 21-24). Working and existential problems (D1-3), and the resulting anxiety and insecurity, emerge at times during the treatment, principally in the latest sessions (when Emma decided to drop out of the treatment).

VTAS-R global index is low all through the treatment period, without substantial improvements.

Within-session examination of the therapeutic alliance

After the preliminary reading of the transcripts and the coding of VTAS-R global indices, we identified three sample sessions (5, 18, and 23) which seemed to be particularly interesting for the purpose of this study—i.e., which seemed to be representative of specific rupture styles (Table 2) or patterns of patient-therapist collaboration (Figure 3) in different stages of the treatment.

Session 5. This session was characterized by the absence of direct rupture markers from the patient, and by a low index of indirect ruptures. Therefore, the patient showed a great prevalence of collaborative processes of average intensity ($\mu = 1.56$). The therapist's positive interventions were quite consistent and varied as well. Nevertheless, the presence of a few negative interventions from the therapist is evident. Among negative interventions, the most frequent was NI5, indicating sudden changes of topic from the therapist, as in the following exchange:

P: I realized that I idealized him [her ex-boyfriend] a lot [...]; it's clear I was wrong to think of him this way. [...]

T: So you were feeling disappointed at that moment, and

Table 2. CIS scores for sessions 5, 18, and 23

CIS item	Presence (Intensity)		
	Session 5	Session 18	Session 23
DRM1: Patient does not agree with therapist about therapy tasks or goals	–	–	–
DRM2: Patient criticizes therapist as a person or for his/her competence	–	–	–
DRM3: Patient strongly refuses a therapist intervention or feels uncomfortable	–	1 (2)	7 (10)
DRM4: Patient complains about lack of progress	–	–	–
DRM5: Patient doubts about current session	–	–	–
DRM6: Patient has doubts about being in therapy	–	–	–
DRM7: Patient complains about parameters of therapy (e.g., session time, fee)	–	–	–
DRM8: Patient has doubts about feeling better	–	–	–
DRM9: Patient is sarcastic toward therapist	–	–	1 (1)
IRM1: Patient talks in wordy manner and/or talks about other people and their doings [...]	–	–	–
IRM2: Patient changes topic or tangentially responds to therapist intervention	–	2 (2)	–
IRM3: Patient gives short answer to therapist open question		3 (6)	2 (2)
IRM4: Patient denies evident feeling state (e.g., anger, fear, shame)	1 (1)	5 (9)	2 (3)
IRM5: Patient intellectualizes his/her inner experience	1 (1)	–	1 (1)
IRM6: Patient alludes to negative sentiments or concerns about therapeutic relationship	–	–	–
IRM7: Patient interacts in a acquiescent manner	–	–	–
IRM8: Patient uses self-enhancing strategies or self-justifying statements	–	–	1 (1)
IRM9: Patient is self-critical or self-blaming	–	–	–
CP1: Patient talks about new significant fact, introduces a topic or elements within a topic	9 (14)	10 (12)	9 (13)
CP2: Patient talks about his/her feeling and/or thoughts [...]	12 (18)	9 (11)	16 (23)
CP3: Patient talks about meaning of events or connects topic to a topic or to a schema, etc.	3 (6)	5 (8)	2 (4)
PI1: Therapist focuses on the here and now of the relationship	–	–	–
PI2: Therapist explores different patient states	4 (5)	7 (9)	3 (3)
PI3: Therapist provides feedback to the patient	5 (8)	1 (2)	7 (9)
PI4: Therapist suggests a patient emotion	5 (6)	4 (5)	4 (7)
PI5: Therapist believes that patient is indirectly talking about relationship	–	–	–
PI6: Therapist furnishes empathic support to patient		2 (3)	5 (5)
PI7: Therapist makes a clarification	4 (5)	4 (4)	8 (10)
PI8: Therapist makes a confrontation	–	–	–
PI9: Therapist admits his/her participation in rupture process	–	–	–
PI10: Therapist self-discloses countertransference feelings	–	1 (1)	–
PI11: Therapist explains or redefines tasks/goals of therapy	–	1 (1)	–
PI12: Therapist makes an interpretation	–	–	–
NI1: Therapist seems to impose his/her worldview or gives unwanted advice	–	1 (1)	1 (1)
NI2: Therapist seems to compete with patient	–	–	–
NI3: Therapist seems to press patient on specific topic	–	5 (6)	2 (3)
NI4: Therapist seems doubtful about strategies	–	–	–
NI5: Therapist changes offhand topic	6 (10)	1 (1)	5 (7)
NI6: Therapist intellectualizes or is not focused on patient experience	1 (2)	3 (6)	1 (2)
NI7: Therapist talks in technical jargon	–	–	–
NI8: Therapist is hostile	–	–	–
IDR	0	0.55	2.63
IIR	0.74	4.72	1.67
ICP	14.44	9.17	9.73
IPI	10.34	8.59	9.50
INI	4.43	3.89	3.08

Note. CIS = Collaborative Interactions Scale; DRM = direct rupture marker; IDR = index of direct ruptures; IRM = direct rupture marker; IIR = index of indirect ruptures; CP = collaborative process; ICP = index of collaborative processes; PI = positive intervention; IPI = index of positive interventions; NI = negative intervention; INI = index of negative interventions. Global indexes (IDR, IIR, ICP, IPI, and INI) range from 0 to 30.

what did you do?

P: I needed to tell someone I was disappointed, so I texted all my friends asking if I could call them [...] Then this morning a friend of mine called me, he was out yesterday when I texted him, and he asked me what had happened. And so in this difficult time in my life I shared something. I was happy to talk with someone [...] because I was home alone.

T: And who was the first person you called from your friend list?

This type of patient-therapist interaction is found in many moments of the treatment. The patient often introduced topics of intense emotional impact, which the therapist did not explore appropriately. In fact, the therapist, despite staying on the same argument anyway, tended to shift the attention from the emotional field to more practical aspects.

As shown in Figure 3, the trend of the collaboration levels is broken with a series of ruptures, which are initially connected to therapists' interventions (point 13). Specifically, it is possible to see how, after a common rupture (17), a positive intervention from the therapist takes place. Despite not being initially captured (19), it provokes a collaborative intervention of the patient in the subsequent exchange (21, 22, 23). However, this intervention is not followed by an appropriate response from the therapist, who makes negative interventions.

Session 18. In this session, the quality of the therapeutic alliance considerably decreased compared to the previous phase of the treatment. One DRM emerged, and IRMs registered a substantial increase, with a prevalence of IRM4s, which refer to patient's mechanisms of negation of emotional states. Compared to session 5, also the patient's collaboration level decreased, although Emma's attitude remained moderately collaborative. On the other hand, the therapist's positive and negative interventions remained almost unvaried, showing similar or slightly lower levels. Therapist's negative interventions nevertheless underwent a qualitative change: While initially focused on N15, they became more heterogeneous. This aspect can be interpreted as a worsening of the global alliance because negative interventions are not referred to a single area anymore, but begin to cover different fields. On several occasions the therapist's interventions assume in fact an inquiring rather than explorative attitude, as in the following example:

T: And in your opinion, why does this happen?
P: I don't know.
T: Because he doesn't trust you?
P: No, I don't think so. He said it is not for this reason.
T: And so, how do you regard your father's attitude?
P: Maybe he is testing me to see if my love is selfless. [...]
T: But is it a topic that you spontaneously discuss?

It is clear that it is particularly difficult for both patient and therapist to maintain a collaborative communication in this session. Matching points between their collaboration processes are intermittent (3, 9-12, 15, 23, 24, 28, 31, 32, 36) and have short duration. Initially the patient kept up a moderately collaborative attitude, but the therapist's negative interventions discouraged the patient's efforts. In this way, the therapist caused a disruption (8) that was not repaired later in the session. In particular, in the following exchange regarding her foster father, there was a culminating moment where the opposite points of view of Emma
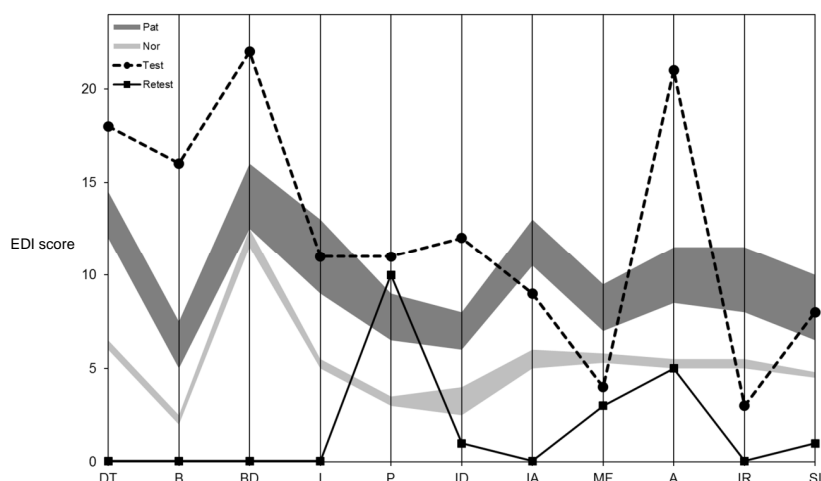

Figure 1. Emma's Eating Disorder Inventory-2 profile before treatment (test), and after six months (re-test). Pat = Eating disorder patient group (normative clinical sample); Nor = Female college group (normative non-clinical sample); Test = Emma's scores before treatment; Retest = Emma's scores at the six-month retest. DT = drive for thinness; B: bulimia; BD = body dissatisfaction; I = ineffectiveness; P = perfectionism; ID = interpersonal distrust; IA = interceptive awareness; MF = maturity fears; A = asceticism; IR = impulse regulation; SI = social insecurity.

and the therapist clashed irreparably:

P: The less I know about his affairs the happier I am.
T: But why don't you want to know? [...]
P: Why should I know about all that? About his affairs?
T: But why shouldn't you know? I mean, it is normal in a family to talk about these topics, isn't it?
P: I don't know. It's all the same to me, it makes no difference.

Session 23. A crucial aspect concerning this session is the presence of a considerable number of DRM3s, which represent the situation when the patient firmly rejects an intervention or feels inconsolable:

T: You are undoubtedly a very strong girl also considering your age, you are mature. Nevertheless, even if you are and are seen to be strong by others [...] this doesn't mean that you have no needs, and so, in those moments where these needs are not satisfied, some vulnerable areas come out. Undoubtedly, [...] you don't want to fall into certain vicious circles again, and you are more confident about your personal resources [...]. You miss a sense of security from your family, but you know that nevertheless you are surrounded by love and warmth. Are you certain of this?
P: Theoretically yes.
T: Maybe not 100% certain.
P: No.

The presence of DRM3 marker indicates that the patient does not take into account the therapist's point of view any longer, and maintains her conviction about the origins of her problems and possible solutions. In contrast with the increasing DRMs score, indirect rupture markers and negative interventions actually decreased (IIR = 1.67 vs. 4.72).

With regard to the collaboration levels, it proves more and more difficult for both therapist and patient to modulate and adapt their way of communicating. Collaborative exchanges decreased even further (5-6, 15-16, 30-35), indicating the difficulty for the patient to benefit from the interaction. Alliance ruptures came one after the other, from both patient and therapist, and were not repaired, as illustrated in the following exchange:
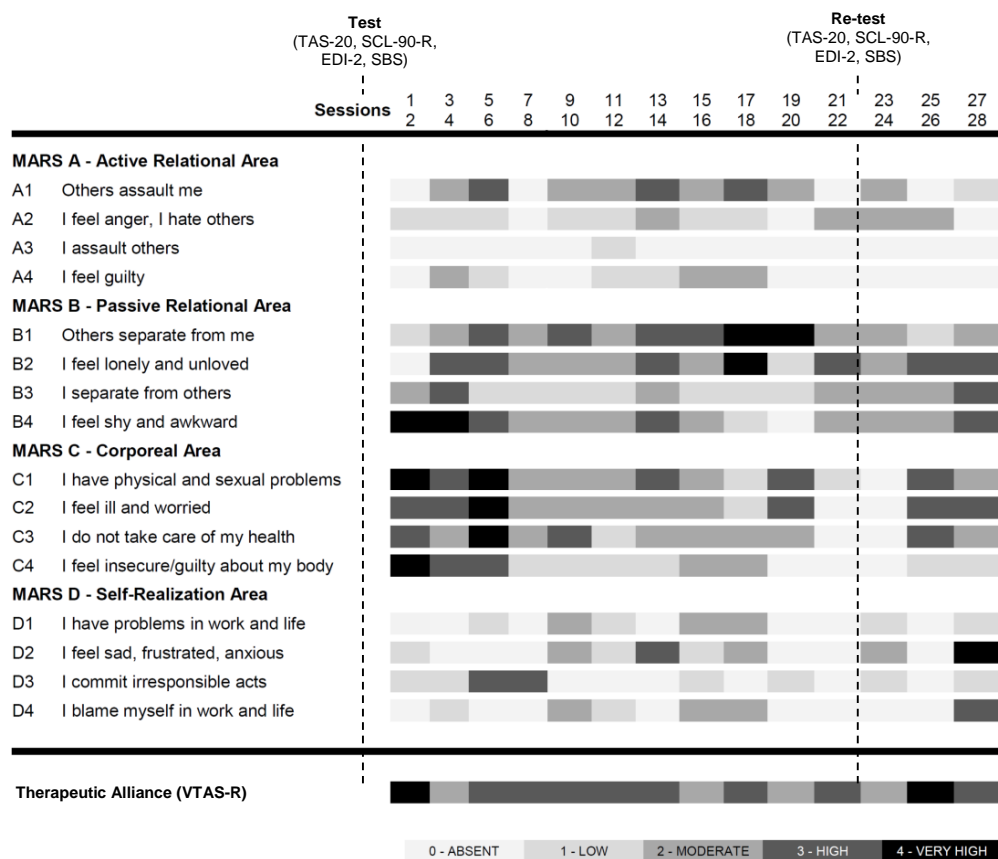

Figure 2. Session-by-session representation of Emma's motivational areas and therapeutic alliance. The graph illustrates the evolution of MARS areas and therapeutic alliance (VTAS-R global index), for 2-session blocks. The more problematic and unbalanced an area is, the darker it is. MARS levels (from white 0 to black 4): 0 = Problem not present or detectable; 1 = Recurrent but not intense problem, or intense but not recurrent problem; 3 = Very intense problem, or intense and recurrent problem; 4 = Intense and persistent problem that dominates patient's thoughts and behavior, or several intense problems belonging to the same category. Therapeutic alliance levels (from white 0 to black 4): 0 = very high alliance (VTAS-R = 21-25); 1 = high (16-20); 2 = medium (11-15); 3 = low (6-10); 4 = very low (0-5).

P: So, you would like me to improve this relationship [with her foster father]
T: At least you should try to change it
P: I don't think it's possible
T: So at the moment you think that going away is the best way [...]
P: Yes, I do. [...] I would like to be more independent, I think our relationship would be better, I don't want to be constrained because...
T: And what are you going to do about your mother?

This passage is particularly relevant: We observe how the therapist's interventions become progressively less adequate and synchronized. Now, patient and therapist move on two different levels of communication, with low chances of meeting one another.

Discussion

This study adopted a single-case, observer-rating approach in order to examine the role of process variables—particularly therapeutic alliance and alliance ruptures—in the dropout from outpatient CBT for EDs. As outlined previously, we assumed that, in the case discussed in this study, the patient's functioning and the therapeutic alliance would not improve during the treatment. Furthermore, we assumed that the patient-therapist collaboration levels and the rupture indices would show no improvement throughout the treat-

ment, indicating precipitating ruptures, mostly related to the therapist's failure to pay attention to tensions in the alliance or to the patient's subjective experience. Although further work is required to gain a more complete understanding of process-based factors involved in dropout from ED treatment, the results support our hypotheses, showing persistent impairment in multiple domains of the patient's life, and several serious ruptures in the patient-therapist relationship. These findings are in contrast with the fact that the patient reported impressive improvements in all self-reported measures. We may explain this discrepancy by hypothesizing that the patient wants to give a positive, agreeable and socially desirable image of herself (as suggested by the lie control scale), or in terms of the deep ambivalence towards the change that characterizes ED patients (Vitousek, Watson, & Wilson, 1998). A detailed examination of the patient's functioning areas during the treatment period shows a pervasive presence, at all stages of the treatment, of problematic areas concerning relationships, work and, obviously, her body. Issues of separation, hostility and withdrawal characterized the patient's functioning in her life and in her relationship with the therapist. The dysregulation of the corporeal area, as expected, was pervasive throughout the therapy. Anxiety and insecurity feelings also emerged, principally in the latest sessions, when the patient decided to drop out of the treatment.
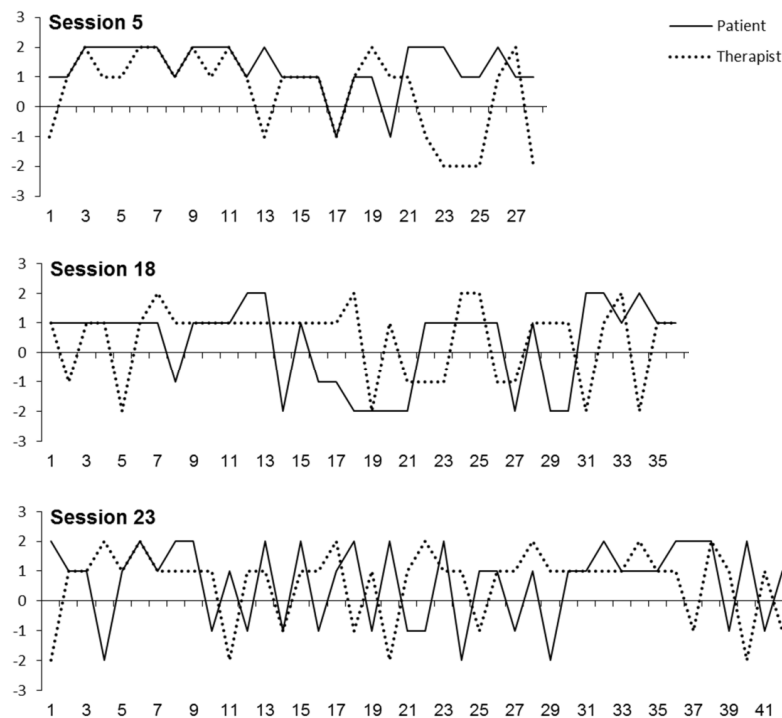

Figure 3. Graphical representation of patient-therapist VTAS-R collaboration levels; *x*-axis: therapist-patient utterances; *y*-axis: −3 = high rupture; −2 = mid rupture; −1 = low rupture; +1 = low collaboration; +2 = mid collaboration; +3 = high collaboration.

Our case study also supported the importance of patient-therapist relationship and therapeutic alliance in affecting the patient's engagement in the treatment. Overall, the patient-therapist collaboration was broken by a series of ruptures, giving the impression that their interaction became difficult, that comprehension and deep confidence that enable an effective communication were withering. Alliance ruptures came one after the other, from both patient and therapist, and were not repaired. In particular, the rising of DRMs in the later sessions can be interpreted as the result of a progressive fall in the patient's confidence in her possibility to receive concrete help from the therapist. The verbal exchanges where the patient no longer took take the therapist's point of view into account were increasingly frequent. In fact, apparently the patient maintained her conviction about the origins of her problems and possible solutions. By examining these late sessions, there are clear signs of the forthcoming dropout. However, the therapist was not able to realize this until the very moment when the patient decided unilaterally to interrupt the treatment prematurely, and therefore she just had to accept the fait accompli. This is consistent with Bergin and Garfield's (1994) definition of drop out as a premature interruption of the treatment, due to a unilateral decision of the patient that is not negotiated with the therapist. Although, after one year and three months, Emma returned to the therapist to "express gratitude for the work done," we should consider this fact in the light of the patient's high scores on the SBS "lie scale," which may be an indicator of social desirability (Procacci et al., 2002).

This difficulty of communication between patient and therapist is illustrated by the fact that every time the patient introduced topics of intense emotional impact, the therapist failed to explore these feelings more deeply, shifting the focus from the emotional field to concrete matters. This negative intervention recurred throughout the treatment, and did not allow the patient to value her own experience, and to know that her therapist knew how important this was for her. In line with previous research (e.g., Ackerman & Hilsenroth, 2001; Castonguay, Goldfried, Wiser, Raue, & Hughes, 1996), such ruptures may depend on the tendency for therapists to respond to strains in the relationship by persisting dogmatically with the application of a therapeutic technique rather than exploring the patient's difficult emotional experience and its impact. The risk that the therapeutic alliance may be overshadowed by techniques and protocols (Mahoney, 1991) is more pronounced for inexperienced clinicians, as in our case; however, the difficulty in managing one's own involvement in interpersonal conflict may be also present in skilled and highly-trained clinicians (Binder & Strupp, 1997).

Therefore, our findings support the argument outlined by Leahy (2008) that the quality of the relationship and the patient's perception of the therapeutic alliance are related to better outcomes and reduced dropout rates, and therefore should be considered as key factors in CBT at least as much as cognitive therapists' skills. Patients and clinicians should work together aiming at allowing the patient to become an active participant in the understanding of what is going on in the treatment. Failure to recognize rupture markers may result in the tendency for therapists to unintentionally exacerbate patients' distress or disappointment and not address significant problems; this may lead to premature treatment termination. On the contrary, resolving ruptures in the therapeutic relationship provides an often essential opportunity for using the relationship as a mean to modify cognitive and emotional problems (Aspland, Llewelyn, Hardy, Barkham, & Stiles, 2008; Katzow & Safran, 2007).

A first strength of this study is to explore, for the first time, *how* therapeutic alliance affects the course of CBT for EDs. We adopted an approach encompassing the whole therapy process; this allowed us to examine session-by-session the evolution of some fundamental changes and microchanges in the therapist-patient relationship and in the patient's functioning, which may affect his or her attitude toward the treatment. Our findings are valuable because process-based factors, such as rupture markers or collaboration levels, are arguably easier to address and modify than individual patient characteristics (Carter et al., 2012). It would be desirable for therapists to have a real-time assessment of these variables during their therapies, in order to flexibly modify their interventions, repair ruptures, and prevent dropout; however, in clinical practice, there is still a long way to go. Second, this study has the merit of using, along with standard test-retest self-reported assessment, independent observer ratings, so as to assume different perspectives on the therapeutic process. The importance of integrating patient and therapist measures with observer ratings is supported by a meta-analysis of 24 clinical studies including different therapies, showing that the effect size of alliance predicting outcome varied depending on the source of outcome report (i.e., client, therapist, or observer; Horvath & Symonds, 1991). It should be noted, moreover, that self-reports should be used cautiously with patients suffering from more serious disorders, because of the risk of biases and manipulation (e.g., patients who minimize or exaggerate their progresses to bring therapist's attention to their illness or to benefit from "secondary advantages"; Corcoran & Fischer, 2000). Therefore, our study emphasizes the usefulness of an integrated use of different process methodologies and perspectives.

The generalizability of this study is limited for several reasons. First, we adopted a single-case approach, and future research is needed to replicate these findings with different therapists, patients, and ED disorders. Second, previous research has indicated that process factors other than those identified in this study are likely to play a role in predicting treatment dropout. For example, the patient's "readiness to

change" may have an important role in dropout from ED treatment (Bewell & Carter, 2008). Other variables of interest are the emotional reactions and cognitions that both patients and psychotherapists experience towards each other; it would be interesting to examine these variables not only in the psychodynamic treatments focused on transference and countertransference, but also in CBT, especially for difficult patients (Prasko et al., 2010). Further research is required to identify the whole range of process variables that may influence patient's dropout from the treatment. A third limitation of this study is that the same two raters evaluated all the sessions with all the measures, creating a bias about the possible "contamination" of ratings. In order to solve this problem, future studies might also include a process analysis based on computerized methods (e.g., Lo Verde, Sarracino, & Vigorelli, 2012). Finally, we did not apply any measures of therapist treatment adherence: therefore, it is difficult to say if the therapist really provided this intervention in its correct form.

In conclusion, one strength of this study is to consider the "therapeutic relationship or alliance as an ongoing process, rather than an achievement that is fixed at one point in time, since the relationship is interactive and iterative, reflecting the patient's response to the therapist's response to the patient" (Leahy, 2008, p. 770). This approach combines a clinical interest to respond appropriately to changes within the patient, and a research interest to find support for the role of these changes in the patient's decision to drop out of the treatment.

Acknowledgements

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